Summer 2009

Imag(in)ing Neuro-Psychology: A Multi-Perspectival, Critical, Autoethnographic Study

Kristen Hennessy

Follow this and additional works at: https://dsc.duq.edu/etd

IMAG(IN)ING NEUROPSYCHOLOGY: A MULTI-PERSPECTIVAL, CRITICAL,

AUTOETHNOGRAPHIC STUDY

A Dissertation

Submitted to the McAnulty College and

Graduate College of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for

the degree of Doctor of Philosophy

By

Kristen Hennessy

August 2009

IMAG(IN)ING NEUROPSYCHOLOGY: A MULTI-PERSPECTIVAL, CRITICAL,

AUTOETHNOGRAPHIC STUDY

By

Kristen Hennessy

Approved April 23, 2009

_____
Leswin Laubscher, Ph.D.
Professor of Psychology
(Committee Chair)

_____
Paul Richer, Ph.D.
Professor of Psychology
(Committee Member)

_____
Michael Sipiora, Ph.D.
Professor of Psychology
(Committee Member)

_____
Ralph Pearson, Ph.D.
Provost /Academic Vice President and
Professor
McAnulty College and Graduate School
of Liberal Arts

_____
Daniel Burston, Ph.D.
Chair, Psychology Department
Professor of Psychology

ABSTRACT

IMAG(IN)ING NEUROPSYCHOLOGY: A MULTI-PERSPECTIVAL, CRITICAL,

AUTOETHNOGRAPHIC STUDY

By

Kristen Hennessy

August 2009

Dissertation supervised by Leswin Laubscher, Ph.D.

Neuropsychology in the United States emerged initially strove to diagnose brain damage. Recently, this diagnostic task has been largely usurped by the emergence of neuroimaging. Despite the encroachment upon the traditional territory of neuropsychology, neuropsychology has continued relatively unchanged. Personally encountering neuropsychology from the multiple positions of patient, family member, and training professional, I wondered about the forces operating that prevented neuropsychology from evolving. I speculated that unseen forces operated to keep neuropsychology stagnant and that the neuropsychologist's function was largely unarticulated. I further speculated that the hidden functions involved very particular (problematic) relationships. This dissertation aims to begin to highlight those hidden forces in the service of creating more liberatory performances of neuropsychology.

Using a multi-perspectival autoethnographic approach, and calling upon Judith Butler's (1999) notion of performativity, I set out to explore the constructed role of neuropsychologists and neuropsychology patients. After exploring the position and function of the neuropsychologist, I sought to imagine new, more liberatory, performances of neuropsychology. With Butler's (1999) performativity informing the way that I approach these questions, I turned to the experiences of my multiple selves on the neurobehavioral unit. I made use of the work of Foucault (1964, 1965, 1975) and Baudrillard (1995) in order to make sense of these experiences.

I discovered that the neuropsychologist was valorized in contrast to the patient, repeating a process similar to that outlined in Foucault's (1965) *Madness and civilization.* Further, I found that patients were stripped of the psychological and contextual, reminiscent of the living corpse characteristic of the anatomo-clinical phase in Foucault's (1974) *Birth of the clinic.* I realized that neuroimaging was exalted to a god-like status, promising to ensure order and certainty. These false promises parallel the hyperreal of Baudrillard's (1995) simulacra. Armed with this new understanding of the performances of neuropsychologists and their patients, I provide new performances – both fantasized and actual – that can offer hope to both neuropsychologist and neuropsychology patient.

TABLE OF CONTENTS

Introduction:

Stated in the briefest manner, this dissertation wants to tell a story about neuropsychology; what it says it does, and what it actually does, what it promises and what it delivers, the face it presents to the world and the face it hides, the potential and the pitfall, the desire and the disappointment. However, in telling this story, and seeking some response – if not answers – to questions evoked in, and by, the telling, I will also be telling my story. Put another way, in order to narrate neuropsychology, I am drawn to also narrating (parts of) myself. I have many selves in relationship to neuropsychology – I am a family member of a patient, I am a patient myself insofar as I display subtle symptoms, and I am a training neuropsychologist. These parts of myself, these selves I am called upon to perform, do not always coexist peacefully, understand or make sense to each other, and often conflictually struggle with the other, so to speak. It is precisely from the irruptive, disruptive, and questioning spaces – in and between the performativity of a self, my self – that I wish to situate the research story and research questions. It will be an autoethnographic story that wants to read how issues of disability are deployed – in theory and practice – within neuropsychology, how neuropsychology defines itself and its task against the threatening backdrop of neuroimaging, and if there are alternative ways to imagine neuropsychology among, across, and within the different voices of my self(ves).

Chapter 1: Imag(in)ing the Question:

This chapter explains my intentions and motivations for this project, exploring why I have chosen to question and deconstruct[1] the habitual performances of the neuropsychologist. I situate this project within the field of neuropsychology and my place(s) within that field. I trace both the history of neuropsychology and its involvement in my own life to show the path I traveled to arrive at this place of simultaneously questioning and valuing neuropsychology. Arguing that the constructed role and habitual performances of the neuropsychologist are facing an identity crisis of sorts in the face of technological changes, I suggest that this is an ideal time to reflect on the constructed identity of the neuropsychologist and to begin to re-imagine the performance of neuropsychology and the neuropsychologist. I further relate this crisis of identity within a broad professional field to my own identity crises in relationship to the constructed role of the neuropsychologist.

Personal Motivations:

Snapshot:

My big brother, aged five, is riding his blue big-boy bike with training wheels alongside my mother who pushes me in my stroller. I am almost three. We are on the way to the swimming pool, and I'm wearing my big, white, plastic sunglasses. Suddenly,

---

[1] Already, I must question my choice of language. One might ask what it means to "do a deconstruction." In one sense, my methodology section provides a satisfactory answer as to what it means, for this project, to "do deconstruction." Yet, in another sense, it is entirely incoherent to suggest that one can "do deconstruction." Deconstuction is not stagnant. It is absurd to propose a methodology to deconstruction. Perhaps, then, it might be best to say that the concept of deconstruction is in my mind as I set out to try to understand the constructed identity of neuropsychologists.

the stroller jolts to a halt and my mother starts screaming: "Matthew!! MATHEW!!!!" I

lean forward in the stroller and crane my head around. He's gone! My mother scares

me with her panic, but it's familiar. After a minute passes the silence is shattered by a

high-pitched scream emerging from the prickly bushes lining the sidewalk. My brother,

struggling more than other little boys to learn to ride a bike, has tumbled – bike and all –

through the bushes and down a hill. I am unfazed by this. He falls so often that, at age

three, I assume all little boys have to soak their knees at night to coax out embedded

pebbles[2].

Growing Up:

My older brother has been 'quirky' all of his life. Since he was a little boy, he has

complained that the world 'didn't look right,' and that somehow things didn't 'come

together' for him. My parents took him to an ophthalmologist, who repeatedly insisted

that his vision was fine above my brother's insistence that indeed it was not. My brother

complained that sounds were 'different' for him than other people despite the

audiologist's assertion that his hearing was normal. He could not quite explain what he

meant, but was insistent. His hands shook all the time, but almost imperceptibly. He fell

off his bike so often that I was utterly immune to other kids in the neighborhood

scampering over to me and happily proclaiming: "Your brother's blood is all over the

sidewalk![3]" By the time he left for college, his situation seemed to deteriorate. By age

---

[2] My brother has had the opportunity to vet all personal references.

[3] This is written from my own childhood perspective, and focuses on what stood out to me as a child. Here, I describe my brother's perspective (reported to me via e-mail) on his difficulties and the impact that they have had on his life. My brother notes that he was not concerned about his childhood bumps and scrapes, but was worried about his performance in gym class. Despite being an active child, he always came in last or close to last as compared to his classmates in contests of strength, endurance, and flexibility. Upon reading a draft of this project, he recalled a class coach sneering: "Are you secluded or something?" Matt

twenty, he avoided taking the stairs outside of college classrooms, opting to wait alone

for the elevator instead. Attending a football game, he found himself forced to sit and

slide down the stairs to his seat.

Throughout our early years, I dismissed all of his 'quirks' just as I dismissed my

own. After all, my hands shake a bit, and my clumsiness reached such epic proportions

that friends suggested that I write a book about my awkward travails. (If memory serves,

this piece of advice came after I called for assistance subsequent to inadvertently

supergluing my hand to my own face.) I knew that my brother inhabited space

differently from many other people. I assumed that his differences were similar to mine.

It just seemed to me that our quirks involved clumsiness and a lack of spatial awareness.

I was fine with that. I spent my childhood in the library, not the playing field. Grace had

never been something to which I aspired. My mother – a nurse – took medication to

steady her hand tremor, but it had never worsened or seemed to impact either how she

was treated or what she was able to do. Besides, the changes in him seemed to happen so

slowly and subtly that I never really noticed. But when Matt went away to college, my

perception started to change. It seems both that his balance worsened and that my

perspective changed when I was no longer seeing him daily.

Snapshot:

Matt is home from college. His first morning home, I feel a knot in my stomach as

I watch him coming downstairs. He clutches the railing desperately with both hands.

---

also wonders if his neuropsychological problems have made his social life more difficult as he suspects that
he misses out on the many subtle auditory and visual cues so vital to social interaction. He describes a
friend telling him that he "stares" for too long and that he appears to find it difficult to switch from one
topic to another. (Matt seems to both accept his friend's assessment but also laughingly adds: "I prefer to
think that I'm merely deliberate, thoughtful, and reflective.")

His whole body shakes as he leans his weight onto his arms which are looped around the
railing before awkwardly jutting his right leg out and then slowly lowering his vibrating
body to the next stair. He slides his arms down a bit, and then repeats the process.
Several times, it appears as though he will fall. It hits me, suddenly, that this cannot be
'normal.'

The Diagnostic process:

A few more years went by as my brother and family repeatedly cycled through
fear, acceptance, and denial. Eventually, he went to his primary care doctor for a check-
up and was referred to a neurologist. That started a several-year long diagnostic process.
As Matt went to doctor after doctor, specialist after specialist, I made my way through
college. He and I lived in the same city, and we made a day out of his MRI. Waiting for
test results became a constant – stressful and exhausting – thrum in the background of our
daily lives.

It all seemed to come to a peak the spring that I graduated. In April, we awaited
news on two major events: the results of my brother's Huntington's Disease test, and the
fate of my application to a doctoral clinical psychology program. In quick succession, I
found out that Matt was not suffering from the fatal illness Huntington's Disease –
therefore neither was I! – and that I had been accepted. At this point, we knew that
Matt's cerebellum was deteriorating. We did not know exactly why but we knew that he
was getting worse[4]. That month, I was faced with questions of conflicting identities.

---

[4] Five years later, we still do not know what caused his cerebellum to deteriorate. Similarly, we do not
know the forces that have since allowed his condition to stabilize and even improve. The longer that he
stays in this less symptomatic condition, and the longer that I go without any worsening of my own
symptoms, the more confident I feel that this current trend will continue. I take the time to mention this in

First, I had to acknowledge that my brother would likely require care in the not-so-distant

future and that he could die within years. Secondly, I had to accept that I had some

symptoms myself and had no way of knowing if or when my own neuropsychological

status would change. My soon-to-be husband and I spent time mapping out my

preferences for care at a time that we were also mapping our preferences for our wedding.

I was entering the profession of psychology and thus adopting the position of

professional at the same time that I began to see my brother and myself as patients.

Snapshot:

I am lying on an exam table with electrodes secured to my scalp, my head

awkwardly resting on a pillow. My hair is coated with a thick goop and my scalp is sore

from the technician scrawling on it with a red pencil. She has just told me that I am

supposed to fall asleep. I am far from comfortable, but try to obey her, making my

breathing slow and deep. I start to feel a bit drowsy when I am startled by a loud

metallic crash. I bolt upright and discover the technician collapsed on the floor. I move

towards the door to get help when the room is swarmed by nurses. They scold me for

getting off the exam table and tell me to 'go back to sleep.' I am led by the arm back to

the table where I feel somewhat inhuman lying there trying to sleep as the technician is

cared for. I realize that, in this moment, I am seen as a patient and nothing else. It is

assumed that I cannot, will not, or should not contribute.

---

order to show that my family's relationship to disability is one that continues to transform. Further, this already highlights the complicated, ever-changing relationship to neuropsychology that I embody. The current position remains complex. Although Matt's situation has improved remarkably, he still struggles. For example, he recently "lost" his car after a football game, recalling vaguely where he had left it but unable to locate it in the dark.

Overlapping Roles:

I became intrigued by my overlapping roles. Simultaneously existing as professional, family member of patient, and patient came easily at times, such as when I convinced my MRI technician to label my MRI and give me one so that I could put it on the overhead when teaching introductory psychology, an act which felt simultaneously playful and subversive. At other times, I found myself feeling as though my self as professional was trying to oppress my self as patient or judging myself as family member. As I explored this further, I became increasingly interested in the subfield of neuropsychology.

I found that I had been deeply changed as a result of my family's contact with neurology and neuropsychology, with neurologists and neuropsychologists. I was both drawn towards it and repelled by it. In my experiences with neuropsychology, I had felt that I was encountering a "useful" profession as well as an agent of social control. I felt that the profession somehow had the potential to 'free' me in some way, while also threatening to define me in ways that I found almost annihilating and viscerally violating. I wanted to understand the roles, task, and duties of the neuropsychologist and to begin to understand the implications of all of this on patients. I was accepted into a 9-month long training program in neuropsychology and began to immerse myself in the literature, turning to it as an induction into the world of neuropsychology. Of course I already had a sense of what it was that the neuropsychologist did, or "was all about", having been on the receiving end of this service (as family member and patient). However, to be on the other side, so to speak, to *be* the neuropsychologist, was sure to provide a different kind of answer to the questions I had about neuropsychology's role, promise, tasks, practices,

and profession – in the sense of the etymological *profiteri,* a "public declaration" (or confession, really) of one's skill. The first signpost, gate, and academic expectation, then, was for me to peruse and internalize the literature for the first professional clues, for the canonical narrative, as to what neuropsychology was, and how it came to be.

The story of neuropsychology:

I discovered that the story of neuropsychology in the United States is a relatively new one, beginning in an inaugurative sense after World War I, when soldiers returned from the battlefield with brain injuries. Not altogether surprisingly, "The need for screening and diagnosis of brain injured and behaviorally disturbed servicemen during the First World War and for their rehabilitation afterward created large-scale demands for neuropsychology programs" (Lezak, 2004, p. 3). Neuropsychology consequently emerged as a way to diagnose the extent and approximate location of brain injury. Its function was diagnosis, with testing as the means with which to accomplish the diagnostic task. The historical purpose of clinical neuropsychology was primarily to assist in the diagnosis of brain pathology, and neuropsychological tests were the best available tool for this diagnostic task (Chaytor and Schmitter-Edgecombe, 2003).

These neuropsychological tests strove to correlate to the functioning of various parts of the brain. Obtaining the necessary information in order to understand the function of various parts of the brain and thus to create tests that were sensitive to each was a rather arduous task. Knowledge stemming from previous cases of brain damage was used to estimate where damage had occurred, and new cases served to further that understanding. A soldier returning from war with a known injury to the front of the

cerebral cortex - what would now be termed the temporal lobes - would undergo testing in order to document the psychological (inclusive of the cognitive, behavioral, and emotional) implications of such an injury. This information would be used in the future in order to estimate whether or not an individual with brain damage of an unknown location had frontal lobe damage, or to determine whether or not a specific injury impacted a specific location within the brain. Each test aimed to tap into a particular cognitive function. At this stage, neuropsychology was wedded to neurology, a point Stuss and Levine (2003, p. 403) make by noting that "the roots of neuropsychology lie in neurology and psychology with no real separation existing among these interests in the initial stages". In the beginning, neuropsychology was about the brain. It was a part of the medical (in this case, neurological) project, making use of psychological knowledge regarding behavior, emotion, perception and cognition in the service of answering neurological questions.

Because of neuropsychological assessment's aim of diagnosing brain disorders, there was little interest in unpacking the subtleties and variations of normal performance on neuropsychological tests. Rather, neuropsychologists were interested in locating an individual's performance in one of two categories: intact, or impaired. Was this patient experiencing brain damage or not? "In the early years of neuropsychological assessment, clinicians would have a sense of 'normal' performance, and anything below that indicated a pathological deficit" (Stuss and Levine, 2002, p. 403). Over time, as the field matured, this somewhat simplistic binary gave way to increased complexity. The stories told by neuropsychology became increasingly nuanced. In addition to diagnosing brain damage, neuropsychology became interested in articulating subtle variations across

8

'healthy'[5] individuals. Rather than simply placing individuals in one of two categories, neuropsychologists began to recognize a range of 'normal' performances on tests, and that even a person without 'brain disorder' will demonstrate areas of personal strength and weakness. Along with this recognition came a desire for standardized norms, interval scales of scoring, and the development of standardized batteries (Stuss and Levine, 2002). To that end, Halstead created the first neuropsychological testing battery to be used in the United States in 1947 (Lewis and Sinnett, 1987). Neuropsychologists became interested in comparing individual patients to others, looking to locate the individual's performance in relation to that individual's peers. It is this, standardized and normed, form of clinical neuropsychology that is currently dominating the field in the United States.

It is important to note that this brief narrative of neuropsychology has been limited to the United States. Neuropsychology's trajectory differed (sometimes vastly) in other countries. In Russia, for example, Luria's approach demonstrates a neuropsychological emphasis that is much more problem-oriented, clinical, and individualized (Stuss and Levine, 2002). Unlike much of the neuropsychological work in the United States, Luria's work attempts to account for – rather than *control* for – context.

> He [Luria] was not as interested in the outcome of the patient's performance as in the means the patient used to solve the problem; he recognized that the patient could give the correct answer or solution even when employing an abnormal or atypical mode of problem solving.   (Lewis and Sinnett, 1987, p. 127).

---

[5] I use quotes around the term 'healthy' as I intend to problematize simplistic distinctions between health and illness.

This case-study approach emphasized the particularities of each individual case on its own terms, rather than the emphasis on norms that emerged in the United States. Neuropsychology in Australia, too, differs from that of the United States in its use of a "process approach" which pays more attention to the way in which a person obtains his or her score than to the score itself (Stuss and Levine, 2002). And, while these approaches avoid some of the pitfalls of the approach in the United States that my project strives to address, they are not altogether immune to critique, especially from the disability rights movement, even as these approaches may at first glance appear more liberating than that of the United States.

The Ascension of Neuroimaging:

My immersion in the literature began to point to a rupture (or rumors of one) that occurred with the emergence of neuroimaging. Until the introduction of neuroimaging into the medical profession, the function of neuropsychology was fairly straightforward, although by no means simple. It strove to diagnose, and it did so through the use of neuropsychological tests. The very emphasis on diagnosis, of course, concedes a value and assumption that has been both valorized and reviled, critiqued and praised. Nevertheless, prior to the introduction of neuroimaging, the subfield of neuropsychology had a certain internal coherence; its intention – if not its *raison d'être* - was a diagnostic one. It did not do this perfectly, but, given the assumption that diagnosis was a valuable aim, it was the best available option for the task. The classic, almost axiomatic, distinction was consequently between the neuropsychologist who used his or her test batteries to confirm a diagnostic suspicion from the neurologist, or to alert the neurologist

to a diagnosis in referral, whereafter the treatment (for example neurosurgery and/or medication) and management fell under the primary purview of the neurologist.

With the advent of neuroimaging, however, this comfortable clarity seemed threatened. Simply stated, neuroimaging includes various technologies that can produce images – structural, functional, or both – of the brain. Computerized Tomography imaging emerged in the 1970's, followed by Positron Emission Tomography (PET) and Magnetic Resonance Imaging (MRI) in the early 1980's (Macapinlac, 2006). Neuroimaging can non-invasively explore both the structure and function of the brain, quickly highlighting areas of concern and arriving at what is believed to be a more definitive diagnosis.

> Neuroimaging in the form of computed tomography (CT), positron emission tomography (PET), single photon emission computed tomography (SPECT), magnetic resonance imaging (MRI), and functional magnetic resonance imaging (fMRI) can reveal the neurobiological bases of both normal mental activity and various psychopathologies. Brain scans may detect early signs of neurological and psychiatric disorders well before their characteristic symptoms appear. (Glannon, 2006, p. 37/38)

The primary function of such technology is diagnosis, and is used to confirm what other forms of assessment have hinted towards. "The main purpose of CT, PET, SPECT, MRI, and fMRI scans in medicine has been and will continue to be to confirm a diagnosis based on behavioral symptoms and established clinical criteria" (Glannon, 2006, p. 38). Neuroimaging is used in order to confirm what has been suspected due to other clinical criteria. By the same token, however, it is entirely possible to envisage a (perhaps not too

11

distant) future where neuroimaging becomes a routine part of visits to a medical practitioner, such that a diagnosis can be made long before any corollary symptoms or suspicions emerge (it may even be possible, inasmuch as we're dreaming a future to make a theoretical point, to purchase a head covering of some electronic sort, for example, at the local pharmacy – with the same ease one does blood pressure machines – which can be hooked up to our home computers, and provide an image of brain activity, providing a self-diagnostic function not unlike pricking one's finger at home to get an effective, almost immediate, and efficient reading of blood-sugar levels)[6].

Indeed, neuroimaging is efficient, and frequently more definitive than neuropsychological testing. (For example, where neuropsychological testing can possibly determine that one is having a problem in one's temporal lobes, neuroimaging can diagnose a tumor, providing the specifications of its size and location.) Neuroimaging seemed able to accomplish the diagnostic task previously under the domain of neuropsychology, but with increased speed and heightened accuracy. It, like neuropsychology, has the potential to predict future deficits. It is much more efficient and precise – albeit more expensive – to use Magnetic Resonance Imaging to diagnose the presence and location of a brain lesion than it is to use a battery of neuropsychological tests to do the same. "In contrast with the exquisite resolving power of the new imaging techniques, neuropsychological testing appears as a rather inefficient, ponderous, and generally less accurate means of tracking down neurological events" (Heinrichs, 1990, p. 172). None of this is to suggest that neuroimaging is infallible or

---

[6] Although brain scans are far from part of a routine physical, a small industry of 'preventative' diagnostic scanning has emerged. These are marketed to individuals without health problems who are interested in detecting problems before symptoms have started. Several can be found on the internet, such as:
http://www.scandirectory.com/content/brain_scan.asp
http://www.thecenterforpreventivemedicine.com/Resources/Glossary.aspx

even all that unique. In terms of the broader project of medical technology,

neuroimaging is one of a multitude of new technologies. It is reasonable to assume that

it, too, shall soon be obsolete. What brings it to the forefront of my narrative is its

encroachment on the territory of neuropsychology.

The implication of neuorimaging is that, other than a few disease processes that

are not believed to show themselves via neuroimaging, neuropsychology is no longer the

diagnostic tool of choice. The largest remaining category of disorders that are diagnosed

via neuropsychological testing is the so-called learning disabilities (Brambati et al.,

2006).   Of course, there is a much disputed, and vigorously contested assumption here,

namely that learning disabilities represent brain dysfunction in the first place (Rourke,

2005).   Despite the existence of a few remaining diagnostic projects for

neuropsychology, neuroimaging has all but taken over the task of diagnosis.

None of this is to imply that neuroimaging provides a perfect, infallible answer to

questions of diagnosis. It is indeed quite helpful in locating lesions and masses in the

brain. And yet, the discovery that particular patterns of lesions correspond to particular

neurological disorders does little to explain why those changes in the brain are taking

place, even on a basic biological level (of course, neither does neuropsychology).

Indeed, the brain remains more mysterious than anything else. Butler and Bennett (2003)

make this point in terms of multiple sclerosis – despite neuroimaging, the process behind

multiple sclerosis and the mechanisms propelling the disease process remain largely

mysterious.   Semrud-Clikeman (2005) similarly point to the confusion regarding the

neurological mechanisms – if there are any – fueling learning disabilities. Although

neuro-imaging is far from perfect, it certainly has taken over a great deal of the diagnostic task that had been the domain of neuropsychology.

Disputed Territory:

The introduction of neuroimaging represents an encroachment of neuroscience on what had previously been the domain of neuropsychology. Neuropsychology is interested in the brain as it pertains to behavior (Lezak, 2004). It is true that there is a sense in which neuroscience (which includes neuroimaging) is interested in the brain for the sake of understanding the brain. One could then say that the goals and aims of neuroimagining and neuropsychology overlap, but also differ inasmuch as neuropsychology emphasizes the behavioral consequences of different brain states while neuroscience emphasizes those brain states in themselves. Such an argument, however, is rapidly starting to point to structural neuroimaging, as it has become known, as against another, burgeoning field of functional neuroimaging. This latter interest is crucial to brain-computer interfaces, and it follows quite logically that if one is to design a neuroprosthetic – say a computer chip to stimulate and sequence coordinated movement in a certain body part – that the behavioral correlate to the brain state become as integral and finely tuned part of the neuroscientific database as the structure of the brain.

The long and short of the story remains that a central, defining core to neuroscientific practice is threatened, and the intuitive response is to wonder to what end and extent neuropsychology risks marginalization! The technology of neuroscience – such as neuroimaging – captures the actual functioning of the brain in a way that neuropsychology simply does not. When this is seen as a value in itself, the utility of

neuropsychology fades. The border between neuroscience and neuropsychology has been somewhat fuzzy prior to this, with neuropsychology existing largely across the boundary. Neuropsychology had previously been used in the service of neuroscience, using its knowledge of the relationship between behavior and brain states. However, as neuroscience is increasingly answering its own questions – however imperfectly – neuropsychology's role as diagnostician has been usurped. Although both can be justly accused of reductionism, neurosciences see the answers to questions regarding humanity as resting in the brain in a way that neuropsychology does not necessarily. Neuroimaging provides a literal view into the brain, and neuroscience sees this literal sight as more valuable than other forms of knowledge or illumination. (It should be noted that there are certainly subsets of neuroscientists who are not at all interested in this reductionism. However, a majority of neuroscientists do see it as providing a definitive answer, and whose views have emerged to question the neuropsychological role and métier.)

The Impact of Neuroimaging on Neuropsychology:

The advent of neuroimaging seemed to have led to a shift in neuropsychology's emphasis away from diagnosis towards questions more directly related to the ability of patients to function. Stated differently, neuropsychology attempted to respond to neuroimaging's encroachment on the territory of diagnosis of injury to the brain by beginning to focus on addressing a different kind of question. Chaytor and Schmitter-Edgecombe (2003) note that neuropsychological referrals increasingly stem from courts, schools, employers, and insurance companies, whereas referrals had previously predominantly stemmed from other medical professionals. The neuropsychologist, on the

15

basis of these referral sources and expectations, is asked to answer different questions, ones that "… are moving away from diagnostic questions to questions about the client's everyday cognitive abilities and disabilities…" (Chaytor and Schmitter-Edgecome, 2003, p. 182). In the courts, for example, the neuropsychologist may be asked to determine whether or not a defendant is competent to stand trial (Denny and Wynkoop, 2000). Even the medical referrals that do remain, primarily focus on the neuropsychologist's assessment of a patient's level of functioning and the practical implications of that functioning[7]. "For many patients who are known to have brain lesions that are not immediately life threatening or grossly incapacitating, the major clinical questions concern living arrangements, employability, prospects for rehabilitation, and the need for specific environmental supports" (Heaton and Pendleton, 1981, p. 807).

Effectively, then, the neuropsychologist's expertise and professional power are different from before, having become a (different kind of) gatekeeper of sorts, making recommendations about what kinds of freedoms a particular person should have as well as making judgments about moral culpability. Foucault's (1974) *Discipline and punish,* reminds us that psychologists have long been involved in exercises of power. Of course, neuropsychologists' historical involvement with diagnosis points to a particular kind of power that they have exercised all along. This is not to say that neuropsychologists have not had power prior to the advent of neuroimaging. Rather, the question is whether the emergence of neuroimaging has caused neuropsychology to enact that power differently, shifting away from an exercise of power relating to diagnosis, to a kind of power that is more overtly connecting to the regulation of patients' daily activities. I further speculate

---

[7] Indeed, even these new questions continue to change as increasingly "functional" neuroimaging technology emerges. Thus, neuroimaging is itself moving beyond the medical domain into other areas, such as business and the courtroom.

that this shift may cause an at least temporary rupture that can offer a unique glimpse of this power; put another way, when so called organic crises occur that powerfully threaten or actually destroy previous ways of organizing events or meaning, there arises a clearer pantheon of ideas and ideologies all proposing to stabilize meaning in a new, or different manner, all the more visible now because of the rupture or crisis.

Neuropsychologists have acknowledged that the shift to neuroimaging has implications for the field. "Questions regarding employability, competence, and skill acquisition are being asked, and neuropsychologists are attempting to answer these questions" (Heinrich, 1990, p. 171). Some have questioned whether or not neuropsychology is suited to answer these new questions. "Unfortunately, there are grounds for believing that neuropsychological assessment, as it is currently practiced with batteries of tests focused on neurodiagnosis, is not well equipped to fulfill its expanding role" (p. 171). Neuropsychology marches on, but without strong definition or a clear mission. In fact, it seems that beyond the articulated acknowledgment that as neuropsychologists, "we" have to consider the impact of neuroimaging, there is a hesitancy to do so – there is, it seems, altogether a surprising silence in general. Professional crises, one assumes, evokes a spirited response – either in fighting for survival or markedly changing what one is about; historical examples abound, from the professions of the iceman to the typist, under the technological threat of the refrigerator and the computer. Yet, the intuitive prediction of a field that either withers away or evolves dramatically does not seem to be the case in neuropsychology. Surprisingly, many neuropsychologists continue to behave exactly as their predecessors did, continuing the same procedures, but with seemingly different – perhaps unclear – aims. Although

there have been attempts to respond to the demands of the changing field, none of these have incorporated a radical re-evaluation of the purpose or means of the neuropsychological project. The field has yet to truly respond to this turn of events. This surprising turn begins to point to an interesting question: Why has the field not evolved? What has prevented that evolution?

It is also here that a moral weight begins to compound the project of studying the identity and performances of neuropsychologists. The neuropsychologist is no longer simply asking questions of diagnosis, but is making decisions with a different kind of power. Again, it is not that neuropsychologists did not have power before this, but rather that the way in which they exercise that power has shifted. Indeed, it seems that neuropsychology's lack of evolution in response to these dramatic changes serves to highlight the power of the neuropsychologist. Plainly stated, the fact that the neuropsychologist has not evolved suggests that one of its functions – perhaps a hidden function – continues to operate under these new conditions and thus prevents the need for evolution.

*Current Definitions***:**

I wanted to be sure(r) though; I wanted to hear from an authority what neuropsychology was about, so I turned to Lezak, Howieson, and Loring's (2004) introductory section of *Neuropsychological Assessment, Fourth Edition*. Lezak's text is a canonical one, immensely important to the field, and commonly considered to be the ultimate authority on neuropsychology in the United States. Thus, even when Lezak's definitions contradict those of individual members and sub organizations in the field, her

work can be read as a recognized authority on the current and/or reigning neuropsychological views.

Lezak's (2004) characterization of neuropsychology –the stage directions that she supplies for fledgling neuropsychologists –is one in which the dysfunctional brain and behavioral expressions of that dysfunction comprises that which is of interest to the neuropsychologist. "Clinical neuropsychology is an applied science concerned with the behavioral expression of brain dysfunction" (Lezak, Howieson, and Loring, p. 3). In such a formulation, the brain itself is the subject of neuropsychological investigations, with the owner of that brain treated almost as an incidental third party. The brain is regarded as separate from the subject – almost lacking subjectivity – and is regarded as its own entity. I find such a distinction inherently problematic – the brain does not own the subject, nor does the subject own the brain. Of course, at this stage – on the academic stage – one may rightly wonder which one of my voices (patient, caregiver, neuropsychology student) voices the objection. But perhaps the question is as interconnected as the argument about subject and brain that may not be "two" at all! To conceptualize the brain as separate from the subject is dangerous, as a body part stripped of subjectivity loses the subject's demand for respect. And thus, each of my selves has reasons to be frightened by the imposition of this false separation.

Lezak (2004) further declares that neuropsychologists are interested in the "neural foundations of behavior" (p. 4.). Subcategories of the brain, rather than the brain as totality, are of interest to neuropsychologists. The quest to explore these neural foundations takes on the flavor of the neuropsychologist as detective – s/he is to seek out new relationships between the brain and behavior while at the same time teasing out

19

confounding variables, and negotiating his or her way through the ruse and subterfuge of neurological and subjective anomaly. The aura of mystery is palpable as Lezak describes "…the possibility of new insights into the workings of the brain and the excitement of discovery" (p. 4). The neuropsychologist has embarked on a quest of discovery in the small units of the brain.

As Lezak's (2004) introduction continues, neuropsychology's need to shift in response to the advent of neuroimaging becomes apparent. She notes that neuropsychologists seek to detect difficulties that are not captured via brain imaging technology, trying to distinguish between neurological and psychological disorders (Lezak, Howieson, and Loring, 2004, p. 5). Although this is phrased in the positive sense, it in fact marks the drawing of new, restrictive boundaries. Without more explicitly addressing these new limitations, Lezak instead elaborates on those tasks of neuropsychology that go beyond the diagnostic question. These tasks include the screening of those deemed 'at risk' for developing various neuropsychological disorders as well as testifying in court cases regarding the neuropsychological status of those involved with the court system. For example, the neuropsychologist is asked to declare whether or not an individual has neurological impairments, whether those impairments could have contributed to the commission of a crime, and whether or not the patient is likely to be able to be rehabilitated. Here, the project of neuropsychology shifts from one of diagnosis, to screening, and then on to legal contexts. These shifts, although quietly noted, have immense implications. As the neuropsychologist shifts from diagnosing disorders to predicting future 'abnormalities', and then on to legal contexts, the neuropsychologist potentially runs the risk of becoming increasingly engaged in a

policing role, enforcing some or other conception of the normal, normative, usual, or even status quo – all terms that are not entirely unproblematic in themselves.

The first of these shifts – moving from diagnosis to screening – may initially appear benign, perhaps even signifying an admirable advance in the profession of neuropsychology. While this statement is not entirely without merit, there are potentially disturbing consequences stemming from this perceived ability to predict future disorder. This debate is quite similar to that regarding genetic testing. On the one hand, there are those who would be glad to know ahead of time that they will – supposedly – be coping with a neuropsychological condition in the future. There are, however, others who do not wish to have this knowledge. As this "knowledge" becomes increasingly standardized, the power of the individual to opt out of this knowledge is stripped away. For example, it is foreseeable that health or life insurance companies may demand to see this information before agreeing to insure a given individual. A given individual is forced to comply with this technology or to go without health insurance entirely. Thus, issues of control – indeed eugenics – emerge. Should the discovery of the likelihood of future problems prevent one from working or receiving education? Should employers be able to mandate neuropsychological testing for those employees who are not exhibiting obvious symptoms of neuropsychological distress? Should insurance companies utilize this as a screening measure in order to assess a patient's risk level for future problems? These questions are further complicated by the argument made by ecological neuropsychology – that performance on neuropsychological testing measures does not necessarily correlate to an individual's ability to navigate his or her daily life (both ecological neuropsychology and the important argument noted here are developed in greater length

21

elsewhere). As such, using neuropsychological testing instruments as a means of predicting who will exhibit problems in the future is problematic both because it is inherently flawed and because it stigmatizes those who are identified as possibly developing neurological problems in the future. The argument, however, may very well be moot in very short measure if the imaginary (but not fantastical) example I made earlier comes to be – namely, that neuroimaging technologies become cheaper (than neuropsychological test batteries and consultations) and more readily accessible (say from one's desktop computer). In this scenario, even screening is a function neuropsychologists may well lose in due course.

In addition, however, such attempts show a definite shift away from patient care and a corresponding shift to the concerns of the market. Perhaps the overt message is one of care, but the underlying message is one of regulation and control. The hypothetical scenario in which an insurance company demands screening as a precondition to providing insurance shows a clear shift from medical to economic concerns. The shift to pre-screening involves a shift away form the concerns of the individual being tested. A regulatory function appears as well. When neuropsychology enters the courtroom, its regulatory function becomes explicit. The assumption behind permitting its entrance is that neuropsychological testing can accurately predict past and future behavior. In this manner, the neuropsychologist becomes a gatekeeper, making judgments about a person's abilities and their culpability in the commission of crimes. Here, neuropsychology has ventured far from its original function. The person to whom it is responsible has shifted.

Neuropsychology also contributes to planning care for patients. Lezak (2004) describes this duty of the neuropsychologist as of a "descriptive" quality (Lezak, Howieson, and Loring, 2004, p. 6). Using neuropsychological testing instruments, neuropsychologists evaluate such qualities as "judgment" (p. 6). In this lies the assumption that judgment can be objectively evaluated by an outside source. It is assumed that the neuropsychologist can recognize good judgment when she sees it, that "judgment" can be normed, and that there are objectively right and wrong answers to questions of judgment. This information is then compiled into recommendations regarding the patient's ability to work, drive a car, manage her finances, and other such activities of daily living (Lezak, Howieson, and Loring, 2004). Neuropsychologists are also involved in informing families of these limitations. Neuropsychologists attempt to use their knowledge to create and implement treatment strategies that are useful to those with neuropsychological impairments and to evaluate those treatments (Lezak, 2004). Lezak defines the function of neuropsychology as including diagnosis, the prediction of future neurological dysfunction, the determination of the degree to which individuals should be permitted freedom, and the rehabilitation of deficits. Again, the role of the neuropsychologist as gatekeeper is clear, as it defines pathology and the consequences of pathology, and brings straying individuals – or, as it would say, brains – in line via programs of rehabilitation and recommendations that limit freedom. Again, whereas the gatekeeping role has always been there, the implication and suspicion is of either an extension or a nuanced change in the shape of this role – for example, if the neuropsychologist stood to referee the boundaries of normality such that the deviant is called out of the game into the rehabilitative penalty box, the neuropsychologist now not

only accompanies the deviant back into the game after he or she served their sentence, but shapes the very sentence itself even as it limits, prescribes, and exercises authority over the very manner in which the game can be played.

*Current Trends in Neuropsychology***:**

By the time I looked at the current neuropsychological literature, my investigation had a dual purpose. I continued to explore with the aim of learning the language and culture of a subfield of psychology in which I intended to be inducted. I also wished to understand how the profession was shifting in response to challenges from neuroimaging. This second purpose circles back to the first, as I found that neuroimaging challenged the utility of one of neuropyschology's (and ultimately one of mine) primary functions. I wanted to understand the identity of the field into which I was being inducted, all the while wondering about the implications of that identity. I turn next to explore some of the major contemporary trends in the field, particularly those that do attempt to account for the changes necessitated by the reign of neuroimaging.

More than anything else, some neuropsychologists and areas in neuropsychology have responded to the changes brought about by neuroimaging through answering questions that rely on assumed ecological validity. The term 'ecological validity' refers to the way in which information or an intervention correlates to an individual's actual ability to navigate his or her life. If something has ecological validity, it is applicable to the patient's daily life. In some contexts, concern for ecological validity might result in a professional visiting the home of a patient and help that patient to develop strategies designed to maximize the patient's ability to successfully navigate the tasks she may be

confronted with on a daily basis.   Ecological validity is an attempt to ethically respond

to the power of the neuropsychologist by seeking to correlate the outcome of

neuropsychological testing to the client's ability to navigate the tasks of daily life.

"Because the recommendations that neuropsychologists make concerning everyday

functioning can have far-reaching consequences for clients' lives, it is important to

demonstrate that neuropsychological tests have ecological validity" (Chaytor, and

Schmitter-Edgecombe, 2003, p. 182).   Ecological validity makes great intuitive sense –

if neuropsychology is now answering questions regarding patients' ability to perform

daily tasks independently, to go to work, and to drive cars, they best have the means to do

it! It seems, however, that ecological validity in neuropsychology does not quite translate

in the manner of the example above – of devising strategies, or wrestling with ways, a

person with a neurological condition may navigate daily life – but has come to refer to

the relationship between a person's scores on various neuropsychological tests and that

person's ability to function in real life situations in an a priori manner of sorts. That is,

the test score is assumed to contain (presumably to a greater or lesser degree) the measure

of the person's ecological performance: "In the context of neuropsychological testing,

ecological validity refers to the degree to which test performance corresponds to real

world performance" (Chaytor, and Schmitter-Edgecombe, 2003, p. 182).

> The ecological validity of neuropsychological assessments is frequently assumed.
>
> It is assumed that the impaired brain processes which lead to poor performance on
>
> a neuropsychological test, will also lead to poor performance in other situations
>
> outside the test situation. In other words, it is assumed that neuropsychological

tests have ecological validity. (Chaytor, Schmitter-Edgecombe, and Burr, 2006, p. 217)

If a test has ecological validity, it makes sense to use the test to answer questions about an individual's ability to drive a car, go to work, or to live independently. Until recently, this assumption has been left untested. "Surprisingly, there has been very little research investigating the accuracy of this assumption" (Chaytor, Schmitter-Edgecombe, and Burr, 2006, p. 217). The existing research indicates that this assumption may be without merit. (Chaytor, Schmitter-Edgecombe, and Burr, 2006).

Ecological validity is difficult for many reasons, ranging from the artificiality of the testing environment to continued disputes regarding what each test measures (Chaytor, and Schmitter-Edgecombe, 2003). "The literature investigating the ecological validity of neuropsychological tests of executive functioning has been inconsistent: with some studies demonstrating relatively robust relationships between test scores and everyday ability, and others failing to find significant relationships" (Chaytor, Schmitter-Edgecombe, and Burr, 2006, p. 218). Furthermore, neuropsychological tests do not take into account the ways in which a particular individual compensates for neurological conditions (p. 185). The testing situation is quite different from daily life. "Yet little attention is paid to the possibility that using behavioral measurement to infer the presence or evolution of brain disease is qualitatively different from inferring the ability to learn a new skill or balance a checkbook" (Heinrichs, 1990, p. 171). Thus, two individuals with identical results on neuropsychological testing could have quite different functional abilities. Although some neuropsychologists continue to try to establish ecological validity (Tomaszewski, Harrel, Neumann, and Houtz., 2003), the current situation is one

26

in which there is a lack of consensus regarding the procedures and theories via which

neuropsychologists should come to ecological decisions. Who should be labeled too

impaired to drive and under what circumstances largely remain matters of (informed)

opinion, and varies across professionals (Reger et al., 2004). Sullivan (2004) emphasizes

the lack of explicit understanding of the procedures and decision points for conducting a

capacity assessment and determining whether or not a patient is able to make independent

decisions (Sullivan, 2004).   The difficulty establishing ecological validity is significant

because in the absence of diagnostic primacy, ecological questions are the one

neuropsychologists are asked to answer! How, then, do neuropsychologists develop their

recommendations regarding ecological questions?

Silent Disability:

Thus far, I have presented trends that I have discovered in the neuropsychological

literature. I now turn to what has been silenced and left unsaid.   In doing so, I introduce

the concept of ableism. Ableism – often compared to racism, classism, and sexism – is

the privileging of those without so-called disabilities over those with so-called

disabilities. This privileging – and concurrent devaluation of disability – results in

negative reactions towards particular ways of being. Ways of being that are considered

to not be disabled are seen as preferable.

From an ableist perspective, the devaluation of disability results in societal

attitudes that uncritically assert that it is better for a child to walk than roll, speak

than sign, read print than read Braille, spell independently than use a spell-check,

and hang out with nondisabled kids as opposed to disabled kids, etc (Hehir, 2002,

p. 3).

From an ableist perspective, disability is viewed as defect rather than acceptable

difference, resulting in problematic assumptions regarding disability. Because disability

is viewed as a defect, the general public and specific professional communities have

struggled to acknowledge matters of oppression related to ableism.

Because disability status has been viewed as a defect rather than a dimension of

difference, disability has not been widely recognized as a multicultural concern by

the general public as well as by counselor educators and practitioners (Smith,

Foley, & Chaney, 2008, p. 304).

An ableist attitude works to remove the symptoms of disability regardless of the degree to

which the symptom is troubling to the person living with it (Hehir, 2007). Similarly,

ableism does not take into account the ways in which society renders particular

symptoms problematic, such as the creation of buildings that cannot be navigated easily

in a wheelchair (Livingston, 2000). Ableism is an attitude towards disability that results

in negative assumptions and treatment regarding disability. With the concept of ableism

in mind, I show the prevalence of ableism within the profession of neuropsychology.

The term 'disability' and other words such as 'impairment,' and 'deficit' appear

in the literature with little obvious reflection, critique, or definition. Without an

exploration of these terms, I found that my identities as family member and patient could

not speak. Furthermore, the terms themselves are affectively loaded and infused with

power. A good deal of my family's concerns during the diagnostic process involved a

questioning of a 'disabled role.' On the one hand, the term declares that my brother and

I are deficient and unable to 'function' properly. It makes me feel like a malfunctioning – albeit productive – machine. (And, from the perspective of capitalism, is that not what I am?) And yet, I have been constructing me (inclusive of myself and my self) as a malfunctioning machine too. It is a complicated term, also at the level of the practical performance. On the one hand, for example, it allows a certain winning understanding for my brother's "quirks". It is part of what gives him the courage to meet the eyes of the clerk who bluntly asks: "What the hell's your problem?" as he slows down her line while trying to force his trembling fingers to separate out bills. He shames her by flatly declaring: "I have a neurological disability." But, I also see him resisting the label as he – long having the habit of referring to himself as The Dude – laughingly announces: "The Dude wobbles. But he doesn't fall!" My relationship to disability is as complicated and ambivalent. My experiences have shown me that neurology and neuropsychology are intimately involved in the creation of a person's identity as disabled. I wanted to explore disability more, sensing that the silence that I have noted is meaningful and that ending that silence will be crucial to forming a position that can encompass all of the roles that I perform.

I begin my explorations with the American Disability Act of 1990 (ADA) which literally legislates disability, creating the official parameters for determining who is properly labeled as having a disability. It is law. (The fact that disability requires legislation is instructive in itself.) According to the ADA, a person who is properly identified by the term "disability" is one who has a "physical or mental impairment that substantially limits one or more major life activities, has a record of such impairment, or is regarded as having such an impairment" (ADA, 1990, p. 2). The activity-limiting

impairment must be relatively permanent, although there is no exact time specification (p. 2). It is notable that the definition dictates that those "having a record of impairment" or who are "regarded as having such an impairment" are among those who are correctly labeled as having a disability (p. 2). Disability is not a label that one applies to oneself – at least not to the extent that the label is regarded as "true" or "fact". According to this definition, an objective source must determine whether or not an individual has the kind of impairment that can be labeled a disability. This is one of the explicit connections to neuropsychology. Neuropsychologists have an enforcement capacity that determines whether or not an individual should be labeled as disabled or not.

The term 'disability' is legislated, but it is also constructed and performed in the sense of Butler's (1999) performativity "under the domain of the medical profession" (Scullion, 1999, p. 651). It follows, then, to turn to descriptions of the term disability by members of the medical community, given that they enforce an understanding of the term in practice. Scullion explores a variety of nursing students' working definitions of 'disability.' One such student calls disability: "any incapacitation, mental or physical, that someone might have, which will create a problem with their carrying out of activities of living that they were formerly able to carry out" (p. 656). This student's definition is reminiscent of the ADA, and frames disability as an inability to perform particular tasks. Others defined disability as illness: "I think all the while you are actually talking about disabilities, then you're talking about illness" (p. 656). Such students related disability not to the impact of an illness on a person's ability, but rather to the presence of illness in itself. Other students connected disability with dependence. "Anything that the individual might need, something to help them like an aid or whatever or special attention

or care to help them do something" (p. 655). These students framed disability as something requiring prosthesis, special care and attention. Other students saw disability as deviance. One such student explained: "There are norms that have been given, and if someone can't fulfill that norm, they're labeled as disabled" (p. 656). Here, disability is a label that is applied to those who fail to conform. Another explains: "There is something that they have to do differently to pretend that they're normal (p. 659)." In this definition lies the assumption that those with disabilities should do what it takes to be seen as normal. Scullion's article shows a discourse surrounding so-called disability that includes incapacity to perform particular tasks, illness, dependence, and deviance. These are among the ways in which members of the medical community define – and the basis from which they enforce – disability.

Disability and Neuropsychology:

Implicit in 'disability' is the creation and enforcement of the disabled body. Indeed, by the very delineation of its tasks, of what it is about, neuropsychology is implicated in the process of defining and creating neurological disability. Neuropsychology's silent acceptance of its role in disability is consequently rather problematic. Of course, I am well aware that the dynamics between neuropsychology and disability demands an examination of considerable subtlety and depth, both of which I hope to provide as I engage with this project. For now, however, it suffices to proceed from the statement that neuropsychology creates disability via diagnosis, its attitude towards various cognitive functioning, and its prescriptions for limiting activity and altering cognitive functioning. Discovering, as I did, a resounding silence about

disability as term, concept, and implication is consequently meaningful: for one, it speaks to (or from) the assumption that disability is something that objectively exists. As I will demonstrate, however, such a view is far removed from the experience of the person labeled thus, and for who, the creation of neuropsychological disability has unique implications as the individual's opinions and preferences shift when viewed through the lens of neuropsychological disability.

Research Question:

It is perhaps becoming clearer that there were many factors – in the language of psychology, one could say both "push" and "pull" factors – that prompted my desire to enter into the profession of neuropsychology. I've made mention of the personal connections to neuropsychology at the patient end, so to speak. But as a budding neuropsychologist myself, as a student of neuropsychology, there remained a literature and praxis I needed to enter into and get to know in a manner somewhat different than that of a patient or family member of a patient. I needed to familiarize myself with a particular neuropsychological language and culture. Several questions stemmed from such an immersion. Most broadly, I wondered about – and worried about – the role of the contemporary neuropsychologist – which is also to say, I wondered and worried about the very profession I was about to enter. Neuroimaging has largely taken over the role of the neuropsychologist, and it seemed no less than responsible career planning for me to wrestle with this very fact. Turning, then, to my peers, mentors, and the contemporary literature, I was – and am - left wanting for a satisfactory response to the changes

brought about by technological 'advances'[8]. Many neuropsychologists continue to administer neuropsychological tests without a clear purpose. And, it seems as if neuropsychologists are not worried about what I perceived to be a solid threat to the very core of the field. What, then, are the dynamics at play within the field such that it does not acknowledge or evolve in the face of technological threat, and simultaneously continue to exist or "do business", so to speak.

Furthermore, as one of the points where my status and identity as patient and family member of a patient intersects with that of neuropsychology student and initiate, I noticed a powerful disconnect or disjuncture between the profoundly important and salient valence disability as term and identity had for me as patient, and the short thrift it received within the professional literature. In truth, in the vast literature, it is not only that disability is absent or silent, but the position and experience of the patient is notably absent. Neuropsychologists create disability[9], and I find that this silence is itself a reflection on how the neuropsychologist uses power. I thus find myself wondering how it is possible for me to find a position that encompasses professional, caregiver, and patient. I wonder how it is possible for me to be all of these at once.

Hence it was that I came to a research question or endeavor that intends to tell a story about neuropsychology as it is practiced and understood within and from a particular location and in the process to highlight precisely those forces which impact on it, both overt and covert. I am attempting to discover the difficulties inherent in integrating the two roles while also seeking to find (or create) a position that does not annihilate the others. Although I do not yet see how they can co-exist, I believe that my

---

[8] I use quotes in order to problematize the term 'advances.' I believe that many technologies are life-enhancing, but I do not believe that technology is inherently progressive.
[9] It may not be a stretch to say that neuropsychologists were created to create disability!

33

unique positioning via my multiple roles in relation to neuropsychology leaves me in a position to contribute something meaningful to the field. And yet, I sense that in doing so, I am at risk for perpetrating violence towards the so-called impaired parts of myself and others. Thus, I am asking about the role of the neuropsychologist as it is presently enacted, as well as the places where there are fissures that indicate the potential for a more liberatory performance. In one sense, this project is intensely personal. And yet, it moves beyond the personal as the struggles captured within it are not mine alone.

Chapter Summary:

In this chapter, I have made a case for reflecting on the performance of the neuropsychologist. I argue that the advent of neuroimaging has shifted the function of neuropsychology without necessarily drastically shifting the performance of the neuropsychologist. The effect, or so I argue, is that the constructed nature of neuropsychology is uniquely visible at this time. Further, I believe that my multiple selves in relation to neuropsychology place me in a unique and advantageous position to explore the question of the constructed identity of the neuropsychologist.

Chapter 2: Methodology:

Having outlined the need – both personal and within the profession of neuropsychology – for an exploration of the performance of the neuropsychology, I introduce the reader to autoethnography, the means by which I explore performances relating to neuropsychology. In this chapter, I introduce the qualitative research methodology of autoethnography, and make a case for its suitability for this project. In doing so, I argue both that autoethnography makes use of my unique multiplicity and that the methodology makes conceptual sense for the particular questions that I ask in this project.

Ethnography and Autoethnography*:*

It is rather common to start an explication of autoethnography with an explanation of, or introduction to, ethnography. I follow suit, and begin by very briefly introducing ethnography. Chambers (2000) states that ethnography is concerned with studying "ethnos" or culture and does so via a "thick description" thereof (Geertz, 1973). This thick description locates particular events in an ever-expanding context, constantly describing the field on which the event takes place. "Ethnography involves an ongoing attempt to place specific encounters, events, and understandings into a fuller more meaningful context" (Tedlock, 2000, p. 455). Because we are all immersed in culture– including ethnographers as they conduct their research – every moment of every day provides potential research data. Culture is comprised of our day-to-day existence and exploring even (or perhaps especially) the minutest moments can illuminate it. Any

given moment can be explored and contextualized in culture, and all are telling of our social locations. Ethnography is "both a process and a product," and treats the research project as data in itself (Tedlock, 2000, p. 455). Exactly what a researcher does as she navigates the world and what she feels and thinks when interacting with her research participants are all of interest as they are moments in culture. Placing individual moments into cultural context is the project of ethnography. Thus, ethnography is not mere observation – it is observation with the purpose of depthful understanding of culture. Indeed, ethnography uses observation in order to comprehend culture.

Of course, ethnography itself can be culturally located, with the student of ethnography reflecting on the ways in which ethnography reflected and shaped culture. In its early stages, ethnography conceptualized the researcher as an impartial observer who was to report the "facts" of what has been "objectively" observed (Vidich and Lyman, 2000). This initial assumption of ethnography had broad – and frequently problematic – implications. First, inherent within this assumption is a corresponding belief in the existence of objective "facts" that can be captured via observation, facts that can be seen and comprehended apart from a cultural filter. Stated differently, early ethnography assumed that ethnographers captured unmediated truth, that their field notes contained objective data regarding the object of ethnographic study. This early ethnographic gaze did not reflect on the impact of observation, the power dynamics inherent in research, or on the culturally constructed nature of both ethnographer and subject of ethnography. The early ethnographer did not reflect on his/her ability to define the reality of the object of ethnography, or question the assumptions within this. (Further, I use the term "object" of ethnography quite intentionally in this context,

referring to its multiple meanings.) Early ethnography believed in objective selves.

These ethnographers were aware only of recording – not creating – reality. The early

ethnographer did not question how his own identity shaped his understanding of the

object of ethnography.

Precisely because of these limiting assumptions, ethnography in this mold and

vein was thrown into crisis when critical theory began to challenge the very idea of the

self-contained individual upon which ethnography rested (Lincoln and Denzin, 2000).

The colonialist assumptions of many early ethnographies emerged as the possibility of an

'objective' observer was thrown into question (Vidich and Lyman, 2000). As the cultural

context in which ethnography exists shifted, it was no longer possible for ethnographers

to deny that their culturally-conditioned selves shaped the narratives that they produced,

and that their gaze itself had an impact on what they observed. Ethnographers were

forced to wrestle with difficult questions, such as "Who is the Other? Can we ever hope

to speak authentically of the experience of the Other, or an Other? And if not, how do we

create a social science that includes the Other" (Lincoln and Denzin, 2000, p. 1050)?

Ethnographic researchers were faced with the daunting task of modifying ethnography in

such a way that responds to the call of the Other, moving away from colonialization and

appropriation towards inclusion and a recognition of oppression.

Autoethnography – ethnography of the self – is one such attempt at a solution or

reworking of ethnography. "Autoethnography is a relatively innovative variation of the

ethnographic approach to research, and it has, in many ways, challenged the

epistemological foundations of much social scientific investigation" (Collinson, 2005, p.

224). As opposed to studying the ethnographic object, autoethnography adopts the self as

the subject of ethnographic exploration. Returning to Geertz's (1973) definition of ethnography, autoethnography is then a process of turning to the self in order to illuminate culture via thick description. This involves turning inwards in a manner that challenges one's experiences and seeks to locate the experienced self(ves) within a social context:

> In the wake of colonialism anthropologists came up with the term self-reflexivity to understand ethnographic limitations and potentials. The concept and method called auto-ethnography is an attempt at practicing this self-reflexivity by having a closer look at one's own longings and belongings, with the familiarity that— when viewed from a distance—it can change one's perspective considerably. This change comes about when the auto-ethnographer places the self within a social context by connecting the personal and the cultural. (Alsop, 2002, p. 2)

In antithesis to the denial of the constructed self and the impact that the subjective self has on the reporting of ethnography, autoethnography takes the subjective and constructed nature of the self as the object of study. The autoethnographer does not insist on objectivity, but rather explores the insights derived precisely from subjectivity. Indeed, the subjective experience of the autoethnographer is embraced as the space where culture can be illuminated. The lack of objectivity is now acknowledged, but is no longer problematic. The subject of auteothnography is, in one sense, the self. But that self is always in context. The subject of autoethnography is therefore also culture, as the self is used as a means of understanding culture.

Because autoethnography studies the self in context, many of the problems of colonialism and problematic notions of the self that had dogged traditional ethnography are reworked[10].

> Arising from the 'crisis of representation' (Sparkes, 1995) in social science, autoethnography can be viewed as one of the reactions to the 'realist conception of validity' (Hammersley, 1992, p. 2) which, according to Denzin (1992, p. 20), seeks to "privilege the researcher over the subject, method over subject matter, and maintain commitments to outmoded conceptions of validity, truth, and generalizability. (Collinson, 2005, p. 224)

Thus, the truth offered by autoethnography is a different one than that proffered by traditional ethnography. It is a truth that seeks to understand culture via an understanding of the (situated and – in the case of postmodern autoethnography – constructed) self. It reports truth, but a truth that originates from subjectivity. Autoethnography makes use of the self as a means of understanding culture, viewing the self as intimately informed – perhaps even created by– culture. The ultimate aim of autoethnography is not to understand the self per se, but rather to understand culture via the self. This is in contrast to the genre of memoir and other autobiographical writing, in which the stated purpose is to illuminate the life of the author. Of course, this distinction is – like all such distinctions – rather forced, and exceptions to this principle are inevitable. Although memoir, autobiography, and autoethnography all inevitably illuminate aspects of the self and culture, autoethnography's explicit aim and goal is to arrive at cultural understanding rather than understanding of the self.

---

[10] I say 'reworked' rather than 'resolved' as issues of oppression are never fully 'solved,' but rather transform and evolve.

Autoethnography represents a turn from the ethnographer as impartial observer of culture to one in which the self of the researcher is herself a lens with which to view culture. This turn represents changing understandings of both the self and culture, and thus transformed understandings of what makes good research, and the appropriate role of the researcher. Autoethnography calls upon a particular kind of reflexivity and study of the self in order to understand culture.

The Many Faces of Autoethnography:[11]

Of course, all autoethnographies are not the same, nor do they follow precisely the same theoretical assumptions or make use of identical strategies. Having articulated what defines the genre of autoethnography in general, I now turn to explain the particular trends within the genre of autoethnography – theoretical and practical –of which this dissertation project is a reflection. I articulate my particular methodology – the specific ways in which I take up this dissertation -- and the theoretical grounding and implications of the form of autoethnography practiced in this dissertation.

Auteothnographic writing: Evocation and analysis:

There are different means of presenting the culturally mediated self of autoethnography, and these different means reflect variance in understandings of the function and purpose of autoethnography. A debate rages between evocative and analytic autoethnography (Atkinson, 2006; Ellis and Bochner, 2006). This debate is, essentially, an argument about the role of evocative description and academic theory in

---

[11] This heading is somewhat of a pun: I refer to the multiple ways in which autoethnography is taken up, but also to the emerging possibility of the 'auto' of autoethnography to become multiple, and thus have 'many faces'.

autoethnography. As such, they reflect differing methods from the earliest stages of research and beyond.

Proponents of evocative autoethnography locate the power of autoethnography in its descriptive powers, in its ability to evoke the scene. They believe that it is description – and emotion - that impact and inform the reader (Ellis and Bochner, 2006).   It is about conveying subjective experience.

> Knowledge and theory become disembodied words on the page and I lose connection. I want to linger in the world of experience, you know, feel it, taste it, sense it, live in it; but Leon wants to use the world of experience primarily as a vehicle for exercising his head. (Ellis and Bochner, 2006, p. 431).

Evocative autoethnographers view the value of autoethnography in the descriptive evocation itself, and the successful evocative autoethnographer writes in such a way that the reader feels the emotional 'flavor' of the scene. Thus, for the evocative autoethnographer, the power of the autoethnography rests in its ability to create an emotional reaction in the reader that is reminiscent of the event in question. It is this, then, that can illuminate culture.

Those on the other side of the debate – the 'analytic ethnographers' – view the inclusion of theory as a means of taking autoethnography further. "Anderson announces his affiliation with those who identify themselves as autoethnographers but adds realist objectives and practices to what we call autoethnography" (Charmaz, 2006, p. 396). Analytic autoethnographers see theory not as diluting the evocation of autoethnography, but rather as adding to the description of autoethnography. Thus, an analytic

autoethnographer describes the moment in question via description and theoretical

scrutiny, and includes both in the presentation of autoethnography.

I tend to view this debate as a false dichotomy, as I believe that theory and

description are intimately intertwined. One deepens and refines the other, and both can,

in my opinion, evoke and describe. In a sense, theory is itself evocative, as it illuminates

ethnos. Both theory and descriptive evocation can serve to illuminate culture. Thus, in

this project, I intend to incorporate both styles of autoethnography, believe that both

descriptive text and the incorporation of theory – and particularly these texts in dialogue

– can "evoke" the performance of neuropsychologist. I therefore intend to explicitly

dialogue autoethnographic reflections with theoretical explorations.

A Turn Towards Multiplicity:

What constitutes the 'self' of autoethnography is another source of debate within

the subfield of autoethnography. This project deviates from 'traditional' – if the term is

permitted in the description of a relatively new research method - autoethnography in one

notable and deliberate manner: the "auto" of this ethnography is a multiplicity as I write

from the perspective of three selves. This project is certainly not the first to include a

multi-perspectival autoethnography, although such approaches are relatively rare

(Wheatley, 2005)[12] it is not unheard of for autoethnographers to explore multiple selves.

"In common with Granskog (2003, p. 48), my definition of self has at least three critical

components, as relevant to this discussion, they are: being a woman, a distance runner,

---

[12] I suspect that this will increasingly change as a shift to the representation of multiple selves seems to
circumvent some of the philosophical problems inherent to writing from the perspective of a singular,
coherent, essential, self.

and a feminist sociologist" (Collinson, 2005, p. 223). This shift to multiplicity is significant due to the philosophical shift that comes about when an author acknowledges herself as a multiplicity. This philosophical shift is one that deviates from the assumption that individuals have an essential, singular self. Writing from the perspective of multiple selves is consistent with the post-structural position that identities are performed repetitions rather than the reflection of an essential nature.[13] This understanding of performed constructed identity allows the thick description of autoethnography to become part of imagining a different future – it no longer describes something that "must" be, and leaves open the possibility for (a) new performance(s).

Autoethnographic explorations of neuropsychology:

Having introduced the method of autoethnography, and the particular subset of assumptions and practices that I intend to follow in this project, I turn to explore the relevance that this method has for an understanding of the constructed performance of the neuropsychologist. Simply put, I wish to explain the natural connection between my research questions and an autoethnographic method. It is here that I explain why, amongst a plethora of quantitative and qualitative methods at my disposal, I chose autoethnography for this project.

Unique Positioning:

My body itself carried several different positions as I moved about the Neurobehavioral Unit. I embodied the roles of patient, caregiver, and training professional and I came from the perspectives of one who is the object of

---

[13] This philosophical stance will be described in much more depth in the following chapter

neuropsychology, a family member on the periphery of neuropsychological

investigations, and one who seeks to learn the craft of neuropsychology. I intend to take

advantage of all facets of my multiplicity in order to explore the forces propelling

neuropsychology. Because some of my selves have competing motives with other selves,

and these competing motives were useful in terms of understanding the constructed role

of the neuropsychologist, I tuned into the way that my multiple selves interact with one

another as my body traverses the unit. As I examine the interactions of my multiple roles

on the unit, I do so with the aim of further exploring the role, identity, power, and

function of the neuropsychologist.

I felt that my multiple selves – particularly those selves that are infrequently given

voice in the academy – permitted a unique and depthful means of coming to understand

the performance of the neuropsychologist. Autoethnography emerged as a method with

which I could explore neuropsychology from several angles at once. Autoethnography –

the ethnography of the self – permitted me to transform my multiple positions in

relationship to neuropsychology into the site of research. Further, my multiplicity in

itself served to question the assumptions made by the field of neuropsychology regarding

patients and professionals.

Disability and Voice:

I argue that disability, and thus neuropsychological so-called abnormality, is

particularly suited to auteoethnographic exploration. As I indicated in the previous

chapter, both neuropsychologists and patients have an intimate, albeit qualitatively quite

different, relationship to disability, so that an ethnographic exploration of disability has to

take *both* (at least) these key players into pivotal account. Insofar as this project interrogates the positions of professionals, patients, and family members in relationship to neuropsychology, it is one that questions relationships to (at least suspected) disability. Moreover, certain so-called disabled groups constitute their own practices, identities, rituals, values – in short, or put another way, their own cultures. Ethnography is well suited to an examination, and demonstration, of the ways in which disability is constructed, experienced, lived, and concealed – again, in both so called disabled populations and the so called abled and/or professional contexts within which disability is lived, managed, and understood.

> First, some groups of disabled people – most obviously the deaf, who
>
> consider sign language their native 'tongue' – constitute culturally distinct
>
> populations. Second, contemporary disability studies has embraced the
>
> paradigm of disability as a cultural construct; the work of scholars in the
>
> humanities, which focuses on ways in which disability has been
>
> represented in various media and historical periods, needs to be
>
> complemented by participatory interactive research on how disabled
>
> people differ from mainstream populations. (Couser, 2005, p. 123).

Perhaps the most compelling case for an autoethnographic study of disability and thus neuropsychology is the fact of oppression, discrimination, and exploitation of the disabled. Autoethnography promises to be attuned and sensitive to the dynamics of power, politics, and oppression, all factors that go a long way toward explaining why those with so-called disabilities are likely to be wary of researchers. Autoethnography makes sense as a means to help prevent the exploitation of those with disabilities.

Disabled people have largely been ignored by ethnographers, arguably to

the detriment of both disabled people and the discipline of anthropology.

But although disability communities are ripe communities for

ethnographic investigation, disabled people, long subjected both to

marginalization and objectifying examination, may resent and resist such

attention. Indeed, like indigenous people, disabled people have sometimes

been treated as colonial populations, and disability ethnography faces

some of the same ethical challenges as ethnography involving populations

subjected to classic Western imperialism. (Couser, 2005, p. 123)

In fact, it is the change to autoethnography that is liberatory. When those with so-called

disabilities shift from the talked-about to the speaker, from object to subject, something

powerful happens. "One phenomenon that has emerged from the recent crisis of

ethnographic authority has been the writing of ethnography by 'natives' who were once

its subjects. Indeed, I would claim that this gesture – which puts the *auto* in

autoethnography – is the distinctive sign of the postcolonial moment" (Couser, 2005, p.

124). Autoethnographic exploration of disability is powerful precisely because it

includes the voices of the previously silenced and challenges that often unquestioned

authority of the medical profession.

Nonetheless, authoethnographic disability texts remain relatively rare. "Aside

from these signal texts, disability ethnography and autoethnography are still quite rare;

there is not yet a very substantial body of autoethnographic discourse concerning

disability" (Couser, 2005, p. 129).   This is not to say that it has not been done or that

nothing similar has been attempted.   There are many texts that have attempted to include

46

some sort of autoethnographic perspective on disability (Collinson, 2005; Couser, 2005; Ettorre, 2006; Jago, 2002; Lorde, 1980; Wheatley, 2005). Still, these texts remain a rarity in comparison to the vast array of texts written *about* persons with so-called disabilities. A need for more voices remains. Of course, many powerful texts have been authored by persons with disabilities. Yet, these texts have not historically been a part of the academic cannon, but are rather placed in the genre of memoir. Many such texts were, indeed, written in the style of memoir without the reflexivity and explicit aim of autoethnography. Simply stated, these texts – memoirs – did not explicitly aim to reflect on and illuminate culture via the self. Those disability texts that did have this explicit aim – perhaps satisfying the criteria of autoethnography – are still *viewed* as outside of the domain of academic writing. Thus, such narratives are not given the weight of authority that is afforded to academic writing.

I choose autoethnography to empower my oppressed patient voice while exploring dynamics of oppression from within. I do so from my multiple positions as it is the constructed patient self that is created by and creates the constructed neuropsychological self. It is impossible to understand the role of the neuropsychologist or the patient without an understanding of the other.

Data Collection:

I now move from the abstract to the concrete, providing the particulars of my approach to this autoethnography. In this section, I detail the means via which I collected autoethnographic data, first through a description of the setting in which my multiple selves interacted, and secondly by detailing the process of writing my autoethnographic

47

journal. Thus, I record the occasion for the observation of self, and the method via which I observed.

Setting:

The data for this study came from my nine-month long practicum as a neuropsychology practicum student on the outpatient neurobehavioral unit of a hospital in the Northeast. For this practicum – which was a part of my doctoral training in clinical psychology – I spent seventeen hours a week in training. The unit's professionals include neuropsychologists, geropsychologists, neurologists, and a nurse practitioner. In addition, neuropsychology technicians, a secretary, a post-doctoral student, and a predoctoral neuropsychology intern worked on the unit. The patients were primarily – although not exclusively – male. They were typically referred to the neurobehavioral unit by their physicians, although a few have requested neuropsychological evaluation themselves. Many were older adults referred to the unit on the suspicion of dementia. Others were younger men who seemed to be exhibiting signs of some kind of cognitive dysfunction as a result of the beginning of a progressive illness, the effects of an undiagnosed learning disability, the side-effects of medication, or the impact of acute neurological trauma.

On the unit, I engaged in clinical interviews, selected testing batteries, administered neuropsychological and psychological tests, scored and interpreted those tests, wrote reports based on those tests, and gave feedback based on those reports. On average, I did one clinical interview, battery, report, and feedback session a week. I was occasionally asked to do short-term psychotherapy with someone who was struggling with both psychological and neuropsychological difficulties. In addition to these duties, I

48

was supervised weekly by the intern and one of the neuropsychologists. Occasionally, my work was supervised by another neuropsychologist. I attended bimonthly neuropsychological case conferences and a monthly geropsychology journal club. This project is based on my autoethnographic explorations of my navigations of the neurobehavioral unit

Orientation to the Unit:

In this segment, I seek to introduce the reader to my various tasks and duties as a neuropsychologist in training. This serves to contextualize my location both within the hospital system and on the unit. It seeks to function as a background for the more thematic discussions to come in subsequent chapters. In short, this segment describes the basic scenes in which I performed training neuropsychologist, patient, and family member. I write this segment autoethnographically both in order to convey a sense of the unit and to provide a further sense of the style I will use in the rest of the dissertation.

Scene:

After saying goodbye to my husband – he drops me off at work as I haven't driven a car since having seizures several years ago – I walk across the hospital grounds and into the building in which I work. I will pass wheelchairs as I go through the automatic doors. Once in the building, I walk through a cozy waiting room with arm chairs and lamps and down a long, pale, gray-carpeted hospital corridor. I walk through another waiting room. This one looks more 'institutional' and is full of lilac chairs. Most days, I will encounter an elderly gentleman wearing a hat sitting in a chair on the left-

hand side of the waiting room. He will make a joke about drinking my coffee. I will

laugh, and walk down yet another hallway and wait for the elevator. I take the elevator

up to the unit. If I'm the first one there, I step out of the elevator and use my

Neurobehavioral Unit key to unlock the door to the unit.

The unit itself is painted a yellowy-white. I pass the locked staff bathroom on my

left. Struggling to balance my coffee, backpack, and keys, I will let myself into my

office, which is about the size of a generous closet. It clearly was, at one point, a

bathroom. My desk has been placed so that it partially conceals a continuation of the

bathroom tile.   The desk itself is heavy and wooden. A tan institutional phone sits in the

upper left-hand corner with a dusty computer monitor in the middle. There are two pink

and wooden chairs, one of which I always use to prop open the door. There is also, oddly

enough, a large pink exam table. I use it to hold my books, a filing tray, and a stack of

charts that I will be using soon. There are shelves on the walls, full of old directories and

other outdated information.

I will drop my bag and coffee off, turn the computer on, and check my voice mail.

Then, I will carry my lunch past my supervisor's office, two testing rooms, and the nurse

practitioner's office to store it in the staff refrigerator. I will continue on down the hall,

past the neuropsychology technicians' offices and the waiting room. The waiting room

has a small bathroom in it, and it has a series of chairs, a fish tank, and some newspapers.

The chairs are a sort of yellowish color. I will let myself into the secretary's office and

check my mailbox before returning to my office.

Neuropsychological Testing:

If I am scheduled to see a patient for testing that day, I will have already printed off his medical chart and read through it, highlighting anything that I deem potentially relevant to the person's neuropsychological functioning. I will spend the first hour or so of my morning pulling together testing material and putting it in some kind of workable order. This will involve scuttling back and forth between my office and a small locked room with filing cabinets overflowing with alphabetized testing materials. If I'm not sure what kind of tests to administer, I will knock on my supervisor's door. I will sit across from him around a large wooden table taking notes on a clipboard as we devise a battery of tests aimed at answering the referral question. Each test is – supposedly – designed to explore a particular aspect of neuropsychological functioning. I will make certain that I can find a stopwatch.

Eventually, my patient will arrive. (Often, of course, my patient does *not* arrive. Some are presumably reluctant because they are aware of my power to change their lives by, for example, reporting to the state that they are unsafe to drive. Others are demonstrating the referral question – they have forgotten that they have an appointment, have gotten lost on the way, or were unable to plan ahead to arrange for transportation.) I will invite him (my patients are typically male) back to my office. Once there, I will ask him if he knows who I am, and why he's here. This is not a test of the patient's so-called "orientation" to time and space. Rather, it is quite often the case that another doctor has referred the patient to us without ever telling the patient. The unit simply sends out letters informing outpatients of the appointments that we have scheduled. Many arrive not knowing what "Neurobehavioral" means, or why they have been told to see us. (This

means that it is quite likely that my patient sees me as a medical doctor and has thus hopped up onto the aforementioned examining table upon entering my office.)

Once I have oriented the patient to the general purpose of the evaluation, I begin the clinical interview. I have a sheet of questions to ask and space to write in the patient's answers. I ask the patient what he can tell me about his problems with memory. Often, he will answer that he has none. I will then ask him what his family or friends might say. (If he has shown up with a relative, I will invite that person into the room with us.) Occasionally, a patient will respond that he has none. After getting a sense of what, if anything, the patient believes is happening with his memory, I will "take his history." I will ask him if he has been knocked unconscious, exposed to chemicals, or told that he has a learning disability. I will ask how he did in school and how much education he has had. I will record his medical problems and the medical problems of his family. I will tell him to detail his work history and the presence of any legal problems. I ask about his current mood, and if he is eating and sleeping well. I write down how much he drinks, drugs, or smokes. I query regarding his marital history. I take note of what he identifies as stressors in his life. With many patients, I am unable to fully use their responses. Depending on the severity of the person's struggles, he might be unable to answer me at all, or he may be too embarrassed to admit that he does not know the answer to questions and will invent answers.

When I have finished filling out my sheet, I invite the patient into one of the two testing laboratories[14]. I tell him that he can ask to take a break at any time. I start with

---

[14] The fact that I always test my own patients speaks to my status as a student. Many of the neuropsychologists that I encountered on my rotation preferred to have neuropsychology technicians administer the tests. Under such circumstances, the neuropsychologist's contact with the patient is limited to the interview and feedback session.

the first test on the top of my clipboard, typically a "word list learning task." I read down

a long list of words. When I am done, I ask the patient to repeat "as many words as

possible, in any order." I record, verbatim, what he says. (I include any spontaneous

comments made by the patient, such as: "Are you kidding? That's ridiculous!") What

tests I administer varies. In general, some of the tests are verbal. (I ask the patient to

name all of the animals that he can in a minute, or list all of the words that he can think of

that begin with a particular letter.) Others are visual. (I show him a complicated

geometric figure and ask him to draw it, or I show him pictures and ask him to point to

the part that is missing.) Still other tests check for different aspects of executive function.

Here, I might ask him to make a "trail" that requires him to hold several things in mind at

once, or see how many categories he can sort out of a pile of six cards. I test for motor

"dysfunction" by teaching a complex series of hand movements. Sometimes I test for

sensory changes by poking a patient with a q-tip. I also do personality testing,

administering series of questions, either through paper and pencil tests or the computer.

When I have led the person through all of the tests – or he refuses to continue – I say

goodbye and tell him that I will contact him within two weeks to meet again and discuss

the results.

Once he leaves, I return to my office and begin the process of scoring. Some tests

can be scored on the computer, and I simply pull up a program and enter his answers.

The computer compiles a report listing T scores and Z scores for his age and education.

For others, I calculate scores myself using standardized testing data. I will later enter

these into a "summary sheet." Theoretically, this process is entirely objective.

Supposedly, I simply apply objective scoring material to the patient's responses. Once I have entered all of the T and Z scores into the summary sheet, I begin writing the report.

In some ways, I do not actually "write" a report. I have been provided with an online template into which I put the particular patient's circumstances. This can take on the feel of a "MadLib" game as I am filling in blanks. The report begins with a summary of the patient's "presenting problem" and reason for referral to the unit. It moves onto the patient's "relevant" history, and then describes the patient's current "mental status" and behavior during the testing. After this, the patient's neuropsychological functioning is broken down into the following categories: general abilities, attention, memory, verbal skills, visuo-spatial/visuo-construction, motor skills, and executive/frontal function. For each, I look at which tests fit into that category, and determine from the T and Z scores if that ability is in the superior, high average, average, low average, borderline impaired, or impaired range. This is simpler than it may sound. Take, for example, the test in which I ask the person to list as many animals as he can in a minute. This tests "semantic fluency." I look at the summary sheet, and find that his Z score falls below -2, and is thus in the impaired range. In the report, I will write: "Semantic fluency is in the impaired range." Once I have done this for each category and test, I will put in a section for diagnosis. If I have decided upon a neuropsychological diagnosis – such as dementia or cognitive disorder – I will list it. Otherwise, I simply go to the patient's chart and list everything that he has already been diagnosed with. At the very end of the report, I include a "Summary and Recommendations" section. In this segment, I summarize the cognitive domains in which the patient is and is not labeled as having impairment, repeat the diagnosis, and make recommendations. A typical recommendation would be for the

person to be in a "supervised environment" – code for nursing home – or for him to enter

psychotherapy if it is believed that a good deal of his problems are psychological in

nature. Finally, I will print the report out and give it to my supervisor. He will request

changes. When it is approved, I upload it into the patient's online medical chart and

provide my virtual signature[15].

Feedback:

After I have written the report, I invite the patient and his family to meet with me

again to discuss the results. Whether or not he does so seems largely based on his

impressions of our first meeting. If he is anxious that I will tell him to stop driving, he is

not likely to return. If he believes that I will tell his spouse that he is doing the best that

he can with his limitations, he is likely to attend. Again sitting in my office, I tell the

patient and his family what is in the "summary and recommendations" section of the

report. At this point, I typically spend a good deal of time checking in with the patient's

incorporation of the feedback. I want to see if my advice makes sense. I ask the patient

for more examples of problems that he has at home, and brainstorm to see what else I can

recommend. I find that often, the family member leaves feeling relieved, although the

patient often seems to be overwhelmed. The patient often leaves my office in a state of

shock.

---

[15] The shift from the paper chart to the online chart strikes me as a metaphor for some of what I later
noticed on the unit, as technology was increasingly revered.

Memory Skills Training:

   I occasionally had the opportunity to work with a patient in a short-term (3 or 4 sessions) memory skills therapy. Typically, patients received this treatment in a group run by the postdoctoral fellow. However, due to a series of circumstances, we were without a postdoctoral fellow for a space of several months. The memory skills therapy that I was taught to do is largely educative. Due to my own philosophical commitments, I made this as much of a collaborative process as I could within the structural constraints of the therapy.

   Typically, the patient had already received neuropsychological testing, and I would have read the report before meeting with the patient. Nonetheless, I would initially want to meet with the patient in order to assess what sorts of difficulties he is encountering in his daily life. Once I have done so, I will then spend some time working the patient to make use of "external techniques" of memory enhancement. These encompass any sort of tool or piece of technology that can help the person to remember important information. This might include the use of a tape recorder, a calendar system, or wristwatch alarms. Next, I will work with the patient around "internal techniques" of memory enhancement. These are cognitive techniques that can be used to remember. (For example, clustering is one such technique, and involves consciously grouping information into relevant categories. If I needed to go to the store to purchase milk, oranges, bread, yogurt, apples, cheese, and bagels, I could put the items into subgroups. Thus, I would remember dairy products (milk, yogurt, cheese), fruit (apples, oranges) and baked goods (bread, bagels). The particular techniques that I recommend will vary based on the person's living situation, neuropsychological strengths and weaknesses, and

motivation. Finally, if time permits, I will work the patient around psychological factors

contributing to memory impairment. I will teach the patient relaxation skills, and

encourage him to seek treatment for any psychological disorders that he has.

Psychotherapy:

Occasionally, I am assigned to work with a patient in individual psychotherapy.

These therapies are expected to be of short duration. Frequently, such therapy involves

working with someone who has recently been diagnosed with some kind of cognitive

disorder. However, it seems that the unit treats people with all sorts of psychological

difficulties, often without any particular expertise in psychotherapy. Dr. G. has made it

clear to me that the psychotherapists on other units are absolutely not interested in

working with those who are "cognitively impaired." Thus, the unit tends to treat those

patients regardless of the nature of their distress[16]. Because of this, and my doctoral

program's strong training in long-term psychotherapy, I was asked to work with one

patient throughout the majority of my rotation.

Neuropsychology Case Conference:

Two mornings a month, neuropsychologists from other parts of the hospital and

from other hospital systems – including where my brother receives care – meet on the

unit to discuss a case. We meet in a large group room and sit around several tables that

are pushed together. Typically, one neuropsychologist presents on two cases. That

---

[16] It is standard for the therapists on the unit to meet with clients monthly. I scheduled to meet with clients weekly. I tended to adopt a sort of humanistic stance with these patients. My psychotherapeutic style is feminist post-psychoanalytic, but I found that a basic humanistic stance was useful for such brief therapies.

person passes around the summary sheet from the case. He or she takes a few minutes to introduce the patient's history – typically only noting illnesses and developmental delays – before leading the group through the summary sheet. Most of the time is spent discussing the likely diagnosis. For my part, I am typically quiet during these meetings. I am a student, and there are a few neuropsychologists who greatly enjoy talking! Furthermore, I feel that what I am pulled to explore – the psychological – is not particularly valued by this group. I mainly absorb. This is useful. I learn a good deal about the controversies that are central to neuropsychology and the various styles of accomplishing neuropsychological tasks.

Autoethnographic Journal:

While on the unit, I kept an autoethnographic journal of my experiences training on the neurobehavioral unit. Akin to the ethnographer's fieldnotes, the dramatic exception of course being that the "native" to be observed was myself, I kept notes of my experiences on the neurobehavioral unit. I was particularly attuned to the ways I was called to perform the role of neuropsychologist. In the course of doing so, quite obviously, my self that was a patient, and a family member of a patient, came into play and relief, each interacting with the other in dynamic and complex ways.

I wrote my autoethnographic journal each day that I worked on the unit. I began by describing what I did that day in a combination of practical and descriptive terms. (For example, a practical portion of an entry might read: "I worked on three neuropsychological testing reports today." A descriptive segment might involve describing my recollections of my thought process, emotional and bodily sensations, and

behavior as I wrote the reports. Such a segment might begin: "I had a hard time focusing on writing my reports today. I found myself feeling that the reports were useless, and could not see the point of mindlessly entering scores into pre-created reports.") I then specifically focused on my emotional and bodily reactions to my duties on the unit as well as descriptions of times when I experienced my self as patient in conjunction or at odds with my self as training professional. (Sometimes these reflections were already integrated in the descriptions.) I then permitted myself to wander in my field notes, believing that doing so had the potential to help me work towards insights of which I was not aware and to detail experiences whose importance were not yet clear to me. At times, I speculated about the meaning of my subjective experience, although my field notes were almost entirely comprised of my embodied experiences. (When analyzing my field notes, I treated these reflections as more data that could be interpreted, thus interpreting my initial interpretations. Indeed, this points to the existence of a fourth self involved in this dissertation project: self as researcher. When I wrote in my field notes, I articulated my embodied experience from the perspectives of the three selves on the unit. When analyzing these notes, I take up the position of yet a fourth self – dissertation writer and researcher – that can see and create meaning not available to my other selves.)

In addition to the practicalities of my interactions on the unit, I was particularly attuned to 'clashes' between my various selves when writing my autoethnographic journal. I saw such moments as rich opportunities with which to explore the very goals and aims of the project, and as fertile ground for highlighting the assumptions, beliefs, practices, and values attendant on the performative role of the self as patient, professional, and family member. Those moments in which I was called to be

incompatible things were especially telling. However, I was not only sensitive to clashes

or conflict, but also noted moments of integration between the roles, seeing these

refreshing moments of coherence as holding a different sort of information, one that

could perhaps be expanded upon in the future. I noted how I was called to enact my

power as a training neuropsychologist, exploring what exactly it is that I was called to

enforce, the justification for that enforcement, and how I concretely enacted that power.

In addition, I noted what that performative call hid, that is to say, what was not obvious,

overt, or apparent even as it had dynamic relation to what was apparent, overt, or

obvious. Similarly, I attuned myself to the reactions of my self as patient and self as

family to such enactments of power. I looked for the power and resistance that my self as

patient and self as family member were able to access. I was also interested in omissions

and points of disjuncture, listening for what was left unsaid and what conflicted with the

official message of the unit. Perhaps it is helpful for me to explain how this entered my

process of writing the autoethnographic journal itself. I asked myself to write down

details on times during the day when I was particularly aware or unaware of my multiple

selves, times when those multiple selves were obviously in conflict or worked together

harmoniously.

I did not keep separate field notes of my performance of the roles of family

member or patient. However, I carried those roles with me as I attempted to take on the

role of neuropsychologist. Without separating them out, I was always already all three.

My body constantly carried these multiple positions, and I myself shifted between them

throughout. Therefore, my performance on the unit includes the performance of the

family member and patient at different moments. I had already learned these roles while

I worked to adopt – at the same time that I was skeptical of – the performance of the neuropsychologist.

Chapter Summary:

In this chapter, I have argued for the suitability of the constructed role of the neuropsychologist for multi-perspectival autoethnographic exploration. I highlighted the context in which autoethnography emerged – notably as ethnography was challenged by a new understanding of its relationship to the Other. I have explained the aims of autoethnography in general and described its suitability as methodology for this particular project. Finally, this chapter outlined the specific context in which this autoethnography occurred.

Chapter 3: Theoretical Framework:

In any form of research, the researcher makes use of a theoretical framework that serves as a basis for the study and for making sense of the data. All research comes from a philosophical and theoretical perspective, and it is useful for the researcher to make explicit – inasmuch as this is possible – the framework and assumptions guiding or buttressing the research. To that end, I introduce Judith Butler (1999) and the concept of performativity in this chapter as the primary framework that I make use of in order to conceptualize identity and selfhood. I call upon Butler's insights to introduce the reader to my understanding of constructed identity and its mode of operating in daily life. Further, I argue that this theory permits a powerful understanding of myself as a multiplicity and offers the hope of a new constructed performance. After reviewing Butler's insights, particularly *Gender Trouble* (1999) and performativity, I move to explain the implications of this theory as it pertains to my own identity and this autoethnographic project.

Gender Trouble

In Butler's (1999) already (in)famous text, *Gender Trouble*, she challenges the rather common and intuitive understanding of gender as necessary, internal, and binary, seeking instead to expose such an understanding as a discourse of truth that serves to limit types of allowable gender expression. Butler looks to disrupt belief in a 'natural' gender. In her reflections on *Gender Trouble,* Butler explains that:

> *Gender Trouble* sought to uncover the ways in which the very thinking of what is

possible in gendered life is foreclosed by certain habitual and violent presumptions. The text also sought to undermine any and all efforts to wield a discourse of truth to delegitimate minority gendered and sexual practices. (p. viii).

By challenging the limits of gender, Butler aimed to expand the field of possibility in regards to gender expression, standing in opposition to the notion that some expressions of gender are 'false' whereas others are 'true'. She does so without the aim of creating a new set of rules to define what is permissible, but rather seeks to expand which gender expressions are possible.

In particular, I opposed those regimes of truth that stipulated that certain kinds of gendered expressions were found to be false or derivative, and others, true and original. The point was not to prescribe a new gendered way of life that might then serve as a model for readers of the text. Rather, the aim of the text was to open up the field of possibility for gender without dictating which kinds of possibilities ought to be realized. (p. viii)

In so doing, she offers an understanding of identity based on performance, in which gender comes to be experienced as a stable, coherent, and essential identity through the repeated performances of gender. Butler (1999) argues that although gender is experienced as internal, it is actually produced through specific stylized performances. There is nothing essential or internal about gender.

The view that gender is performative sought to show that what we take to be an internal essence of gender is manufactured through a sustained set of acts, posited through the gendered stylization of the body. In this way, it showed that what we

63

take to be an 'internal' feature of ourselves is one that we anticipate and produce

through certain bodily acts, at an extreme, an hallucinatory effect of naturalized

gestures. (p. xv).

Thus, Butler offers an identity which is constructed via performance and could, therefore,

be constructed differently. Butler introduces performativity as a means of shifting –

queering – a performance and thus producing a change in the performance. For Butler,

this project is important because the categories of gender are punitive and exclusionary

for, and of, those who do not fit into those "naturalized" gendered categories.

Having provided a brief overview of the mission of *Gender Trouble* (1999)*,* I now

shift to a description of those theoretical developments of Butler's that are most relevant

to this dissertation project.

Denaturalized Gender:

Gender trouble (1999) opens with a critique of stable notions of 'women' that

appears in certain forms of feminist theory. Butler notes that, historically, much feminist

theory has taken the existence of the category and identity of 'women' for granted.

Believing in the existence of a category and identity of 'women,' this kind of feminism

naturally[17] sought to increase the political representation of women.

For the most part, feminist theory has assumed that there is some existing identity,

understood through the category of women, who not only initiates feminist

interests and goals within discourse, but constitutes the subject for whom political

representation is to be pursued (p. 3).

---

[17] The use of the term 'naturally' is a play on words, referring both to the flow between the theoretical assumptions of these feminists and a call for a increased political representation and to their belief in gender as 'natural'.

Butler, however, is troubled by – and wishes to trouble – the concept and category of

'women' itself. Although she acknowledges that representation within feminism comes

from an attempt at change, seeking to improve the political visibility of this category, she

does not believe that successful feminism simply increases the political representation of

the category of women. Butler instead argues that accepting the category of women is

itself problematic, created as it was via a normative function of language. In other words,

Butler is troubled by the normative function of this language, which seeks to affirm

certain so-called truths about women, defining and prescribing what is possible and

acceptable for women. For Butler, regardless of whether or not these so-called truths

improve the lot of the category known as 'women,' it remains exclusionary.

> But *politics* and *representation* are controversial terms. On the one hand
>
> *representation* serves as the operative term within a political process that seeks to
>
> extend visibility and legitimacy to women as political subjects; on the other hand,
>
> representation is the normative function of a language which is said either to
>
> reveal or distort what is assumed to be true about the category of women. For
>
> feminist theory, the development of a language that fully or adequately represents
>
> women has seemed necessary to foster the political visibility of women. (p. 3 – 4)

Butler questions the unity of the category of 'women,' even when the category is

expanded to include a plurality of kinds of women. She is not convinced that the

description or term 'women' aptly describes a particular category of persons. She

challenges the ability of the term as a descriptor of persons with a common identity.

> Apart from the foundationalist fictions that support the notion of the subject,
>
> however, there is the political problem that feminism encounters in the

assumption that the term *women* denotes a common identity. Rather than a stable

signifier that commands the assent of those whom it purports to describe and

represent, *women,* even in the plural, has become a troublesome term, a site of

contest, a cause for anxiety. (p. 6)

As Butler is not convinced that the signifier 'women' aptly represents a group at all, she

questions whether or not feminism is on the right track when it makes use of the term

'women' at all, wondering if, instead of aiming to increase the political legitimacy of so-

called women, it is more useful to challenge gendered categories themselves. She thus

calls for a radical rethinking of identity and feminism.

Within feminist political practice, a radical rethinking of the ontological

constructions of identity appears to be necessary in order to formulate a

representational politics that might revive feminism on other grounds. On the

other hand, it may be time to entertain a radical critique that seeks to free feminist

theory from the necessity of having to construct a single or abiding ground which

is invariably contested by those identity positions or anti-identity positions that it

invariably excludes. (p. 8)

Butler calls for a radical critique that breaks free of the identity of 'women.' Her

concern, amongst others, is that feminist theory that turns towards the category of

'women' invariably excludes those who do not fit within gendered categories, operating

itself as an oppressive regime.

Having introduced the need for a radical revision of identity, Butler (1999) next

considers the way in which much feminist theory has addressed the problem of

constructed identity, namely via the division of sex and gender into two separate

categories. This division has been used to make space for different ways of being a woman, arguing that although sex is (at least in such an argument) fixed by biology, gender is a result of cultural forces. Thus, the existence of the category of gender already disrupts or contests the unity of the subject.

> Although the unproblematic unity of 'women' is often invoked to construct a solidarity of identity, a split is introduced in the feminist subject by the distinction between sex and gender. Originally intended to dispute the biology-is-destiny formulation, the distinction between sex and gender serves the argument that whatever biological intractability sex appears to have, gender is culturally constructed: hence, gender is neither the causal result of sex nor as seemingly fixed as sex. The unity of the subject is thus already potentially contested by the distinction that permits of gender as a multiple interpretation of sex. (p. 10)

Within such a formulation, sex is 'natural' and gender is culturally constructed, but space for contesting the unity of the self is already emerging. Further, Butler is, as we shall see, skeptical of the distinction between sex and gender, ultimately arguing that sex and gender are both culturally constructed.

> If the immutable character of sex is contested, perhaps this construct called 'sex' is as culturally constructed as gender; indeed, perhaps it was always already gender, with the consequence that the distinction between sex and gender turns out to be no distinction at all. (p. 10 – 11)

Thus, for Butler, there is no distinction between sex and gender, as both are expressions of culture. Sex is really gender as it is said to appear on the body.

Having problematized the distinction between sex and gender, Butler takes a closer (critical) look at gender itself. (Since sex *is* gender, she is actually exploring both.) Butler questions what sort of attribute gender is – if it is something that one *has* or that one *is.* She does not answer the question here, simply problematizing the assumed answers.

> Is there 'a' gender which persons are said to *have* or is it an essential attribute that
>
> a person is said to *be,* as implied in the question 'What gender are you'? When
>
> feminist theorists claim that gender is the cultural interpretation of sex or that
>
> gender is culturally constructed, what is the manner or mechanism of this
>
> construction? If gender is constructed, could it be constructed differently, or does
>
> its constructedness imply some form of social determinism, foreclosing the
>
> possibility of agency and transformation? (p. 11)

Having questioned the kind of entity that gender is or does, Butler presses the theory further, questioning the essential nature of the body onto which gender is said to be transcribed. Butler notes that 'the body' is typically described as passive and its existence is taken for granted. The body is viewed as the passive and already-present surface onto which culture can ascribe meaning. Butler questions the assumed already-present body, postulating that instead, the (gendered) body is itself a construction.

> Within those terms, 'the body' appears as a passive medium on which cultural
>
> meanings are inscribed or as the instrument through which an appropriative and
>
> interpretive will determines a cultural meaning for itself. In either case, the body
>
> is figured as a mere *instrument* or *medium* for which a set of cultural meanings are

only externally related. But 'the body' is itself a construction, as are the myriad

'bodies' that constitute the domain of gendered subjects. (p. 12 – 13)

With the body itself reformulated as a construction, Butler questions the wisdom

of turning to the goal of 'unity' within feminist theory. In other words, she questions

those versions of feminism in which the goal is unity amongst women. For Butler, the

goal of unity amongst women within feminist theory is exclusionary and neglects

precisely the constructed nature of the body and the category of 'women'. "In other

words, the insistence upon the coherence and unity of the category of women has

effectively refused the multiplicity of cultural, social, and political intersections in which

the concrete array of 'women' are constructed" (p. 19 – 20). Further, in addition to

refusing the construction of women, 'unity' is prescriptive, ruling out as it does those

gender configurations that do not conform or make sense within this supposed unity.

This call for unity amongst women takes for granted that the category of 'women' exists

in a natural state. Butler asks:

> Does 'unity' set up an exclusionary norm of solidarity at the level of identity that
>
> rules out the possibility of a set of actions which disrupt the very borders of
>
> identity concepts, or which seek to accomplish precisely that disruption as an
>
> explicit political aim? (p. 21)

Believing that 'unity' does indeed exclude, Butler turns away from this formulation and

aim of feminism and its corresponding understanding of gender, and turns instead

towards an understanding of gender that defies totalizing definition, one that permits

wanderings within (without?) gender without a normative telos.

Gender is a complexity whose totality is permanently deferred, never fully what it

is at any given juncture in time. An open coalition, then, will affirm identities that

are alternately instituted and relinquished according to the purposes at hand; it

will be an open assemblage that permits of multiple convergences and

divergences without obedience to a normative telos of definitional closure. (p. 22)

Gender, then - in answer to her earlier question of whether one *has* or *is* a gender –

emerges as something that one *does*. "Identities can come into being and dissolve

depending on the concrete practices that constitute them" (p. 22). Identity – including

gender identity – is comprised of, and constituted by, concrete practices.

Having radically shifted the conception of identity, Butler (1999) asks the reader's

next question: "What can be meant by 'identity,' then, and what grounds the presumption

that identities are self-identical, persisting through time as the same, unified and

internally coherent" (p. 22)? For Butler, stabilized concepts of sex and gender permit a

stable concept of identity. Therefore, when individuals do not conform to traditional

notions of sex, gender, and sexuality, they call into question the concept of stable identity

itself. They are persons who are, according to the laws of identity, incoherent. And yet

they do exist, and their existence is thus threatening to the stability of the concept of an

internalized identity.

Inasmuch as 'identity' is assured through the stabilizing concepts of sex, gender,

and sexuality, the very notion of 'the person' is called into question by the

cultural emergence of those 'incoherent' or 'discontinuous' gendered beings who

appear to be persons but who fail to conform to the gendered norms of cultural

intelligibility by which persons are defined. (p. 23)

Thus, there is an intense pull towards the creation and maintenance of 'intelligible' genders, or those genders which create a sense of continuity in identity via continuity in sex, gender, sexual practice, and desire. "'Intelligible' genders are those that in some sense institute and maintain relations of coherence and continuity among sex, gender, sexual practice, and desire" (p. 23). Of course, not all gender identities conform. Those that fail to conform are classified as developmental failures. Still yet, they persist and proliferate. Their existence – their refusal to disappear – serves as a disturbing reminder that identity itself is not stable.

> Indeed, precisely because certain kinds of 'gender identities' fail to conform to those norms of cultural intelligibility, they appear only as developmental failures or logical impossibilities from within that domain. Their persistence and proliferation, however, provide critical opportunities to expose the limits and regulatory aims of that domain of intelligibility and, hence, to open up within the very terms of that matrix of intelligibility rival and subversive matrices of gender disorder (p. 24).

For Butler, then, gender construction can be hopeful as it offers a chance to enlarge the field of possible gender configurations. Gender construction is hopeful when it acknowledges the contingency of constructions of gender, and therefore its arbitrariness. "Only when the mechanism of gender construction implies the *contingency* of that construction does 'constructedness' *per se* prove useful to the political project to enlarge the scope of possible gender configurations" (p. 49). The construction of gender opens up possibilities for new expressions of gender.

Performativity:

So far, this brief introduction to Butler has traced the development of a theory of gender in which sex, gender, identities, and bodies are all constructed. Coherent genders are used to maintain the illusion of a stable identity, partially explaining – in conjunction with patriarchal motivations – the intense pressure to eliminate 'incoherent' expressions of gender. I now turn to Butler's performativity, her way out of constraining gender configurations.

In essence, Butler's argument is that an internal core of the self is experienced only as a result of words, acts, gestures, and desire that are played out on the surface of the body. Indeed, these words, acts, gestures, and desires construct the body on which they play out. These words, acts, gestures, and desires are performative; they pretend to express an internal identity which is but a fabrication created precisely by this performance.

> In other words, acts, gestures, and desire produce the effect of an internal core or substance, but produce this *on the surface* of the body, through the play of signifying absences that suggest, but never reveal, the organizing principle of identity as a cause. Such acts, gestures, enactments, generally construed, are *performative* in the sense that the essence or identity that they otherwise purport to express are *fabrications* manufactured and sustained through corporeal signs and other discursive means. (p. 173)

The experience of interiority, including the interiority of gender – the internal experience of gender – is a fabrication created by performance. The implications of this are profound – there is no gender (or identity!) apart from the acts that constitute the

performance of gender. Possession of a gender core is an illusion maintained in the service of heterosexuality.

> That the gendered body is performative suggests that it has no ontological status apart from the various acts which constitutes its reality. This also suggests that if reality is fabricated as an interior essence, that very interiority is an effect and function of a decidedly public and social discourse, the public regulation of fantasy through the surface politics of the body, the gender border control of the subject. In other words, acts and gestures, articulated and enacted desires create the illusion of an interior and organizing gender core, an illusion discursively maintained for the purposes of the regulation of sexuality within the obligatory frame of reproductive heterosexuality. (p. 173)

Gender cannot be real and it cannot be false. It is simply performed. It is the result of a discourse and performance of stable identity which is inscribed onto bodies. Gender is neither real nor not real.

> If the inner truth of gender is a fabrication and if a true gender is a fantasy instituted and inscribed on the surface of bodies, then it seems that genders can neither be true nor false, but are only produced as the truth effects of a discourse of primary and stable identity. (p. 174)

There is nothing essential about gender identity. It is produced on the surface of the body via repetition. It is not inherent or truly internal.

The problem, however, is that the myth of an internal gender is an oppressive one, demanding that individual (constructed) bodies conform. It demands that each individual

believe in a distinction between inner and outer, and demands that it experiences and expresses a 'true' gender identity.

> Gender is, thus, a construction that regularly conceals its genesis; the tacit collective agreement to perform, produce, and sustain discrete and polar genders as cultural fictions is obscured by the credibility of those productions – and the punishments that attend not agreeing to believe in them; the construction 'compels' our belief in its necessity and naturalness. (p. 178)

Butler is concerned about the pressure to conform as well as the violence committed towards those who fail to perform gender in a 'proper', convincing manner. This, then, is Butler's motivation for fighting to shake up gender. She turns to drag as a means of intentionally subverting the performance of gender identity, arguing that drag plays with gender and gender identity in a manner that can expose the notion of a 'true' gender identity as a (dangerous) myth. "I would suggest as well that drag fully subverts the distinction between inner and outer psychic space and effectively mocks both the expressive model of gender and the notion of a true gender identity" (p. 174). As Butler explains, drag imitates gender in a way that exposes gender as an imitative structure in itself, thus highlighting its contingency. "*In imitating gender, drag implicitly reveals the imitative structure of gender itself – as well as its contingency*" (p. 175). For Butler, the ability of drag to expose gender as a contingent imitative structure is a major contributor to the pleasure that can be derived from drag. Exposure of the contingency of sex and gender evokes is pleasurable.

> Indeed, part of the pleasure, the giddiness of the performance is in the recognition of a radical contingency in the relation between sex and gender in the face of

74

cultural configurations of causal unities that are regularly assumed to be natural

and necessary. (p. 175)

Further, it is not that drag parodies an 'original' gender. Rather, gender drag parodies the

very idea that there is an original or real gender that can be repeated, instead exposing

gender as an imitation without origin. Drag, as a performance, highlights that all of

gender is performance.

The notion of gender parody defended here does not assume that there is an

original which such parodic identities imitate. Indeed, the parody is *of* the very

notion of an original; just as the psychoanalytic notion of gender identification is

constituted by a fantasy of a fantasy, the transfiguration of an Other who is always

already a 'figure' in that double sense, so gender parody reveals that the original

identity after which gender fashions itself is an imitation without an origin. (p.

175)

For Butler, performativity involves looking for performances that disrupt gender,

exposing its contingency, and paving the way for something new and different to emerge.

Performativity, Neuropsychology, and Autoethnography:

Now that I have introduced the reader to the concept of performativity, I will take

the reader through the specific ways in which the concept of performativity influences

this dissertation project. Many of these implications have been hinted at already, as

performativity deeply influences my concept(s) of self(ves). Even as I write, I am aware

of the absurdity of referring to a 'self' or referring to myself as an "I." The fact that 'I'

must make use of a self-referential term that implies a coherent and stable identity is

precisely part of Butler's point: my body and self are constructed and are limited by language. In this section, I examine the ways in which Butler's performativity influenced the form that this project takes.   It is this that provides a theoretical backdrop for my work, offering a way of understanding neuropsychology through my multiple relationships to the discipline.

This project begins with the assumption that identity is constructed, and that the supposed stability of identity is illusory. One way of queering the myth of stable identity is to acknowledge one's own plurality. This dissertation is itself an embracing of my multiplicity, and is thus a queering of notions of coherent and stable identity. Conceptualizing myself as a plurality already disrupts the fiction that 'I' am singular, stable, and coherent. Performing multiple (supposedly contradictory) performances, I am always already in drag. Writing as a plurality promotes (a) different self(ves). Acknowledging my self as patient, professional, and family member, I already disrupt the notion of stable identity. It is Butler's (1999) performativity that permits me to conceptualize myself in such a manner. Making use of multiplicity in autoethnography disrupts problematic concepts of singular identity.

In addition to the ways in which the acknowledgement of my multiplicity disrupts the notion of a stable identity in itself, the project is disruptive in ways particular to neuropsychology. This dissertation thus begins with a kind of accidental performativity, as my body itself is a queering of neuropsychology. Yet, I find that, as I begin this project, I am not quite clear about the implications of the constructed identity of the neuropsychologist. My constructed selves interact with and create one another, but it is unclear as to how, and why, each was formed. These performances do not involve the

76

kind of intentionality that is characteristic of Butler's (1999) performativity. My

self(ves) as neuropsychology trainee, patient, and family member are constructed, but

their construction was accidental. It is only their accidental location within the same

body that introduces an element of transformation. Although I am already in drag as I

begin this project, I am looking to create different selves in relationship to

neuropsychology that are more carefully considered in their disruption and

transformation. In other words, my "drag" performance thus far has been largely

unreflexive and accidental. I turn, now, to understand the current state of

neuropsychological identities and provide a more carefully considered queering of

neuropsychology. I attempt, first, to use the concepts of constructed identity and

performativity to authoethnographically explore neuropsychology. Secondly, I attempt to

imagine new performances in which the queering of neuropsychology is done with

intention. This dissertation, then, aims to both play within the realm of autoethnographic

multiplicity, but also to intentionally queer habitual performances of neuropsychological

professionals and patients. Butler provides both a means of understanding my

multiplicity and offers hope for the creation of more liberatory performances.

There are some notable differences in the problematic nature of performance of

neuropsychologists and patients versus gender. Power and oppression are clearly at play

in relationship to both, but they operate differently. To begin with, the identity of the

neuropsychologist is constructed in a more formal and explicit manner. One is not said to

be 'born' a neuropsychologist, but rather adopts the knowledge base, training, and

demeanor of one via an explicit training process. One can cease to be a

neuropsychologist. The construction of disability is murkier. Some individuals are

constructed as disabled from birth, and others are socialized into disability later in life. It is possible for a person who is constructed as disabled to be constructed as able-bodied in the future. The socialization process is not formalized like the neuropsychologist's, but neither is disability seen as necessarily central to identity as gender. Gender, with rare exceptions, is ascribed at birth. Training in the performance of gender is constant yet 'unofficial.'   Despite these obvious differences, a process of construction is involved in all.

In this dissertation, I am looking to understand how it is that the myth of a coherent and stable identity of the neuropsychologist and patient evolves. I scrutinize my current and habitual performances, making use of Butler's performativity to conceptualize my plural selves, as well as to discover – create – new ways to queer these habitual performances. I do so with the aim of discovering the motivation behind the performances of various perspectives within neuropsychology. I explore from the boundaries of my own body.

Theoretical Multiplicity:

Butler's (1999) concepts of constructed identity and performativity provide the overarching theoretical framework from which this dissertation operates. However, this dissertation is not, per se, a Butlerian study. Her work offers an understanding of self and identity that this dissertation draws upon, but it is not the only theoretical perspective that is utilized. As I dwell within the autoethnographic, the specter of other theorists may emerge. At those times, I will meander with those other theorists, permitting their voices to contribute to my developing understanding of the constructed identities of

neuropsychologists and patients. Throughout this dissertation, my multiple selves will

interact with multiple theorists in an attempt to understand various relationships to

neuropsychology.

Chapter 4: Separation of Professional and Patient:

Introduction:

I turn first to the separations – both literal and figurative – that serve to split neuropsychology professionals and patients. While on the unit, I had the sense that there were multilayered – often unconscious – efforts to keep professionals and patients separated. Indeed, I felt that my self as training professional and my self as patient were at odds with one another, struggling to separate and yet contained in the same bodily space. In this chapter, I explore this separation, speculate about the function of this separation, explore how the process of separation itself constructs – and constricts – the identity of patient and neuropsychologist. The implications of this construction/constriction begin to appear. Initially, they appear bodily as I find myself struggling with the tensions between my constructed selves in relationship to neuropsychology. Following my auteothnographic explorations of this dynamic, I make use of Michel Foucault's (1965) *Madness and Civilization* as a new frame for understanding these separations.

Hiding Impairment:

Almost as soon as I stepped foot on the unit, I noticed that I became hyperaware of my neuropsychological impairments and that I had a corresponding urge to mask them. I felt a strange urge to monitor myself for evidence of my "impairments"[18] and to

---

[18] The quotation marks around "impairment" indicate my ambivalence regarding the use of this term. I will be in dialogue with this ambivalence throughout this text. My use of the term in this context refers to the way that I am seen, positioned, or cast. What I may refer to as eccentricity is labeled as impairment on

80

disguise that evidence. I put myself in charge of monitoring and disciplining my own

body, eradicating evidence of my self-as-patient. The self-disciplining of my body took

on increased urgency as it is my body that is to be used in order to enforce the regulation

of the bodies of my patients. I am to discipline myself so well that I can become the

model according to which the bodies of my patients are disciplined. And thus, my body

poses a dilemma. On the one hand, I am the standard of normalcy. On the other, I am a

disciplined façade of normality, having reigned in my own deviance. Indeed, the very

fact that I, as someone with neuropsychological impairment, can perform the role of the

neuropsychologist shakes up the notion of neuropsychological normality or abnormality

as having an ontological status[19].

Scene:

I sit with Sondra[20], the neuropsychology technician, as she teaches me how to

administer various neuropsychological tests. She administers each one to me, and asks

me to then administer each to her. I feel a bit exposed, caught, as I scan for tests that

might "catch" me in impairment. I am wary of the Rey figure[21] as I recall a professor

looking over my shoulder at my pathetic excuse of a copy during a class and blurting:

"Kristen! Has anyone ever told you that you're learning disabled? Well…you

compensate well…" I do not wish to be "caught". I feel anxious, as though I will be in

the unit. I use the term in quotes, then, to indicate that this is the part that I am supposed to play, to
become, but that I am ambivalent about doing so.

[19] I wish to be cautious here. I do not deny the existence of symptoms. (For example, I do not deny the
existence of my hand tremor.) Instead, I deny the ontological status of the *identity* that corresponds to the
normality of the neuropsychologist and abnormality of the patient

[20] All persons have been given pseudonyms

[21] The Rey figure is a complicated geometric design. The patient is told to copy the design. The
neuropsychologist then removes the design and the patient's copy and asks the patient to draw the figure
again from memory. Then, twenty minutes later, the patient is again asked to produce the design.

trouble for my deviance, as though I am a fraud who is about to be discovered. I feel that

I cannot be both a neuropsychology trainee and someone with neuropsychological

impairments. Similarly, I shy away from a test that requires me to place the tiny little

metal pegs into tiny little holes as I am timed. I know that my wobbly fingers cannot

accomplish the task as quickly as the norms demand. I tell Sondra, quickly, that these

particular tests look simple to administer and that I'll practice at home with my husband.

She laughs, and says that the family members of students end up receiving full

neuropsychological testing batteries. I slide the materials into my bag, relieved to escape

Sondra's casual scrutiny. I am surprised by my shame, puzzled that I am overtaken by it,

wondering about this new compulsion to obsess over and try to hide my impairment.

Scene:

I am again sitting across from Sondra in the group room, still learning how to

properly administer various neuropsychological tests. She continues to teach me how to

administer tests by administering them to me. This is, admittedly, the best way to learn,

but I'm anxious as all hell. She reaches down the table and slides a wooden contraption

towards me, called the Tower of London[22]. It has pegs of different lengths, with different

colored rings on each peg. She hands me a sheet which shows the figuration into which I

am supposed to arrange the pegs. I stare at the contraption intensely, as though I am

challenging it. I try one strategy of hopping the pegs into the correct color combination,

and it fails. I giggle nervously. I try another. Again, it fails. I pause, take a breath, and

glare at the wooden pegs and painted pieces. I try to think through the puzzle rationally,

---

[22] The Tower of London is designed to test what is termed "executive functioning." However, it also
appears to tap into spatial reasoning, a personal area of weakness.

but it appears logically impossible to accomplish the task. This is the first of several such

configurations that I am supposed to arrange with the rings and the pegs. This one is,

supposedly, the easiest. I feel heat rush to my face. I am absolutely confounded. I turn

to Sondra, and say, my voice full of anxiety but still trying to laugh the whole thing off:

"I can't figure it out!" She is calm and reassuring. I ask her to show me. She quickly

grabs the red peg from its position on a peg, lifts it, and drops it a few pegs over. Relief

floods through me. "Oh, umm, you don't have to hop them over? You can just take

them off and skip pegs?" She laughs. "Yes!" I laugh and declare like a proud child:

"Well, then I think I can do it!" Later, it dawns on me that Sondra was completely

nonchalant when I appeared to be horrifically impaired. I feel anxious, and wonder if I

have demonstrated my impairment at other times, too, and she has covered over any

surprise or concern. I was relieved that my performance[23] on the task was not so

impaired after all. But Sondra's grace in approaching the situation unnerved me[24].

Scene:

I roll my desk chair over to the pink exam table, half-heartedly thumbing through

the Neuropsychology Bible (aka Lezak). Stood up by a patient, I'm bored and tired, but I

feel like I should try to do something useful. I leave the door to my office propped open

with a chair, desiring privacy, but noting that the informal rules of the unit seem to

involve open doors. I've also noticed that it's not uncommon for someone to simply

burst into someone else's office unannounced. I sigh as I flip through page after page,

---

[23] Here, the term "performance" refers to the standard language of neuropsychology reports and case presentations. Nonetheless, Butler's performative lurks – appropriately – within the term.

[24] I do not criticize Sondra for her handling of the situation. I would have, in fact, been absolutely mortified if she had, at any point, responded to me with alarm. Rather, this points to an emerging paranoia on my part and the ever-increasing desire to be undiscovered.

reviewing tests and disorders. Nothing captures my attention. I come to the Rey Complex Figure. I glance out the door, straining to assess the level of activity on the unit. The hall is quiet. I solemnly slide my clipboard towards myself, rip out several sheets of notebook paper, place them on the clipboard, and flip open to a page in the middle. Again glancing stealthily around to ensure that I am alone, I begin to carefully copy the design. My lines are not straight, and I have some trouble making the design in the middle. Nonetheless, I finish the design, close up Lezak, and flip to the next page on the clipboard. I take a breath, and attempt to reproduce the design from memory, muttering to myself as I go. Again, my design is sloppy, and I sit, carefully concentrating and feeling a little bit anxious as I strain my memory. "Okay, there's a cross-like thing down here, then I draw that square with the line through it, and the circle up there…." I talk myself through the process. Nonetheless, I mess up, and flip the paper over, starting again. (This is, of course, cheating.) I work slowly and deliberately. When I finish, reproducing as much as I can possibly remember, I flip Lezak open again, and critique my performance. Not exactly wonderful. I had put an extra line in and left out some details. I hear footsteps coming from down the hall. I fold up my productions and shove them into my backpack. I flip Lezak open to another section. Twenty minutes later, I again flip to a blank sheet of paper hidden in the middle of the pile on my clipboard, trying to reproduce the design once more. This time, I did even worse. I stare at the design longer this time, and I try to copy from memory very slowly. I do better, but still not well. I try one more time before folding up the whole pile into a small rectangle and tucking it covertly away in my backpack.

Scene:

This is my first time testing someone, and Sondra has already prepared a battery of tests for me to administer. She handed it to me, a fat packet of paper, clipped to a clipboard. I feel nervous. I flip through the order several times, and wonder whether or not I remember each test well enough to administer it properly. Sondra sits and observes. I begin with the CVLT[25], and I find myself chuckling awkwardly as I read the instructions aloud in an attempt to read the directions verbatim while still sounding human. Mr. Jones is nervous, and he sort of scoffs at the tests.

I fumble around a bit, and Sondra has to correct me when I forget to administer a part of the CVLT, and she adds in more instructions as I introduce the Trails[26]. I notice that my own hands are shaking as I reach out to hand Mr. Jones a pencil. I glance to see if Sondra notices. Later, I mention that I had to use my Albuterol inhaler earlier in the day, trying to explain away my shakiness. I had indeed used my inhaler, but the effects had long ago worn off. What was that about? Why do I have to excuse my tremor? I feel as though I have done something wrong. The guilt could come from my deception, but it was that guilt that propelled my deception. I felt guilty for being a patient. I felt like, if the professionals on the unit knew, they wouldn't see me as competent. I am trying to pass as free of neuropsychological impairments, and I am constantly searching for evidence that I have been "discovered."

---

[25] This test involves reading a patient a list of sixteen words, then asking the patient to repeat back as many as they can, in any order. This aspect of the test is repeated five times before variations on the task are introduced.

[26] "Trails" is yet another test of so-called "executive functioning." The patient is timed as he connects numbers in order, like a game of Connect-the-Dots. He then does the same thing again, this time alternating between numbers and letters.

Scene:

I have bronchitis, and I keep erupting into distracting coughing fits. I grab some of my "sick teas" – an attempt to avoid steroids whenever humanly possible – and head out to the staff kitchen. I grab a Styrofoam cup and dump my herbal concoction into it. Sondra stops me, and tells me to use a glass container so that I don't absorb the toxins from the styrofoam. Obediently, I pour my mixture into a glass measuring cup. I feel her eyes on me and the eyes of the geropsychologist on me as well. I start to navigate the microwave, and I can't figure it out. It's a really old one, and I keep hitting buttons and nothing happens! Eventually, I turn to Sondra, anxious as hell, and say, laughing: "Ummm, I guess I'm having poor executive functioning. How do I work this thing?" She graciously shows me. I feel vaguely humiliated and patronized. Again, I do not believe that Sondra is behaving in a patronizing manner. Rather, I believe that there is something about my position – my role – that leads to me feeling patronized. I want to prove my competence but feel that, somehow, by trying, I will show the opposite.

Scene:

I take a break and go to lunch with two of the post-docs. I laugh at myself as I struggle to pull the lid off my cottage cheese, my hands fumbling awkwardly. I chuckle and laugh: "See, I'm failing the motor stuff today!" I both feel ashamed that I struggled and that I misrepresented myself.

86

Scene:

I went to the hospital to see a relative last night, and I'm feeling generally frazzled today. I casually chat with Sondra in the hall, and she asks me if I'm going to journal club. I say that I am, and she tells me that it started at 8 am. Shit! I had written it in my schedule for 8:30 and a quick glance at my watch tells me that it's already 8:20! I grab my clipboard and prepare to rush off. Sondra walks down with me, although she does not stay for the meeting. I am embarrassed to realize that I couldn't have found it myself, even though I've been there several times. There is a tunnel system beneath the hospital, and it looks like a huge maze. I find it to be entirely disorienting. Sondra once told me that she would use the maze as an impromptu test, seeing if patients are able to independently navigate it. I know that I wouldn't pass! I can find things like the cafeteria and the store, but only because they are on the same hallway as the elevator, and I go there nearly daily. I wondered if Sondra walked with me because she suspected that I wouldn't be able to find it myself. It was kind of her if she did, but I am mortified by the thought!

Explorations:

I find myself embarrassed by the intensity with which I tried to hide my neuropsychological "eccentricities." This is particularly curious as I am typically open about my situation. At a conference explaining this project, I found myself holding out my trembling hand as gestured evidence of my dual status. It is not something that I typically conceal. In fact, I typically cope by being bluntly matter-of-fact about my tremor and klutziness. I laugh about it a lot. I know that I have a tremor, that my balance

is atrocious, and that I can get lost anywhere. In general, I accept these as just part of who I am, much like my affinity for hot tea. So, I am left wondering what is different about my experience of the unit or my role of the neuropsychologist that is fostering this. Some of this may stem from the unit's shaking of my defensive humor. As I reflect on the meaning of my anxiety of being "caught" having neuropsychological impairments while on the unit, it occurs to me that I am affording the others on the unit with an almost mystical power. I am behaving as if an "impairment" of mine, seen by this particular category of professionals, will lead to something terrible happening to me. It is as though I fantasize that I will become fixed in that impairment; that it will overtake my being. It is as if I believe that the gaze of the neuropsychologist will transfix me into an "impaired state," that something in the gaze itself will permanently morph my "eccentricity" into "disability." I am thus willing to go to great lengths to avoid that transforming gaze. There is something about the power, the authority, performed by the neuropsychologist that seems to call for this. And, of course, it is I who is performing the role of the neuropsychologist. I can exert this power on myself, and find that I am constantly anxious and wary of myself as neuropsychologist. I find that I am trying to "pass" as someone without neuropsychological impairment and that I am simultaneously fearful of my own power to use the power of the neuropsychological to define myself.

This concealment itself seems to perpetuate something, but I'm not quite sure what it is. It is almost as if I begin by feeling guilty for having whatever it is that I have – believing, almost, that there is something inherently shameful about having neuropsychological "issues."[27] The concealment – sometimes downright dishonesty –

---

[27] The awkwardness of my language stems from my struggles to find a non-pejorative word to describe whatever the hell it is that makes me wobbly. Whatever it is that that I use to label my experiences of

that I use to avoid being "caught" as neuropsychologically imperfect leaves me feeling

guilty for both the condition and its concealment. This cycle is self-perpetuating.

It occurs to me that this is, in fact, a narcissistic dynamic. Like the narcissistic

parent telling the child that he or she must be perfect in order to be loved, it seems that I

am experiencing a demand for neuropsychological perfection in order to be acceptable[28].

I feel as though I am restricted to two positions: "normal" or "impaired." Like the

budding narcissist, I find myself concealing my perceived flaws in order to be viewed as

acceptable. My neuropsychological perfection is a façade, and I fear exposure.

Seemingly because of this fear, I find myself noticing the minute details of my

neuropsychological eccentricities in a way that is not typical for me. I do not usually

attend to my tremor, clumsiness, or other symptoms in my daily life. In other contexts, I

do not worry that my gait is lurching or strange. When I am on the unit I feel as though

my flaws somehow degrade my worth as person.   I wonder if there is anything in the

performance of neuropsychology that fosters this dynamic. Patient after patient comes in

concealing symptoms, and I test them while hiding my trembling hands. I wonder how

this came to be.

The Standard of Normalcy:

I notice that the neuropsychologist is expected to perform "normalcy," and is the

standard to which the patient is contrasted. The neuropsychologist is exalted, presented

---

neuropsychological difference is disparaging. I can choose "illness," "disability," or "impairment." The use of these words seems to point, precisely, to this shame and guilt. The term "eccentricity" does not quite capture it either. I struggle to find a term that neither dismisses the difficulties of different symptoms nor leads to an oppressive shift in identity.

[28] Here, I think of Alice Miller's work, particularly *The drama of the gifted child (1997),* in which she empathically explores the dynamics of narcissism. It is her understanding of narcissism that is behind this explanation.

as one who has more than just knowledge to authorize his or her reign, but is sovereign by the manner in which s/he is clothed, or wears – on the body – the purple of that normalcy the patient is not or cannot. I feel as though I am deviating from my job duties when I stray from neuropsychological perfection. I must be normal for my patients to emulate me. This is not quite right. I must be neuropsychologically perfect – superior to normal – such that my patients can attempt to mirror my own performance. My performance must be seamless as I am the standard to which their performance is compared and labeled as defective. My body must be thoroughly disciplined as it is vital for disciplining the bodies of others. And, as my body's multiple roles so clearly demonstrate, this standard of normalcy that is to be performed by the neuropsychologist such that the patient might emulate it is a fictional ideal. It is impossible for the patient to perform this ideal, and it is impossible for the neuropsychologist to truly 'be' what she pretends to be. This 'ideal' is therefore an oppressive ideal, demanding the impossible from the patient, as the neuropsychologist pretends that her performance of neuropsychological perfection represents something real. As my body shows in exaggerated form, the so-called perfection of the neuropsychologist is a false one and a regulatory one. Even more than the impossibility of perfection on the part of the neuropsychologist is the prospect of perfection performed by the patient. The patient, therefore, is left in a state of constant striving. Moreover, the patient is told that she need not strive for neuropsychological perfection, that she should simply *have* that perfection. I find that I am pulled to perform neuropsychological perfection, but to do so seamlessly, effortlessly. I feel pulled to hide my impairment in such a way that looks effortless.

Perhaps the big secret that I conceal from my patients is the effort that it takes to present the 'normal' surface of my body.

Scene:

I am in the process of testing my first patient by myself. Everything has gone fine so far, but now it is time for the finger tapping test and motor programming test. I suddenly feel tense. For the "finger tapping test" I am supposed to place my hand on a board with a lever and a counter on it, and demonstrate keeping the rest of my hand still and pressed flat to a board as I rapidly press the lever with my index finger. It is a situation where my tremor can not only emerge, but interfere. I take a breath and reach for the tapping board. I manage to demonstrate without disaster. Now, it's time to tackle motor programming. For this, I am supposed to demonstrate a series of somewhat complex hand movements. I feel a strange surge of pride when I succeed[29]. (Again, I am falling into the trap of equating 'normalcy' with 'intact' performance.) I have mastered the test! It feels strange to me that I am the standard to which the patient is compared. This is so taken for granted – I casually demonstrate the "correct" way to do it and then carefully observe to see if the patient can do it. Except, in order to be able to do this, I have spent several evenings at home, practicing over and over while muttering to myself: "Fist, flat, side. Fist, flat, side…" I spent a good deal of time training each finger to tap my thumb in succession without any "double-taps." I am supposed to present the face of normalcy to which my patient is compared, but I had to train in order to do so.

---

[29] Here, I am equating an intact performance with an unimpaired neuropsychological state. I thus grant the tests the power to exonerate me, to declare me "normal."

Scene:

I am sitting with Mr. N., doing an assessment following what he terms "a bang that [he] heard in [his] head." Neuroimaging suggests that he has had a stroke[30]. He is somewhat aphasic, meaning that it has become very difficult for him to express himself verbally. He quickly became frustrated with testing, and told me that he wished that he had not "gotten into this business," meaning that he regrets having shown up for testing. Dr. G. has told me to administer the Wisconsin Card Sort[31], and to do it by hand. I feel nauseous, but I still do it. For the Wisconsin Card Sort, I lay out four cards, and tell the patient to match each card from the stack with one of the four cards. I cannot tell the patient how to do this, and he is supposed to use trial and error in order to logically deduce how to match the cards. Each time the patient places the card, I am supposed to give the patient "feedback" by stating: "correct" or "incorrect." Once the patient has matched so many cards correctly, I change the rules without telling him. The patient is supposed to repeat the process and figure out the next way to match the cards. Mr. N. does not catch on. Each time he places a card improperly, I must say: "incorrect." He is wrong each time. He stares up at me with surprised and hurt eyes at each measured "incorrect." Eventually, I cannot stand what I'm doing to him and I end the test. I awkwardly take the stack of cards away from him and say, cheerfully: "Okay! Good!" in a lame attempt to make him think that he did well. This is an exaggerated version of the entire testing situation. I sit across from the patient, and question him. He does not

---

[30] I have referred to neuroimaging in a brief, declarative sentence. In subsequent chapters, I will dive into the philosophical and ethical complexities brought about by the emergence of, and reliance on, neuroimagine. For now, however, I simply use the term in a manner that reflects the current function of neuroimaging in neuropsychology.

[31] This is designed to test executive functioning, which means that it supposedly tests abilities such as abstraction and problem solving. The test can be administered on the computer or "by hand" with the neuropsychologist or neuropsychology technician sitting across from the patient. Administration is typically done by hand when the patient's "frustration tolerance" is under question.

know how I will evaluate him. I adopt the role of the one who has the answers. The contingency of my knowledge – my literal possession of the answer key – seems to fade into the background. In the position of the neuropsychologist, I am the one who knows in contrast to my unknowing patient.

Scene:

I walk Mr. T. back to the waiting room and tell him that I'll be back in a few more minutes to give him some tests. He smiles and assents: "Alright." I check in with Dr. G., who tells me to give him a "standard battery"[32]. I go and gather up all the testing material, head back to the waiting room, and walk down with him to the testing room. I start with the CVLT, and he laughs at himself for not getting more. I notice that my voice, as I read, is firm and declarative. I try to keep my voice cheerful as I give the instructions for each additional repetition. Always, though, my voice is firm and knowing as I read the list. His, in answer, is tentative, questioning, and sometimes disgusted. I feel like a slightly patronizing teacher with a cheerfulness that borders on denial. I move on to the Trails test. He does fine until the second set of trails, where he makes some errors. I "redirect him", explaining the task to him, and showing him his "errors." I have watched carefully, and it is assumed that I will notice when he improperly approaches the task. He doesn't seem to understand what I'm asking of him, and I repeat myself again and again until he catches on. Again, I am the one who knows and he is the one who does not. My knowledge and his ignorance do not need to be stated. They are implicit in the testing situation itself. On the information subtest of the

---

[32] A standard battery includes tests designed to assess simple and complex attention, visuospatial abilities, verbal abilities, motor functioning, and executive functioning.

WAIS[33]– a task where I ask the patient questions about information that is part of a standard high school curriculum – he begins by answering my questions authoritatively. As standardized administration demands, I try to keep my voice impassive, not telling him whether or not he is answering correctly. Near the end of the subtest, he seems to become embarrassed that he no longer knows the answer. After he misses six wrong in a row, I cheerfully say: "Okay! Good!" as I close the book. Like before, a sugary cheerfulness enters my voice. It sounds patronizing, but seems preferable to total impassivity. (At the same time, I realize that I am doing precisely what I fear that my colleagues on the unit might be doing: noticing impairment and pretending not to.)

Scene:

This could be Any Meeting, as this scenario occurs almost any time a group of us gathers. Dr. G., or Dr. S., or someone will forget to bring something essential, will drop something, or otherwise become involved in some minor mishap. Inevitably, the person involved will laugh and quip: "Uh-oh! Maybe *I* have (fill in disorder of choice.)" This comment is immediately followed by hearty laughter from all present. The comment is funny due to the presumed absurdity of the speaker really having such a disorder. Indeed, it is funnily absurd that the person in question could ever develop such a disorder! It reminds me that, through the process of becoming a neuropyschologist, it becomes difficult – although not impossible – to complete neuropsychological testing oneself. The tests require that the patient is not familiar with either the content or the aim of the test, and the very administration of the instruments renders them incapable of

---

[33] WAIS stands for Weschsler Adult Intellignce Scale and is the most commonly administered intelligence test.

measuring oneself. But, given the presumed absurdity of ever developing such a

disorder, no-one seems to be overly concerned about this.

Explorations:

It is this presumed normalcy that begins to contextualize my shame for lacking

neuropsychological perfection and my subsequent attempts to hide my own

neuropsychological eccentricities. I am supposed to perform normalcy from which my

patients are to be compared. Indeed, it is so assumed that I am neuropsychologically

"normal" that the testing situation literally requires that I am. There is something

educative about my presentation to the patient. Through my presentation, I am supposed

to demonstrate to the patient the desired performance of normality. I try to hide my

queering of the performance of neuropsychologist, as I expect that I will be punished for

deviation. I am repeating the performance of neuropsychologist, which is also supposed

to be the standard of normalcy. This means that it is difficult for me to embody –

perform – both neuropsychologist and patient simultaneously. The construction of the

performance of neuropsychologist is in opposition to the performance of patient. Indeed,

the performance of one relies on that of the other. The neuropsychologist is contrasted

to, and in a certain sense, created by the patient. A thick barrier between the two is

required for the identity of each.

I consider the question of censure and punishment for deviation. This has not, by

any stretch of the imagination, been a direct threat. And I am not quite certain of my

specific fear. The men and women with whom I work are certainly too kind and ethical

to take any kind of direct action against me in response to my deviation. Indeed, I do not

95

see my coworkers as consciously enforcing the performance of the neuropsychologist. Indeed, I suspect that I am only aware of the performances that create the appearance of the categories of patient and professional as I do not fit neatly into the available categories! I seem to fear a particular vision of myself, a way in which my identity will shift if I queer the performance. I will no longer be viewed as a part of the group. I will lose my insider position. I imagine, too, that this could have implications for my training. Would I be seen as "just not fitting in", in some hard-to-define way that slips into my evaluation? Would I just be seen as vaguely "not good enough?" I notice that this insider position seems to be associated with some kind of moral superiority. The patient is seen as flawed.

Patient as Flawed:

The idea that the patient is flawed is never presented explicitly and would likely be fervently denied, although I find that it is ever-present. The patient's body is in need of discipline. The patient must come to see his own way of being as impaired and flawed in order to accept the disciplining offered by the medical profession. In a capitalist medical structure, the services of professionals are peddled, and individuals with varying medical conditions must be convinced that they require treatment. I find that I am called to view the status of patient as one of inherent flaw.

Scene:

My patient, a man in his thirties with a diagnosis of multiple sclerosis, is about an hour late. (I must comment on my use of the phrase "my patient." The term is one that is

96

used on the unit frequently – "Kristen, your patient is here." I am ambivalent about the term as it both points to the very capitalistic possession that I alluded to in the previous section but it also points to an ethical call in that the patient's care is my responsibility, as an ethic. And I find myself hovering between the two – a kind of capitalistic, oppressive, possession and an ethic of care.) I'm scoring tests and working on reports as I kill the time. I notice a guy in his thirties walk down the hall, so I kind of followed him down to the waiting room. He stands at the check-in window, and I call out "John?" He nods and apologizes for his tardiness. He had mistakenly driven to a neighboring state, and blamed his mother for misdirecting him. He asks for the bathroom. I direct him back around towards the waiting room and show him the patient bathroom. I walk down the hall, then back up, not wanting to hover outside the bathroom. As I do, I reflect on John's appearance. Jeans. Leather jacket. Friendly face. Just a few years older than my husband. Looking at him, I'd never guess that he has MS. I wonder why I assumed that I would be able to tell.

Scene:

I start an interview with a patient with suspected dementia by asking him a series of questions about his memory loss. This is a little bit absurd. He doesn't remember! He tells me when he first noticed it, but then speculates that his wife likely noticed years earlier. I ask him to describe the kinds of things that he forgets, and, as he speaks, I mentally scan for what might be wrong, running through lists of possibilities of diagnoses in my mind. As he tells me about "forgetting to check" lists, I start to think of executive dysfunction. I ask him about histories of head injury, and he tells me about a brutally

97

violent incident from his childhood. I empathize with him, but only momentarily before asking him for an estimation of the length of the resulting loss of consciousness. I am not listening to his answers for their meaning to him, but rather for patterns of deficit. I am listening to hear "strange" ways of answering questions – like when I ask about a family history of neurological disorder, and he tells me about his stepfather. (I note to myself that he has missed the point of the question!) I become suddenly aware of my detached, impersonal, deficit-oriented stance when I am briefly flung out of it. I ask him how many years of education he has – a required piece of knowledge to generate properly standardized norms – and he tells me that he earned a BA in political science. I pause, and murmur "cool!" finding myself wondering more about his life. Suddenly and unexpectedly my patient became a person again rather than potential deficit. It felt to me that the ear with which I could listen to him as a man with an interesting life story was not the same ear that could be a neuropsychologist.

Scene:

　　Leaning against the doorway, I chat with Amber, the intern. We seem to spend a good deal of time in this position, leaning against the wall and chatting. I typically ask her to explain various testing or disease processes to me. Other times, though, we chatter and whine. Today is one of those days. As we chat, Amber relates an embarrassing anecdote: "Oh my *God!!* I was so embarrassed! I treated the mailman like a patient!" I was left considering all of the implications of that statement, and wondering if we should strive to treat all of our patients like they are mailmen!

Scene:

At the end of the day, I slump over my desk working on a report, basically killing time until I can leave. I see, through the open door, two men walking down the hall together. I hear slight commotion on the unit and I walk down the hall to check it out. Sondra and Marilyn are out there. They're excited, and ask me if I saw the men. I said that I did, but not clearly. Sondra has called the hospital cops. She tells me that she stopped the men and asked them if they needed help, and they replied that they were just looking around, then asked her if that "makes [her] nervous." When the police come, they ask us if the men "looked like patients." We all concur that they did. But what does that mean? They were a bit scruffy looking, and it is true that they were not wearing the kind of clothing that is permissible for many of the jobs in this hospital. Yet, I still have not been supplied with a badge and technically have nothing that identifies me as a professional on the unit. No-one seems to think that I look like a patient, but I technically am one, although not on the unit. Am I not seen as a patient because of the way that I am dressed? What does it mean to "look like" a patient, anyhow?

Scene:

I am in Sondra's office choosing from a pile of manilla envelopes containing consultations, selecting which patients to work with. (This is an odd process. The intern, post-doc, and I will trade charts with one another like they are baseball cards: "I'll trade you a traumatic brain injury and competency evaluation for a Parkinson's Disease…") I hold up a folder containing a consult from a neurologist who has noted that the patient had been "inappropriate." I ask: "What happened?" Sondra laughs, and tells me that the

patient "creeped out" the neurologist by his "vague flirtation." I slump into Sondra's

chair and roll my eyes. It is an open secret that this particular neurologist has a penchant

for sexually harassing female students. We are laughing that, for once, he is the one who

felt uncomfortable! But I notice something in this. When a patient is vaguely flirtatious

in an interview, a consult is put in for neuropsychology to evaluate him for executive

dysfunction. When the neurologist has a decade long record of harassing students, new

students are covertly warned. What is viewed as impairment in a patient is simply

accepted as scandalous fact in the neurologist. (There are certainly sexist and

heterosexist dynamics at play here as well. The neurologist was "creeped out" by the

sexuality of another man. It was probably easier to pathologize this and label the

flirtation as "deviant" because of a prevalent homophobic viewpoint. Furthermore, it is

typically the male neurologist harassing female students. There is a way that such

appalling behavior is accepted and tolerated under a lingering "boys will be boys"

attitude that did not appear when the male patient flirted with the male doctor. However,

the presence of these dynamics does not discount those of professional and patient.

Rather, all of these overlap.) This makes me wonder if my "impairment" is "forgiven"

by my status as training professional, and if so, if this is part of my motivation for

training. My fears of losing professional status remind me that it is that very status that

permits me to be "quirky" without obtaining a label of deviance.

Explorations:

I have noticed a pervasive assumption that there is something wrong with

patients. This often has a moral tone to it that is never directly articulated. I have noticed

that I look at my patients through a lens of impairment, and I am surprised when I encounter the patient as a person. When the police asked if the men seen intruding on our unit looked like patients and I agreed, I subscribed to a belief that there is an identifiable way that patients look. This difference is labeled impairment. A patient's flirtation is inexcusable and defined as executive dysfunction, whereas a neurologist's is begrudgedly accepted. I subscribed to a narrative that declares that patients are fundamentally and recognizably different from practitioners. It is, therefore, not surprising that my own identity on the unit feels so confused. I wonder who I am when it feels like my multiple selves are incompatible. When I think of the liberty which is granted the neuropsychologist but not the patient, I notice that there is something prescriptive about each identity. It is not that the behavior of the patient leads to the label of impairment. Rather, it is the label of "patient" that leads behavior to be categorized as impaired. It is for this reason that I am intensely ambivalent about my role as patient. Because the interpretation of behavior depends so heavily on whether someone is in the category of "patient" or "professional," the boundaries between the two are supposed to be thick.

Valorizing the Neuropsychologist:

I notice that, in addition to the direct devaluation of patients, there is a corresponding valuation of neuropsychologists in contrast to those patients. The neuropsychologist's desires and comfort is privileged above those of the patients almost exclusively, and with little reflection or discussion. In order for the patient to become convinced of the need to discipline his body, the neuropsychologist's body – indeed, her very being – must be valorized.

Scene:

I want to schedule an appointment with a patient whose consult I have just received. I send Jeanette an e-mail – on the secure server – that tells her when I want to schedule him for. I add in: "Send the usual." This means that Jeanette will mail the patient a letter and a questionnaire for the patient and his family to fill out. I am fascinated – and somewhat appalled – by the letters that we send out. The letter informs the patient of the time, date, and location of his appointment. It explains that, should he cancel this appointment, a new consult will need to be submitted before a new appointment will be made. It notes that this will likely take a few months. These letters do make scheduling convenient – for me, anyhow! – but they certainly value my time over that of my patient's. It is assumed that whatever the patient had intended to do at the time that I scheduled the appointment is less than necessary and can be easily changed or eliminated from a schedule. My time is assumed to be more valuable.

Scene:

I am meeting with Dr. G., and we are discussing a patient who I may have some questions about. I am not quite to the point where I can easily determine which tests to administer. I have adopted a standard battery, and can adjust it somewhat based on what I see happening. (For example, if someone struggles with the Rey Complex Figure, I will then administer a series of tasks that break down the various skills involved in the Rey, in an attempt to determine what exactly is going wrong.) Still, I am not always sure what to administer, and Dr. G. has told me to come to his office between the interview and

administering the tests if need be. On the one hand, this makes sense, and it ensures an

efficient use of my patient's time. But, whenever I do send my patient down to the

waiting room and pop into Dr. G.'s office, I feel disrespectful. These meetings do not

seem to take into account the person who is sitting and waiting for me. They are

leisurely. As I sit around his table and he hands me some interesting articles, I realize

that me being interested is valued more than whatever time commitments my patient

might have. I think back to my own waiting room experiences, the endless reading or

knitting often while excruciatingly anxious.

Scene:

The bathrooms seem to symbolize the unit's respective understanding of the

various persons on the unit. The staff bathroom is not labeled as such and requires the

possession of a key to enter. It is discreetly located at one end of the hall. (My status as

a student is clear in the dubious honor of owning the office next to it.) There is a sliding

"in use" sign outside. The patient bathroom, however, is labeled as such. It is about the

size of a small closet and is attached to the waiting room. It is not extraordinarily private,

as the flimsy door is literally inches away from waiting room chairs. The attitude

towards each group can be captured by the differences in the bathrooms.

Explorations:

Overall, the message of the unit is that my time, comfort, and knowledge is

superior to that of my patient's. This does not seem to require justification, but is rather

simple truth. It would seem as though this valorization of the patient serves to perpetuate

the notion that the patient is supposed to behave in a manner consistent with the myth that the neurospsychologist is both different from, and superior to, the patient. Again, it is my dual roles that points to the construction – and absurdity -- of such an assertion. It is this absurdity that permits me to address these problems.

Being Torn:

I experienced the separation between the neuropsychologist and patient quite bodily during the first part of my rotation. I dreaded going into the unit for the first several months of the rotation, feeling as though my body simply could not tolerate the tension of embodying both positions simultaneously. I felt called to perform two antithetical positions, and I felt exhausted by the attempt. How could I, simultaneously, be the model to be emulated and the one trying to learn? How could I possibly discipline my body well enough to be a convincing model? Why would I consent to trying? It deeply disturbed me that I found myself attempting to be "normal." I was angry with myself for siding with the neuropsychologist in me and oppressing the patient within, but I was also frightened and frustrated that I could not do this successfully. This bodily tension is reflected in my field notes. Initially, I struggled to articulate what was happening to me. I felt awful without understanding why. All I knew was that I had intense anxiety and physical reactions when I thought about going to the unit. This confusing dread made frequent appearances in my field notes:

> October: "I really hate this. I actually despise going into work. I woke up today feeling nauseous. I actually felt dread in the pit of my stomach. What's strange is that I'm alright when I'm actually there, but the thought of going in makes me

feel absolutely horrible. I hate myself for going there, but I'm not really sure

why! I'm trying to unite all of these aspects of myself, but I just don't seem to be

able to!"

Later, I became more able to articulate the difficulty that I encountered when struggling

to stuff multiple – contradictory – performances into one overburdened body.

November: "I know that it looks shady because I was just out of town, but I called

off today. I'm aching, coughing, and have a fever. I spent the day lying on the

couch in my pyjamas and working on a paper for a critical race theory class. I am

legitimately sick, but I think working on my critical race theory paper was

something that I needed as well. I felt like I've neglected the part of myself that

resists and subverts, and I am not liking myself as a result…It's hard for me to

just get through the day there. I'm torn between wanting to be a good trainee and

hating what it is that I'm learning. Or maybe it's more that I hate what I'm

becoming. I'm starting to literally feel the tension in my body when I'm there.

My migraines have come back – both as reminder of my own neuropsychological

risks, and as a manifestation of this tension literally within my body. It really

does seem like these two positions are at odds with one another."

I began to notice that the physical sensations seemed to relate to the tensions between the

roles of patient and neuropsychologist. I was surprised that this was such a *physical*

experience! And yet, it seemed that the way out – rather, the way *through* – these

tensions involved the auto-ethnographic journal itself. By writing the experience,

beginning to follow the traces (Derridian) that could help me to make sense of this, I was

able to begin to bridge (transcend?) the positions that split me in two.

Late November: "God, I hate it. I'm still oscillating between trying to absorb

myself in what I'm supposed to be learning and despising what it requires of me.

I feel frozen, perpetually guilty, and trapped. I feel guilty for learning and getting

absorbed in the role of NP, but I also feel guilty for not trying harder to learn. I

feel as though I am betraying my own values, but that I am simultaneously being

a "bad student."   In order to do enter into one position – here, an urgency wants

me to label this a 'self' – I am annihilating the other.

The thing that's surprised me the most is that I'm having a hard time being

subversive there. It's like there just isn't the space for that. I try to react to

patients in a way that makes space for liberation, but it feels like I just can't. It's

like…I can't even *think* of a way of being there that could possibly be libratory.

It feels like I have been stripped of everything that's important to me when I'm in

there."

As I continued to feel the embodiment of the neurospychologist within me, I found that

the aspects of myself as patient that are interested in resistance fell silent. As I became

increasingly aware of the separation of patients and professionals on the unit that led to

these bodily tensions, questions remained as to exactly how and why these separations

functioned.

Madness and Civilization - Foucault and Separations:

As I struggled to understand the separations of patients and professionals that both

create and are created by the performance of the neuropsychologist and the resulting

questions regarding the function and enforcement of those separations I was reminded of

106

Foucault's (1965) *Madness and civilization.* In particular, the chapter entitled "The Birth of the asylum" came to mind through its characterization of the period of time after the shift from externalized to internalized control. I came to realize that it was this internalized control that operated on my body and the bodies of my patients and could help to explain the ways that the separations featured in this chapter functioned.

In *Madness and civilization* (1965)*,* Foucault tells a tale of changing beliefs regarding madness, and thus the ways in which madness was responded to and controlled in Western culture. Foucault analyses the history of psychology and its use of power, observing that the power of psychology has shifted from exerting physical control over the body to an internalized control in which patients are taught to discipline their own bodies. Instead of control of the mad being accomplished through the use of physical restraint and punishment, the mad were taught to control themselves. *Madness and civilization* is largely the story of this transition. Although Foucault does not specifically explore the history of neuropsychology, the historical analysis conducted by Foucault is relevant as neuropsychology had not yet been distinguished from psychology itself. As previously noted, neuropsychology did not emerge as a distinct subspecialty until after World War I. Thus, Foucault's *Madness and Civilization* encompasses a historical analysis of neuropsychology. I turn now to briefly outline the historical eras presented in *Madness and Civilization.*

Middle Ages:

Foucault's historical analysis of the transition from externalized to internalized control of the mad begins at the end of the Middle Ages, when leprosy had "disappeared from the Western world" (Foucault, 1965, p. 3). The epidemic of leprosy left behind lazar houses on the literal margins of communities, empty and uninhabitable. Foucault argues that the lazar houses which had housed the lepers fulfilled an important symbolic function that lasted beyond leprosy itself. When the lepers left, the need for the symbol of the leper remained. The lepers's exclusion fulfilled important symbolic functions. Madmen filled the void.

> Leprosy withdrew, leaving derelict these low places and these rites which were intended, not to suppress it, but to keep it at a sacred distance, to fix it in an inverse exaltation. What doubtless remained longer than leprosy, and would persist when the lazar houses had been empty for years, were the values and images attached to the figure of the leper as well as the meaning of his exclusion, the social importance of that insistent and fearful figure which was not driven off without first being inscribed within a sacred circle. (p. 6)

The symbolic space which had been filled by the leper was left open, with the literal space of the lazar house calling to be filled. The exclusion of a fearsome group was necessary, and madmen were called to fulfill this function. Madmen were placed on the Stultifaras (the Ship of Fools) and literally cast out of society, set afloat on a sea of purification. Water functioned symbolically, serving to literally carry away the madman, but also to purify. "But water adds to this dark mass of its own values; it carries off, but

108

it does more: it purifies" (p. 11). The symbolic space left after the decrease of leprosy

was filled by expelling madmen out onto the water on the Ship of Fools. Thus, at the

time of the Ship of Fools, madness was formulated as requiring purification. Once

leprosy no longer carried its mysterious threat, society needed the madman in order to

cast him out on a sea of purification, to hold him in a marginalized position. The

madman was controlled via his perpetual voyage, cast out from society with no ultimate

destination.

By the seventeenth century, or the Great Confinement, the *Hopital General*

housed both the mad and the physically disabled, replacing the Ship of Fools in the

symbolic and practical handling of the mad. The mad were confined within the hospital

rather than cast out on the symbolic Ship of Fools. The *Hopital General* was not a

hospital in the contemporary sense of the term – there was no provision of medical

treatment, but the hospital rather functioned as a means of establishing and maintaining

order. "Before having the medical meaning we give it, or that at first we like to suppose it

has, confinement was required by something quite different from any concern with curing

the sick" (Foucault, 1965, p. 46). The mad were not sent to the *Hopital General* to

improve their health, but instead to maintain order via their separation from the rest of

society. "In its functioning, or in its purpose, the Hopital General had nothing to do with

any medical concept. It was an instance of order, of the monarchical and bourgeois order

being organized in France during this period" (p. 40). The *Hopital General* functioned as

a condemnation of idleness, and madness was an ethical rather than medical problem.

Control of the madman during the Great Confinement came from outside and was

physically applied to the bodies of the mad via confinement.   The message sent by this

physical control was that the objects of control were unacceptable deviations. Madness was physically controlled via segregation from the rest of society. The Great Confinement involved physically removing the mad from society and confining them in the hospital as a means of moral condemnation. The control of confinement is a physical one – the body is itself restrained.

This confinement was not to last forever, and eventually some called for a different kind of treatment of the mad, one that did not rely so heavily on physical control. Tuke's Quaker Retreat, in which madmen were unchained and put to work in a religious environment, is one such example. Rather than the physical restraints of constraint, the madmen were given a regimen of relative physical freedom and religious ideals. Although it is commonly believed that the unchaining of the mad that occurred following the Great Confinement represented an act of benevolence, Foucault swiftly challenges this common (mis)perception.

> Tuke's gesture, first of all. Because it is contemporary with Pinel's, because he is known to have been borne along by a whole current of "philanthropy," this gesture is regarded as an act of 'liberation.' The truth was quite different, (p. 243)

According to Foucault, Tuke's Retreat was not motivated by benevolence, but rather by a belief in the power of religion to enforce rule and instill reason and therefore effectively combat madness. It was for the purpose of the control induced by religious principles, argues Foucault, that Tuke established his Quaker Retreat for the mad:

> But the principal reason lies elsewhere: it is that religion can play the double role of nature and of rule, since it has assumed the depth of nature in ancestral habit, in education, in everyday exercise, and since it is at the same time a constant

principle of coercion. It is both spontaneity and constraint, and to this degree it

controls the only forces that can, in reason's eclipse, counterbalance the

measureless violence of madness. (p. 244)

Religion is coercion, and the Quaker Retreat strove to coerce the madman into proper

behavior. Religion is called upon for its ability to control. Foucault goes further. The

aim of Tuke's Retreat is, in some ways, the very antithesis of a humanitarian act! Far

from aiming to decrease the anxiety of the mad by removing them from their chains,

Tuke's Retreat rather aimed to *increase* the madman's anxiety via the introduction of a

moral element:

> Religious segregation has a very precise meaning: it does not attempt to preserve
>
> the sufferers from the profane presence of non-Quakers, but to place the insane
>
> individual within a moral element where he will be in debate with himself and his
>
> surroundings: to constitute for him a milieu where, far from being protected, he
>
> will be kept in a perpetual anxiety, ceaselessly threatened by Law and
>
> Transgression. (p. 244 – 245)

Tuke established an environment where the madman must be perpetually anxious. The

Retreat transformed madness from something that causes fear to something that is itself

afraid. Madness was no longer feared, but madmen feared (p. 245). Thus, Foucault

argues that Tuke's aims were not humanitarian ones of liberation but rather of control,

albeit a different kind of control than that of the Great Confinement. Tuke's Retreat

created a different kind of order in which the madman was perpetually judged by himself.

This different kind of order had a profound impact on the freedom of the madman. When

subjected to physical confinement, the madman is still free to embrace his own madness.

He is subject to the control imposed upon his body but he is not compelled to condemn

his own behavior. He was free to want what he wanted. This changed with the

introduction of the religious sensibilities imposed by Tuke. The madman became subject

to a control from inside himself. He had to evaluate and judge himself. Thus, while

given more physical freedom, the madman's internal freedom was drastically limited

though the control of conscience.

> We must therefore re-evaluate the meanings assigned to Tuke's work: liberation
>
> of the insane, abolition of constraint, constitution of a human milieu – these are
>
> only justifications. The real operations were different. In fact, Tuke created an
>
> asylum where he substituted for the free terror of madness the stifling anguish of
>
> responsibility; fear no longer reigned on the other side of the prison gates, it now
>
> raged under the seals of conscience. Tuke now transformed the age-old terrors in
>
> which the insane had been trapped to the very heart of madness. The asylum no
>
> longer punished the madman's guilt, it is true; but it did more, it organized that
>
> guilt; it organized it for the madman as a consciousness of himself, and as a non-
>
> reciprocal relation to the keeper; it organized it for the man of reason as an
>
> awareness of the Other, a therapeutic intervention in the madman's existence. In
>
> other words, by this guilt the madman became an object of punishment always
>
> vulnerable to himself and to the Other; and, from the acknowledgement of his
>
> status as object, from the awareness of his guilt, the madman was to return to his
>
> awareness of himself as a free and responsible subject, and consequently to
>
> reason. (p. 247)

The external control of chains and physical abuse was exchanged for an internalized control – self-restraint via anxiety and guilt. The chaining of the heart and mind is more significant than the unchaining of the body. The Retreat strove to create an atmosphere where the madman developed a conscience and was subsequently put in charge of his own behavior and returned to so-called reason. This shift is of the utmost importance, as it marks the introduction of 'self-restraint' into the life of the madman. Guilt, not physical constraint, emerged as the primary means of control:

> We see that at the Retreat the partial suppression of physical constraint was part of a system whose essential element was the constitution of a "self-restraint" in which the patient's freedom, engaged by work and the observation of others, was ceaselessly threatened by the recognition of guilt. (p. 250)

The madman's guilt controlled him instead of chains. This new internalized control was concerned with external appearances alone. The experience of the madman, the thoughts of the madman are not of importance. What is left is what is visible:

> It [madness] is judged only by its acts; it is not accused of intentions, nor are its secrets to be fathomed. Madness is responsible only for that part of itself which is visible. All the rest is reduced to silence. Madness no longer exists except as *seen.* (p. 250)

The madman was compelled to render his madness invisible. Through this shift to madness as seen, authority has been born: "Something had been born, which was no longer repression, but authority" (p. 251).

Thus, we see that Tuke's Quaker Retreat made use of religion in the service of control, in order to reign in the madman. The madman is made to feel anxious and guilty,

and these emotions are used in the service of controlling his behavior. The conscience is used in order to compel the madman to erase the signs of madness from his body. The Quaker Retreat is not, as it first appears, representative of a reduction in the control exercised over the madman, but rather of a shift in the kind of control employed. A shift from external control that is applied to the body of the madman is traded for an internalized control in which the madman himself condemns and regulates his madness.

Pinel:

Foucault (1965) next unpacks Pinel's Asylum and the corresponding manner of 'freeing' the madmen, one that called upon a different kind of segregation than Tuke's but that was contemporaneous with it. It is this model that remained in the form of the asylum. In contrast to Tuke, Pinel had no religious aims or methods. "Pinel advocates no religious segregation. Or rather, the segregation that functions in the opposite direction from that practiced by Tuke" (p. 255). Pinel, instead of establishing a religious retreat, worked to retain some of religion's authority sans religion: "The asylum is a religious domain without religion, a domain of pure morality, of ethical uniformity" (p. 257). As such, the asylum works to achieve moral uniformity. Pinel aimed to keep the morality and uniformity of religion, but without a religion. He did so with the aim of creating an environment in which the madman succumbs to a uniform morality:

> In one and the same movement, the asylum becomes, in Pinel's hands, an
> instrument of moral uniformity and of social denunciation. The problem is to
> impose, in a universal form, a morality that will prevail from within upon those

114

who are strangers to it and in whom insanity is already present before it has made

itself manifest, (p. 259)

Pinel sought to introduce a kind of morality that can be introduced to someone in the

grips of insanity. This morality serves as a normalizing force, eradicating all that

deviates. "The asylum reduces differences, represses vices, eliminates irregularities" (p.

258). The asylum imposes its morality and eliminates all else in its path, resulting in the

elimination of difference.

The asylum makes use of several strategies in order to impose its normalizing

morality, calling upon silence, recognition by mirror, and perpetual judgment for the

project of disciplining bodies into proper 'moral' behavior. Each of these is a strategy

designed to throw the madman back upon himself, to force him to be confronted with his

own madness. Silence is the first strategy employed to force the madman to face the

truth of his madness. The silence itself forces the madman to be alone, to face himself, to

face 'truth':

> But the chains that fell, the indifference and silence of all those around him
>
> confined him in the limited use of an empty liberty; he was delivered in silence to
>
> a truth which was not acknowledged and which he would demonstrate in vain,
>
> since he was no longer a spectacle, and from which he could derive no exaltation,
>
> since he was not even humiliated. (p. 261)

The mirror functions in a related way, as it also forces the madman to face himself. He is

forced to observe himself and his own madness, forced to recognize himself as insane.

Condemnation thus comes from within. This mirroring could, for example, be provided

in the form of another madman with a similar delusion. The madman recognizes the

115

madness of the other and sees himself as the other. He then turns his gaze back to himself, and denounces himself as mad.

> This, then, is the phase of abasement: presumptuously identified with the object of his delirium, the madman recognizes himself as in a mirror in this madness whose absurd pretensions he has denounced; his solid sovereignty as a subject dissolves in this object he has demystified by accepting it. He is now pitilessly observed by himself. And in the silence of those who represent reason, and who have done nothing but hold up the perilous mirror, he recognizes himself as objectively mad. (p. 264)

Through observation of the other, he turns the critical gaze upon himself, and thus upon his own madness. The mirror, then, functions as an invisible tribunal, with the madman confronted from a view from the outside. He must examine himself from the outside, subjecting himself to a kind of invisible tribunal, exacting judgment.

> By this play of mirrors, as by silence, madness is ceaselessly called upon to judge itself. But beyond this, it is at every moment judged from without; judged not by moral or scientific conscience, but by a sort of invisible tribunal in permanent session. (p. 265)

All together, the madman is coerced into constant self-observation in which he interrogates his own behavior, then judges and restrains it. He becomes is own judging tribunal. This tribunal's judgment is swift and unquestioned. "The asylum as a juridical instance recognized no other. It judged immediately, and without appeal. It possessed its own instruments of punishment, and used them as it saw fit" (p. 266). In Pinel's asylum guilt reigns supreme.

Everything was organized so that the madman would recognize himself in a world

of judgment that enveloped him on all sides; he must ever know that he is

watched, judged, and condemned; from transgression to punishment, the

connection must be evident, as a guilt recognized by all. (p. 267)

The madman's guilt is not questioned, it is rather created. The asylum is created such

that the madman is compelled to imagine the other who watches him in judgment. He

comes to perpetually see himself through the eyes of that imagined judging other, and

condemns himself. The madman comes to experience guilt, and is compelled by this

guilt to reign in his deviant behavior.

Pinel's asylum creates guilt in the madman through silence and mirrors that lead

to a state of perpetual self-judgment, calling the madman to recognize his own madness.

This is clearly a form of internalized control – the situation is such that the madman

himself finds himself guilty of madness. Chains are not needed as the exertion of control

happens within the madman. The madman in Pinel's asylum is no freer than the chained

madman of the Great Confinement. Pinel's asylum makes use of a radically different

form of control than previous historical eras, one that involves creating guilt within the

madman.

The Doctor:

Foucault (1965) incorporates a discussion of the asylum doctor in his discussions

of the structure of the asylum. For Foucault, the asylum doctor is of immense importance

as he turns madness into a medical condition through his presence. The position of the

doctor is even more central to the asylum as are silence, the mirror, and perpetual

judgment.

To silence, to recognition in the mirror, to perpetual judgment, we must add a

fourth structure peculiar to the world of the asylum as it was constituted at the end

of the eighteenth century: this is the apotheosis of the *medical personage.* Of

them all it is doubtless the most important, since it would authorize not only new

contacts between doctor and patient, but a new relation between insanity and

medical thought, and ultimately command the whole modern experience of

madness. (p. 269)

It is the presence of the medical doctor that turns madness into a medical event, thus

ushering in a new era of 'mental illness.' The presence of the medical doctor transforms

madness into a medical phenomenon. Without the presence of the asylum doctor, mental

illness cannot exist. "With the new status of the medical personage, the deepest meaning

of confinement is abolished: mental disease, with the meanings we now give it, is made

possible" (p. 270). The asylum doctor, however, is more than simply present. Rather, he

is at the center of the asylum, an essential ingredient without which the asylum could not

exist. "The physician, as we have seen, played no part in the life of confinement. Now

he becomes the essential figure of the asylum" (p. 270).

The essential figure of the asylum doctor is a complicated one. It might be

expected that, logically, the authority of the asylum doctor would stem from the doctor's

medical knowledge. According to Foucault, this is far from the truth. The asylum

doctor's authority does not stem from his knowledge of medicine at all, but rather from

his status *as a doctor.* Thus, it is not the knowledge that he gained in medical training

that is of importance, but rather the self of the doctor that matters.

But within the asylum itself, the doctor takes a preponderant place, insofar as he

converts it into a medical space. However, and this is the essential point, the

doctor's intervention is not made by virtue of a medical skill or power that he

possesses in himself and that would be justified by a body of objective

knowledge. It is not as a scientist that *homo medicus* has authority in the asylum,

but as a wise man. (Foucault, 1965, p. 270)

It is the perceived wisdom of the doctor, the kind of person that he is assumed to be as a

doctor, that is thought to cure madness. Thus, Tuke and Pinel introduced a personality

with mystical powers into the asylum, not a figure whose power rests in medical

knowledge: "It is thought that Tuke and Pinel opened the asylum to medical knowledge.

They did not introduce science, but a personality, whose powers borrowed from science

only their disguise, or at most their justification" (p. 271). The doctor's medical

knowledge transforms madness into a medical condition, but it is the doctor's personality

which is to cure madness. The authority of the asylum doctor rests in his status as judge:

The physician could exercise his absolute authority in the world of the asylum and

only insofar as, from the beginning, he was Father and Judge, Family and Law –

his medical practice being for a long time no more than a complement to the old

rites of Order, Authority, and Punishment. And Pinel was well aware that the

doctor cures when, exclusive of modern therapeutics, he brings into play these

immemorial figures, (p. 272)

The doctor operates as father and judge, and the true function of the medical doctor is one

of order, authority, and punishment. It is this, not the medical treatment itself, that is

curative. However, the asylum doctor does not acknowledge – and later, even recognize

– the source of his power beyond his medical training. His power is increasingly

mysterious – even miraculous – as its true source is obscured, and seen as coming from the doctor himself. With the source of the doctor's power obscured, the appearance of the power coming from the doctor himself is strengthened.

> As positivism imposes itself upon medicine and psychiatry, this practice becomes more and more obscure, the psychiatrist's power more and more miraculous, and the doctor-patient couple sinks deeper into a strange world. In the patient's eyes, the doctor becomes a thaumaturge; the authority he has borrowed from order, morality, and the family now seems to derive from himself; it is because he is a doctor that he is believed to possess these powers… (p. 275)

The trick, though, is that the doctor cannot believe himself to be a thaumaturge, as it is contradiction to his positivist understanding of medicine and his own role within it. Soon enough, madness itself became the justification for the mystical, magical powers of the asylum doctor.

> But if the doctor soon became a thaumaturge for the patient, he could not be one in his own positivist doctor's eyes. That obscure power whose origin he no longer knew, in which he could not decipher the patient's complicity, and in which he would not consent to acknowledge the ancient powers which constituted it, nevertheless had to be given some status; and since nothing in positivist understanding could justify such a transfer of will or similar remote-control operations, the moment would soon come when madness itself would be held responsible for such anomalies. (p. 276)

With the real source of the doctor's power obscured from even the doctor himself, the figure of the doctor gains in importance, the only thing left is the relationship between patient and doctor. Madness itself is seen as the source of the doctor's power.

> Thus while the victim of mental illness is entirely alienated in the real person of his doctor, the doctor dissipates the reality of the mental illness in the critical concept of madness. So that there remains, beyond the empty forms of positivist thought, only a single concrete reality: the doctor-patient couple in which all alienations are summarized, linked and loosened. (p. 277)

It is easy to see the transition to psychoanalysis, with its explicit emphasis on the relationship between the patient and doctor as the curative element of treatment.

Foucault's (1965) description of the asylum doctor points to the peculiar, mysterious power that is the hallmark of the asylum doctor. This mysterious power, connected to authority and justice, hides its true source even from the doctor. This only enhances the asylum doctor's authority, as he comes to believe that madness itself explains the doctor's power.

Foucault Application*:*

The Neurobehavioral Unit is reminiscent of the asylum and aspects of the neuropsychologist resonate with the role of the asylum doctor. Madness and neuropsychological disorders are constructed as disorders of reason, and the asylum physician and neuropsychologist are charged with eradicating irrationality. Thus, both are disorders of reason that are to be treated by professionals who are to impose the lacking reason. Neuropsychological impairment is viewed as a violation of the

rationality of the brain. The brain is viewed as the seat of rationality, the place from which all rationality radiates. Secondly, as I will argue, the neuropsychologist's power functions in similar ways as does the power of the asylum physician. Both operate with a kind of magical power that requires particular kinds of separations between doctor and patient.

The Structure of the Unit: Silence, Mirrors and Judgment:

The structure of the unit, and particularly of the neuropsychological testing, is reminiscent of the asylum, with neuropsychological testing itself functioning as both silence and as a mirror in order to force patients to judge themselves as neuropsychologically flawed. Further, the physical set-up of the unit described in this chapter that separates patients from professionals serves to increase the mystery and power of the neuropsychologist.

Testing protocol demands silence from the neuropsychologist administering neuropsychological testing[34]. Many of my descriptions of the unit feature this – sometimes cruel – silence during testing, as I sat impassively while patients struggled through question after question, answer after answer, scanning my face for clues as to their performance. Ostensibly, the function of this silence is to prevent the patient from discovering whether or not his answer was correct, and thus influencing the style or content of subsequent answers and 'contaminating' the results of testing. Yet, while administering testing and taking tests in training, I found that this silence functioned like a mirror, although this mirror is a very different one from the one in Pinel's asylum.

---

[34] This is true of almost all neuropsychological tests, but there are, as always, exceptions. The Wisconsin Card sort (described on page x) is one such exception, and is the only exception on which I was trained during my time on the unit.

When I trained on tests by taking them, the lack of response from my trainer/examiner

forced me to scrutinize my performance from outside of my body. I knew that right and

wrong answers existed, and that I was being evaluated (judged) according to the

provision of my answers. The examiner's pencil, concealed behind a clipboard, scribbled

out judgment. But, the examiner did not tell me *how* I was judged, and I was thus forced

to evaluate myself. I became a harsh judge, acutely aware of each tiny abnormality,

struggling to detect every minute deviation from a supposed norm(ality). When I became

the silent judge behind a clipboard when I tested patients, the clipboard and I took this

one step further. As I wrote down, verbatim, every spontaneous comment and gesture of

the patient, I signaled to the patient that his every move and communication is a potential

indicator of pathology. The patient thus realizes that his intense scrutiny should not be

limited to his performance on the testing itself, but rather should extend to the rest of his

existence. In a sense, my clipboard functions as the mirror and silent tribunal. The

patient knows that he is judged, but is set-up to imagine his own judgment, and thus, to

judge himself. Thus, the testing situation itself functions as a mirror and tribunal, causing

the patient to label himself as deviant without intervention of the examiner.

The Neuropsychologist as Asylum Doctor:

Here, it is helpful to note that many neuropsychological disorders fell under the

domain of madness. Indeed, neuropsychology seems to operate in a border territory

between psychology and medicine, existing in a state where it is both and yet neither.

Although neuropsychology has subsequently differentiated itself – partially – from other

kinds of clinical psychology, it remains true that neuropsychologists are licensed as

psychologists and share a common history with the asylum doctor. The asylum doctor was a representative of medicine but did not make use of medicine in order to exact a cure. The neuropsychologist is partly a medical figure, and yet, the involvement was a bit of a performance. (I think of the white laboratory coats worn on the unit at various times for no particular or apparent reason, other than a heightened identification with the medical profession.) Like the asylum doctor, the neuropsychologist is represented as one whose medical (or neuropsychological) knowledge is what affords status and privilege. Yet, the irreconcilability of the role of the neuropsychologist with the role of the patient which made it feel so impossible for me to inhabit both roles points to something other than neuropsychological knowledge contributing to the role of the neuropsychologist. Knowledge, in itself, would not make those two roles irreconcilable. One could be a neuropsychologist who had a neuropsychological problem.

The role of the asylum doctor and his mysterious power resonates particularly strongly with my experiences on the neurobehavioral unit, both as patient and as training neuropsychologist. I found myself feeling confused by the tenacity of the separation between patient and professional, and surprised by the tension I felt so literally in my body. Reflecting on the role of the asylum doctor, the need for this separation becomes clear in a new way. The separations featured in this chapter were confusing, as I had assumed that a good deal of the power of the neuropsychologist stemmed from the training of the neuropsychologist. Indeed, I assumed that it stemmed from the neuropsychologist's knowledge of the brain and cognitive function. Yet, from the framework of *Madness and civilization,* my surprise stemmed from a misunderstanding of where my power rested as the neuropsychologist. My power did not come from my

training, but from the fact that I was in the role of training neuropsychologist. Without

realizing it, I had assumed that it was my very presence that was healing. The confusion

resulted from embodying an impossible set of identities – she whose presence heals

unreason, and she who lacks reason. It was this that led to my sense that these tensions

were *impossible* to maintain.

Foucault Application Summary:

Foucault's (1965) *Madness and civilization* helps to shed light on the function of

the separations highlighted in this chapter. These separations are necessary in this

formulation of medicine and neuropsychology. The structure of the unit is in the service

of separating patients and professionals, in order to foster the patient's adoption of

internalized control, and to permit the neuropsychologist to take on mystical powers with

his/her presence that can supposedly heal. With the power of the neuropsychologist

stemming from his/her symbolic, mystical power, then it is vital that the

neuropsychologist is differentiated from the patient.

Chapter Summary*:*

This chapter focused on my experienced sense that neuropsychologists and

patients must be separated, and certainly should not co-exist within the same body.

Beginning with auteothnographic explorations and reflections and ending with a

discussion of Foucault's (1965) *Madness and civilization,* this chapter has explored the

ways in which I felt as though patients and professionals were rather deliberately

separated on the neurobehavioral unit. This chapter also began to explore the motivations

for these separations.

Chapter 5: Disappearing Subjectivities:

Beyond the separation of patients and professionals highlighted in the previous chapter is an even deeper kind of separation – the isolation of the neuropsychological from the rest of the patient's identity. This separation pulls the patient apart from his testing results, ultimately discarding the patient himself. Throughout my time on the unit, I found myself as neuropsychology trainee de-emphasizing the psychological and contextual. At times, I felt that the role called for me to aggressively eliminate anything other than test scores, essentially eradicating the subjectivities of both my patients and myself. I obliterated my patients' complexity and subjectivity in favor of the certainty and security of test scores, and found that doing so offered a strange sort of pleasure. My patients became irrelevant as the scores of tests became the only thing truly of import. In this chapter, I explore the motivated lack of context in the neuropsychological project, looking to understand both how stripping of the contextual occurs and the possible relevant motivations and implications.

De-emphasis of the psychological[35]:

Perhaps one of the most surprising aspects of my performance of neuropsychology professionally was the shunning of the psychological. It was my training in a clinical psychology program that permitted me access to this unit, and I expected some degree of integration of the psychological. I was surprised to observe myself actively de-emphasizing the psychological. When I struggled to bring the

---

[35] For the sake of simplicity, I have separated the psychological and contextual in this chapter. I see this as a false distinction. The psychological and the cultural/contextual are intrinsically intertwined. Culture, in particular, influences the psychological. I am aware that, in doing so, I am guilty of the very critique that I advance against the role of the neuropsychologist. Yet, I find that it is difficult to discuss the dynamics of this separation as it occurs in neuropsychology without participating in this arbitrary distinction.

psychological into my interactions with patients – times when I felt myself as family, patient, or clinical trainee re-emerging – I found that my attempts led my role as neuropsychology trainee to all but disappear. I found that the more I attempted to integrate the psychological, the less that I was able to stay in the role of neuropsychology trainee. I thus found my professional identity rapidly alternating between clinical psychology trainee and neuropsychology trainee. I was surprised by the opposition between the two as the very name "neuropsychological" implies the integration of the neurological and psychological.

Scene:
 I sit with Dr. G. at his round wooden table, observing as he completes – performs – a neuropsychological interview. I balance a notebook on my lap, taking notes both on the process that Dr. G. uses to interview and the content of the patient's answers as I follow along on the "interview worksheet" that I will later complete when interviewing my own patients. I feel self-conscious as my observer position dictates that I am to be as close to invisible as possible, leaving me hyper-aware of my very visibility. The interview starts off normally enough, although Mr. Smith is clearly struggling to answer Dr. G.'s questions, speaking in a monotone and providing very brief answers. I meticulously write Mr. Smith's answers to Dr. G's questions.

 Dr. G. asks Mr. Smith about the recent death of a family member and Mr. Smith collapses into sobs. Dr. G. simply moves on to the next question: "Do you remember what you ate for breakfast today?" Mr. Smith chokes out an anguished: "cereal." Dr. G. hands him a tissue and says "I think you have a cold." I am horrified, and yet I am frozen, avoiding eye contact, and shying away from connecting with either Mr. Smith or

Dr. G. I find myself wishing to ally with neither. I feel that my role as neuropsychology trainee calls me to deny the distress of this patient but that I feel an ethical objection to doing so. I am not willing to directly break character, so I pull back, trying to not perform anything at all. Of course, this is impossible, and I end up performing some kind of strange and awkward withdrawal.

After the interview, my supervisor, alone with me, explains that he did not want to delve into Mr. Smith's grief because he did not want to increase his disorientation. Dr. G.'s explanation points to practicality: Mr. Smith's psychological distress gets in the way of the assessment of his neuropsychological condition. I, feeling overwhelmed, simply nod in response. Dr. G.'s explanation did make sense as Dr. G. is not Mr. Smith's therapist, so exploration and processing of the grief would not have been appropriate. Yet, it seems that Dr. G.'s response involved an active denial of the existence of Mr. Smith's suffering. He did not respond empathically before transitioning back to the interview, or even shift back to the interview without comment. Rather, he re-labeled Mr. Smith's psychological distress with the physical label of a cold. Learning to perform the role of neuropsychologist, I felt that I could not offer support to Mr. Smith, even in the form of supportive eye contact.

Scene:

In neuropsychology case conference, a bi-weekly meeting to discuss interesting or difficult cases, I sit at a large table packed with neuropsychologists and neuropsychology technicians. I quietly sip my coffee, doodling on a summary sheet, throughout the first case presentation. The second case, though, piques my attention, and I look up from my coffee. The patient's history notes that she had been badly abused in an automobile as a

129

young child.   Her current complaints are of memory loss following an automobile

accident. I wait for someone to mention the possibility of a post-traumatic reaction,

assuming that this will be conceptualized as one of several possibilities. The group pores

over test results and neuroimaging, debating whether she has brain damage or if she is

malingering. They suspect the latter, as her performance on testing was strong overall

with some sudden, strange, lapses. Surprised that no-one has suggested post-traumatic

stress disorder or dissociation as a third option, I interject it as a possibility. The

conversation continues as if I had not spoken. I wonder if I was ignored because I am a

student, and if Dr. G.'s encouragement for me to talk in the meetings was misguided. I

had the sense that my comment was simply dismissed as irrelevant.

Scene:

I hang up the phone and trudge down to Dr. G's office to consult with him

regarding a therapy patient who called to report losing time and "coming to" having

wandered into traffic. Dr. G. calmly says: "Oh, so Mr. T had a seizure." I inwardly

groan and resist the urge to roll my eyes. I feel as though we should have resolved this

debate long ago.   On top of that, I am genuinely concerned about this patient's well-

being, realizing that this patient has been in danger. I, somewhat snippily, reply: "No.

He dissociated." I've done a very careful rule-out of these seizures. Not only has this

client presented with alternate ego-states, he has a horrific early childhood abuse history,

and loses time only under circumstances that he feels are similar to his abuse. On top of

that, he had an "episode" during his electroencephalogram – a neuroimaging technique

that measures the electrical currents of the brain and, thus, the abnormal discharges of

seizure activity – and no such activity was detected[36]. Somehow, all of this remains

unconvincing to Dr. G, so he chooses this moment to again point out to me that those

with particular kinds of brain trauma dissociate. I agree, still fighting the urge to groan or

roll my eyes, but note that this client does not seem to fit that profile given the severity of

the trauma that he has endured, the extent and intensity of his post-traumatic symptoms,

combined with numerous neuroimaging scans. Dr. G. concedes, but said that it could still

be "organic" that he dissociates. To me, this feels like an odd insistence on the

neurological, when all evidence points to the psychological!   I feel trapped. There was

no way that I can definitively *prove* that Mr. T. was experiencing an altered state of

consciousness due to something with psychological meaning, but it feels increasingly

absurd to deny it!

Only upon reflection can I (partially) understand Dr. G.'s position. In terms of

this particular patient, I have positioned myself as a psychotherapist rather than a

neuropsychologist in training. (I am actually this man's therapist, and his therapy takes

place in my office on the neurobehavioral unit.) I am examining – indeed, criticizing –

our level of care with this patient through the lens of psychology. Dr. G. is the head of

the neuropsychology unit, and, when I work with this particular patient, I do abandon the

project of neuropsychology. Simply put, Dr. G. is admonishing me for breaking

character! He is right that I am not performing the role of neuropsychologist when I

work with this patient. But what does it mean that discussing this patient's

psychotherapy psychologically precludes neuropsychological performances?

---

[36] I have turned to neuroimaging to "prove" the answer to a neuropsychological and psychological question
by referencing the electroenchaphalogram.   The following chapter will examine this move as a rhetorical
strategy and explore the impact of the turn to neuroimaging on neuropsychology.

Scene:

Mrs. N. walks with me, very slowly, down the hallway towards my office. This is our second meeting together, as she became frustrated with the tests the first time around and tearfully asked to finish early. I try to balance walking unnaturally slowly with not leaving her behind. I lead her directly into the windowless testing room – I've already gathered everything up and attached it to my clipboard – and start off with the REY. She complains right away and asks me if I am going to make her play "stupid word games." I reply, trying to sound apologetic: "Well, today we will mostly play stupid visual games." She groans. As she tries to copy the REY, she rapidly becomes discouraged. She blurts out that she's "too stupid" to do it, flings her pencil down and cries. I shift into a more therapeutic mode as I pull the REY and her attempt to copy it away. I slide my clipboard of tests off the table and into my lap, taking them away as an implied promise that I won't ask her to do anymore just now. Slumped over on the table, she tells me that she'd like to just end it all, that seeing how "stupid" she is makes her have "bad thoughts" of committing suicide. I do the standard suicide assessment, and she does not seem to be safe to go home. I introduce the idea of voluntary hospitalization, and she agrees that it is a good idea. I leave her with her friend who has been patiently reading a newspaper and go find a supervisor. I am surprised when the supervisor does not know who to contact regarding hospitalizations, and so I wait until Dr. G. arrives. When he does, he asks to meet with myself and Mrs. N. Once we are all seated around the familiar round wooden table, Dr. G. proceeds to talk her *back out* of hospitalization, emphasizing to her that she will not be permitted to smoke as often as she likes! I feel appalled and confused.

Scene:

I asked a patient how his weekend was, and he replied that he has been told that he had a seizure the day before, that he had been really dizzy and didn't remember it at all. He was depressed, and asking me if I thought that he was to blame for "everything" in his life by not understanding social cues. I struggled to navigate his need to talk with my mission of completing the testing. He started by talking about his seizures, but then moved on to his romantic problems, childhood issues, etc. He was tearful and spacey. I tried to listen compassionately, while returning to the testing. His spaciness interfered with his ability to do the testing. He stared at the Rey for literally 3 minutes before very tentatively attempting to copy the design. He made a tiny little copy and was almost entirely unable to reproduce it right after. I felt cruel. I asked him to do FAS[37]. He never got more than 4 per letter. When I presented him with the letter "S," he waited for thirty seconds, before muttering: "stupid." He waited another ten seconds before adding: "stupidity, but I guess that already counts under stupid." I couldn't do it anymore. I asked him if it was just a bad day for us to do testing and offered to reschedule. I assured him, in response to his questions, that it wasn't a waste of my time, and rescheduled him for next week. I felt terribly torn between being supportive and getting him through the testing. In this case it was the combination of neurological factors (the seizure) and psychological factors (his depression in response to the seizures) that made it difficult for him to get through the testing. I felt that my role did not prepare me – or permit me – to work with these difficulties. I felt that he needed support to handle the testing process,

---

[37] This is a test of phonemic fluency. The patient is asked to list as many words as he can that begin with a particular letter in the span of a minute.

but by now, I am so firmly entrenched in the role of neuropsychology trainee that I can no longer seamlessly introduce the psychological.

Explorations:

This section focused on the discounting or minimizing of psychological distress. It seemed like the psychological was eliminated via oppressive repression! I was explicitly told that my duty was to keep the psychological out of the way of testing, to prevent it from interfering and altering patients' performance on standardized testing. This is certainly logical, but actual performances – both my own and those that I observed – seemed to involve something much stronger than making space for the neuropsychological. It did not feel that the psychological was being set aside in order to be dealt with later by other practitioners – although this did happen in some cases – but was rather being forced underground, repressed, excluded, perhaps even foreclosed. Indeed, reality was rewritten in the name of preserving the neuropsychological – a patient with tears streaming down his face is not grieving, he just has a cold. It seems to be telling to me that often the conflict between neuropsychology and psychology played out in relation to trauma. I cannot see how acknowledging the reality of the psychological while focusing attention on the neuropsychological harms the neuropsychological project. Something else seems to be at play, and it seems to be strongly motivated to exclude the psychological.

I should acknowledge that the psychological is occasionally included, but only as a mitigating factor. I am told to think of the psychological as causing a "false positive" on neuropsychological screening. I am reminded of the woman who was discussed in neuropsychology case conference – the role of the neuropsychologist could consider the

possibility that she was malingering, but not that her symptoms represented true psychological difficulty. I am most attuned to the possibility of malingering – as I have been taught – but also to symptoms caused by psychological factors alone. For example, processing speed and attention can be impacted by depression. Thus, the time that I am to attend to the psychological is not while I sit across from my patients, but rather when I am reviewing summary sheets.

It also strikes me that many of these "scenes" involved dissociation and trauma. This is, in some ways, predictable – the time loss that can accompany dissociation mimics memory loss, and the intrusions of flashbacks can cause people to seemingly "forget" incidents that it only appeared that they were present for!   There is something else to this, which relates to the next subsection. Trauma related disorders are those that are explicitly, by their very definition, caused by problematic environments. It seems that the role of the neuropsychologist was most forcefully opposed to acknowledging traumatic disorders, and this implies reluctance to acknowledge the contextual's role in disturbance.

I notice, too, that the elimination of the psychological strips me of my own context. Without the psychological, my own motivations for working on the unit fade away. With those motivations, my ethics and radical edge flutter away. And thus, I found myself called to perform the neuropsychological and minimize the psychological, but I found myself intensely ambivalent about doing so, both because it felt alienating to patients, and because I found what I do like about the role of neuropsychology disappearing.

I think of the uncertainty, complexity, and wonderful messiness of the psychological. I contrast it to the confident certainty of neuropsychological tests, and it begins to make sense to me that the psychological is minimized. The neuropsychological project, as it is constructed, relies on a certainty that is not often a part of psychological explorations. And yet, I know that this is not an explanation in itself, as I have not yet begun to answer why order is privileged over chaos. Furthermore, this explains the minimization that I encountered, but certainly not the active denial.

Minimization of the Contextual*:*

The role of the neuropsychologist called for the elimination of the contextual, a phenomenon that has been hinted towards through explorations of the minimization of the psychological. In the role of training neuropsychologist, I was called to note and account for context such as race, gender, educational and occupational history, and living situation. However, the very process of accounting for the contextual contributed to its eventual elimination. The contextual is viewed as a mitigating factor that must be noted in order to ensure that it does not bias the results of neuropsychological testing, and thus I account for it in order to control for it and attempt to remove its impact[38]. I was not called to work with patients regarding their context but simply to remove its impact from reports.

Scene:

I invite a patient to sit down in one of the squishy chairs in my office, and I begin to take him through the standard interview. I am clutching the ever-present clipboard. Using the unit's standardized intake worksheet as my guide, I ask questions geared

---

[38] The transformation of context into scores is the topic of the next subheading.

towards answering the diagnostic question. I query regarding his history of head trauma, exposure to toxins, and duration of symptoms. I ask him where he lives and how he gets his money. I ask if he has children and about his marital history. I question him regarding his employment history.

I translate each piece of this information – the patient's personal and cultural context –into the neuropsychological. When I discover that he has changed jobs every two years, I view this as a potential symptom of neurological problems that may have led to this "unstable" employment. I estimate his overall I.Q. based upon his educational and occupational history. If he worked in a "low-skilled" job, I am to assume that he is less intelligent than if he has a doctorate. Such a formulation ignores and renders invisible complications resulting from classism and racism. It is implicitly assumed that all patients have had equal access to education and job training, have been given equal "breaks" in life, and have had similar support systems. I am to assume a fair playing field. A person's educational and occupational success is attributed to the patient's innate abilities alone, and lack of so-called success is a personal failure of his. (It does seem that a minimum standard of intelligence can be assumed when one has earned a doctorate. The opposite, however, does not logically hold. The lack of a doctorate does not necessarily mean the lack of *ability* to obtain one. Furthermore, even this critique fails to take into account the systemic forces that can prevent one from having the skills that tend to be valued in higher education in the United States.) In order to "confirm" my suspicions about his IQ based on his life, I also ask about his parents' educational and occupational histories, and make similar assumptions about their IQs. If their educational and occupational situations even remotely mimic the patient's, I have an even stronger

case for labeling the patient's own situation as genetic. The lens with which I look at the patient's personal context is one that is devoid of cultural context.

Scene:

Sitting in neuropsychology journal club, I stare intently at the clock on the wall, glancing at it whenever I can throughout the hour-long meeting. I have chosen my seat specifically so that I am able to subtly watch the clock and calculate how much longer I must tolerate the meeting. Due to my vigil over the clock, I am able to report on the various lengths of time that is spent on each part of the cases. Once we have all sat down, the day's presenter distributes copies of two anonymized cases around the table. The presenter is only supposed to present one case, but – as is typical – tries to "squeeze in" a second one. She rushes through her presentations in order to attend to both cases. She remains seated as she begins by briefly introducing her patient: age, gender, occupation, neurological risk factors (such as high cholesterol or diabetes), and relevant symptoms. This entire introduction takes no more than five minutes, and at least half of that time is spent listing the patient's vast array of physical ailments. After getting this out of the way, we all stare intently at the scores on the summary sheet as the presenter guides us through it, pointing out pieces that don't seem to fit. This takes another five minutes with the remaining twenty dedicated to various people offering theories to explain the results. Thus, we collectively devote five minutes to the life of the patient, whereas we devote twenty-five to the discussion of scores and possible disorders. I take note of this in case I am eventually asked to present in such a meeting.

Scene:

I sit across from Mr. X who I am evaluating for brain damage following a severe head injury. As part of the standard interview I ask him where he lives. He tells me, matter-of-factly, that he is living in a homeless shelter. I scrawl the information onto the worksheet that I'm balancing on a clipboard on my knee. I will later note it in a single sentence in my final report. I know that the particular shelter in which he lives is good, and is known for its success at job and housing placement. My recommendations are standardized. I tell him that, since his accident, he will be more sensitive to minor neurological changes. I suggest that he should therefore be particularly cautious of lifestyle factors that can contribute to neurological disorder. I encourage him to eat healthily and to exercise.

It does not occur to me at the time that my interventions are absurd. In the role of the neuropsychologist, I view my interventions as simple medical advice. And yet, he has only the most minimal control over what he eats, forced to choose between the selections of foods presented to him. Produce is expensive. Not only does his context not figure into my assessment – for example, he is likely to be experiencing high levels of stress that could impact his performance – but it renders some of my standardized interventions useless. I tell him the obvious – that he should eat well, reduce his stress, and exercise – but I do not work with him around the very difficult questions of *how* to do that in his current context.

Scene:

As I sit alone in my office writing up a report, I think back to the interview with

the patient whose report I am working on finishing.   The interview took no more than

fifteen minutes to complete. I did not need to ask the patient many questions, as his chart

held the answers for me. I could fill in information regarding his head injury, medical

history, current and past medications based on the notations of other medical

professionals. It was as if his presence was eclipsed by his chart. And again, I noticed

something nice and orderly about it, even as the patient himself faded into the

background. Writing the report is easy: the answers are on paper in front of me, either

neatly typed into his chart, or from the scrawled notes from our conversation.

Scene:

I invited Mr. D., escorted by a staff member from a local drug rehabilitation

center, back to my office. He is in a hooded sweatshirt and torn jeans. I am dressed

uncomfortably professionally in a skirt and dress-shirt. His primary memory complaints

sound like they could relate to alcoholic black-out. When I asked for an example of the

kind of thing that he forgets, he said matter-of-factly: "I have the sense that I stole a car.

But I can't remember doing it." I am slightly taken aback by his blunt answer, and find

that I feel both sad and amused. Throughout testing, he stops me repeatedly to remind

me that he needs to perform extremely well on the testing because his high-level job

requires him to think clearly and quickly. I keep thinking to myself that, given the

circumstances, he should be satisfied with a less prestigious job. I am annoyed with him.

But when I look at my reaction from the position of patient, I see it as ridiculous and feel

ashamed of myself. I know that writing and reading keep me sane, that I love working as

a therapist, and I know how frightened I would be if that was taken from me[39]. I know

that working is important to me. Yet, I find that I am frustrated by his concerns about his

life, somehow seeing them as a distraction! There are several dynamics at play here: I

see myself as different from him – indeed, *better* than him—and I am frustrated that he

wants more than what I seem to believe he should have. I also am irritated that he is

slowing me down with his anxiety! I am fully in the role of the neuropsychologist and

am looking at his life and its concerns as mere distractions. I find that I want him to be

quiet so that I can get on with the testing.

Scene:

Mr. C., an elderly man with several problems, returned to the unit with his wife

for a feedback session. I walk nervously down the hall to meet them. I have been

dreading his appointment for some time. In our first meeting, Mr. C. spent a good deal of

our time together asking me to "prescribe" his wife to have sex with him, and doggedly

persisted in describing every detail of his sexuality. His wife, clearly pushed beyond her

limits, refused to speak at all and spent the entire appointment glaring out the window.

Today's meeting begins in much the same manner. Mrs. C. stares passive-aggressively

out the window immediately after plopping down in her chair. Mr. C. stares at me with

big eyes and a smile. I try to suppress my intense irritation.   I overcompensate and chirp,

as though I am going to lead a cheer: "Okay, so, here's what we found!" and begin

talking through the results of Mr. C.'s testing, noting his memory problems and very little

---

[39] This dynamic refers back to that explored in the previous chapter involving valorizing the
neuropsychologist while devaluing patients.

impulse control. As I speak, Mrs. C. stops staring out the window and smiles at me. Mr. C. looks at me with a somewhat blank, child-like gaze, smiling boyishly, and looking slightly baffled. When I finish speaking, he says: "But, that can't be right. I've been a vegetarian all my life. I run." I realize that I'm hurting him by wresting away his sense of control over all of this. I realize that a part of me might even *want* to do this – this is the man who pissed me off with his vanity and insistence that I tell his wife to fuck him. I feel aggressive. I take a breath and try to help him. I say: "You know, it's good that you did that. That means that you did what you could to stay healthy. I bet things would be a lot worse if you hadn't taken such excellent care of yourself. But, you're also dealing with heredity and some plain luck. That's how, even though you did all of that, you can still have some problems." He seems surprised. I provide a list of interventions for the couple, noting to myself that none of these will be very effective if they cannot handle being in the same room together. Still, I cheerfully provide a list of recommendations. I try to take into account the context of their marriage, suggesting that Mrs. C. join a caregiver support group and that she look into adult day care. I would not have made this suggestion if they seemed to enjoy one another's company.

Two things stand out about my work with this couple. As I become increasingly interested in test scores myself, I have begun to feel frustrated when patient's react emotionally to the information that I provide them.   Mr. C.'s anxiety annoyed me. I wanted him to react as someone dispassionately receiving information, but I was providing him with terrifying information about his memory! (I should note that my irritation with Mr. C. certainly contributed to my reaction. I had been disgusted by his feeling of entitlement to his wife's sexuality. He truly believed that buying flowers

obligated her to be sexual.) Furthermore, my interventions with the couple only minimally addressed the problems between the pair. Again, I feel that my interventions are largely useless as they do not address the context of the patient. In the role of neuropsychology trainee, these are the interventions that make sense, and they have been endorsed by my supervisors.

Explorations:

When I see everything else in a patient's life as a potential symptom, I am actively ignoring all other possible factors contributing to his life. At the start of the rotation, I saw my primary function as helping patients to cope with the often terrifying news that I delivered. Yet, it was myself as family member and patient that fostered my sensitivity. As I increasingly performed "neuropsychologist" this sensitivity faded. Instead, everything beyond the scope of testing became an irritation to me. I believe that this did indeed help me to accomplish the task of testing optimally. But that seems to tell me that the testing situation works the best when the contextual – and all of the power that is located in the contextual – is eliminated.

Perhaps it is here that the function of the isolation of the neuropsychological at the expense of anything contextual comes most clearly into focus. As the cultural and contextual are eliminated and the brain itself is increasingly taken as the sole cause of health or disorder, dynamics of power and oppression simply disappear. In this sense, the function of neuropsychology seems to – at least partially – relate to the maintenance of a status quo, and the concealment of power. Scientific language is, as is typical, used in order to justify eradicating that which is most married to power.

Reducing to Scores*:*

As the testing procedure continues, this stripping of the contextual continues until only scores remain. Indeed, the contextual (including the sociocultural) is translated into norms and converted into scores. Even the patient and his family's descriptions of symptoms recede into the background as scores increasingly take over as "truth." Due to their standardization, the 'objective truth' of scores takes precedent over all other 'subjective' truths[40]. Thus, the patient's context becomes nothing more than potentially interfering variables. The further that they can be kept from the testing situation, the more I can find the 'truth.' The more that I enter into my role as training neuropsychologist, the more I see my work in terms of summary sheets rather than patients.

Scene:

I am spending the day working on reports, as I do not have patients scheduled for the day. In other clinical settings – in the role of training clinical psychologist – I find that I dread paperwork and most enjoy my time spent with patients. In the role of training neuropsychologist, I enjoy the report writing and often look forward to it more than the clinical work itself.

Once I've scored the tests, I calculate the z-scores, thus determining where the patient falls in relation to his age and education peers. I go through the various categories

---

[40] Many qualitative researchers have critiqued the privileging of so-called objectivity in quantitative research, arguing that objectivity is an impossible goal. Fischer (1994) addresses this specifically in terms of intelligence tests. "Tested intelligence is the sampled effectiveness expressed statistically in relation to one's age peers of ones approaches to situations in which competence is highly regarded by our culture" (p. 360). In other words, tested intelligence is a reflection of cultural values, and one's cultural location logically impacts one's score.

on the summary sheet: general abilities, memory, language, visuo-spatial, motor, and executive functioning. The intern sent me a template to use. Large portions of the report are thus already written, and I simply have to add in the proper adjectives. I have lists of z-scores in front of me, and I turn to a sheet that Dr. G. gave me to find the cut-offs for each category of adjectives. Even the choices of adjectives are provided for me! There is standardization for where "average" ends and "low average" begins. I end up with a report that lists where a patient's performance is "superior," "high average," "average," "low average," "borderline impaired," and "impaired." The report is written as a narrative, but most of it is a simple template.

Scene:

I'm late for supervision with the intern, so I rush into her office with testing materials and a summary sheet. I show her the patient's drawings of the REY figures, and we lament how "awful" they are. Pointing to the summary sheet listing his scores, I talk about how badly I feel for the patient, how he doesn't have good visual or verbal resources. She tells me that the case is fascinating and that I should present it at neuropsychology case conference. At no point does it occur to me to tell her anything about my patient's life story or his current situation. If I had done so, it would have been a distraction.

Scene:

I enjoy scoring the CVLT-II. It is strangely fun how the interruptions (words he said that hadn't been on the list of words to remember) and repetitions (words that he repeated in a given recall session) light up in red when I type them into the scoring

program. I have to slow down my typing so that the program can guess what word I am typing. I find myself allied with the computer, working together to enter scores. When I finish entering my patient's answers, a report pops up on the screen. I hit print. So nice and neat! I take the report and copy the z scores into my summary sheet. I make my numbers nice and neat and feel oddly competent as I flip through charts on norms. I take everything over to the tech, and we talk just a little bit about how it could all be interpreted. It's "very frontal" she tells me. I realize that I had greatly enjoyed making the chart and felt a sense of satisfaction when I finished, but that, without assistance, I had no idea what those numbers meant.

Scene:

Now that I feel more comfortable in my role as training neuropsychologist, I experience this odd, almost laughing, sense of security as I realize that I have not been missing out on layers of meaning after all – it really is this simple. Saying that feels bratty, because I know that I still don't "get it." The others here can declare, without delay, what particular score profiles correlate to which disorders, and which parts of the brain (are believed to) correlate to various cognitive functions. I still often need to refer to a textbook or database for that information. At the same time, all I'm asked to do is plug in numbers and type them in. The first time I typed up a report, I felt like I had neglected to add in several important layers of meaning. It turns out that I was looking to add in layers that just don't need to be there.

The project is viewed as scientific, so the theoretical is supposedly not needed. Of course, the theoretical is always already present – indeed, the purpose of this project is

to uncover the invisible theoretical assumptions lurking behind neuropsychology.

Nonetheless, when I am in the role of neuropsychologist, the theoretical assumptions

underlying the project become obscured. The information plugs into a conceptual system

that assumes the numbers to be accurate measurements. So far, I've had this

overwhelming feeling that I'm really not doing all that much here. And then I feel guilty,

because I know that everyone works hard here. I just can't figure out what exactly it is

that we produce. Of course I am aware that we produce reports, but it often seems as

though we are reproducing something that has already been produced by neuroimaging[41].

The report truly represents nothing! And yet, I enjoy the report. The report gives me a

(false?) sense of productivity, and it is in this mode that I feel the most like a

neuropsychologist. When I find myself enjoying the neat certainty of normed summary

sheets, I feel that I have the performance down.

Explorations:

The reduction to scores is surprisingly seductive, and I find that I have come to

enjoy the neat certainty of a summary sheet. But this mode obliterates the subjectivity of

my patients. Indeed, it obliterates me, as well! In this mode, I am entirely absent as a

patient and caregiver, but also – oddly – as neuropsychologist. I forget my own

multiplicity, and I am eclipsed by summary sheets myself. I note that, in the pieces of

field notes incorporated in this chapter, my own subjectivity is minimized. Not only is

the life context of my patient missing, my own context and history is silenced. I am

devoid of context, and the specters of my selves seem to float away. The deeper into the

tidy certainty of scores I permit myself to immerse, the less I can interrogate the meaning

---

[41]The role of neuroimaging is the subject of the next chapter.

of my own behavior; indeed, the less it occurs to me to try to do so! I find that I can be seduced by this mode of thinking. My patient – indeed, the world – is rendered definitively comprehensible[42].

When I am fully performing "neuropsychology," I am no longer aware of ignoring patients. Instead, I feel annoyed by their insistence on their own subjectivity. Their desire to participate in our work feels like a nuisance that will reduce my effectiveness. There is even a way that I feel myself muttering: "Shhhh!!! This isn't about you!"

Conspicuous Absences:

I have explored the ways in which my performance of neuropsychology involved the stripping of the psychological and contextual, and the resulting disappearance of myself and my patient. This disappearance of the person of our bodies is reminiscent of Foucault's (1974) discussions of patients and doctors in the *Birth of the Clinic*. Foucault's work offers an understanding of the motivations behind the disappearance of the subjectivities of patients and neuropsychologists on the unit.   .

The patient's psychology, life, and relationship to the power structure are nothing more than distractions that can obscure the physician's view of the disease. The physician's (or, in this case, neuropsychologist's) personal agency and powerful position in relation to the patient are overlooked. The neuropsychologist performs a role, but

---

[42] This statement, too, requires caution. There are plenty of cases that neuropsychology would itself label as perpetually murky. Perhaps it is more accurate to say that I am seduced by the *promise* of certainty and clarity. Whether or not I find this clarity in regards to a particular patient, the path by which certainty is to be discovered is certain.

aspects of that role require the neuropsychologist to disappear. The ultimate goal is for

the neuropsychologist to glimpse the functioning of the patient's brain.[43]

The patient's subjectivity becomes something to be controlled for – indeed,

controlled! – and the patient is reduced to an object[44]. Because the patient is objectified

and stripped of everything other than scores on tests, there is no space for explorations of

oppression. I am deeply concerned by the silence of racism, sexism, and classism in the

performance of neuropsychology. It is not that these entities are entirely absent, but

again that they are variables that must be accounted for by the neuropsychologist. Thus, I

can look at norms for various races and genders, because it is believed that these factors

can "skew" results.

Problematizing this requires several layers. First of all, treating race and gender

in this way presumes that they are natural entities, that a person's status in one racial or

gendered category is both stable and genetic. I refer to Butler's (1999) performativity yet

again to problematize the notion of a stable gender, and to Goodman (2001) to destabilize

concepts of race[45]. One patient stands out when I consider the problematic use of race in

neuropsychology on the most practical of levels. As I glanced through his chart, I

noticed that several professionals had noted his race as "African American" whereas

several others had noted it as "Caucasian." This patient was "unreadable" to various

---

[43] The desire to see the brain will be explored and critiqued in the following chapter. For now, it is perhaps
enough to note that the neuropsychologist's attempts to glimpse the brain are losing the battle to
neuroimaging which can provide literal pictures of the brain. Thus, the ultimate goal of this performance of
neuropsychology is performed best by someone else.
[44] The consequences of this objectification on patients is the subject of chapter five.
[45] "Race is a biological concept; it is a way of constructing and thinking about human variability. We tend
to think of it as a reality, because it has become reified to us by its constant use and lack of questioning of
its underlying reality" (Goodman, 2001, p. 34). There are many ways to disprove race as a biologically
"real" entity. Perhaps most relevant to this project is the fact that "within group variation is much greater
than between-group variation" (p. 35).

medical professionals, and yet, they had to "declare" his race in their notes[46]. It is

possible that he would land in an "impaired" or "intact" category differently based on

what his neuropsychologist perceived his race to be. He is viewed as fitting both, or

perhaps neither. This is another way of destabilizing race – if whiteness and blackness

were natural, it should be possible to accurately and consistently code this patient. The

first problem that I have with using such categories is that it cannot be done!

One might ask what the harm is of using such categories despite their logical

incoherence. Simply put, the harm is that treating these categories as essential, rather

than constructed, is to cover over issues of power and oppression. If there are differences

in performance across various so-called racial groups, it does not necessarily follow that

such differences are the result of inherent differences. To do so denies the impact of

oppression. When we believe that particular racial, gender, educational, or class groups

perform at different levels due to biological reasons, we reinforce the idea that some

people are simply biologically superior to others. It is such reasoning that has led to

eugenics programs[47]. This also gives us a societal pass – if we use biology to explain

group difference, we do not need to accept responsibility for collectively creating the

conditions in which particular groups "perform" better than others. Power recedes, and

there is simply no space for discussions of systemic oppression.

---

[46] As Goodman notes, there is no true marker to delineate one race from another, yet another argument that race is not a biological reality.

[47] Claims of biological racial difference have been used to justify everything from slavery to the Holocaust. As Lifton (1986) discusses in *Nazi Doctors,* members of the medical profession actively joined in the extermination of human life both by providing so-called scientific justification for the extermination of groups of people and by categorizing atrocities such as forced sterilization as medical procedures.

Birth of the Clinic:

Although I turned to *Madness and civilization* (1965) in the previous chapter, it makes sense to turn now to a later, different, Foucault and draw upon *The Birth of the clinic* (1974) for this chapter. Shifting from Foucault's description of the birth of the asylum to the birth of the clinic demonstrates that neuropsychology has been deeply influenced by *both* the history of madness and the history of medicine. Neuropsychology treats a borderland of madness and medicine; it functions to tease apart – and re-unify – both. The history of the clinic is also the history of the neuropsychologist, both as psychology had been the domain of medical doctors, and as the neuropsychologist operates on a mixed terrain. Much as *Madness and civilization* (1965) offered the previous chapter, *The Birth of the clinic* (1974) provides a means of understanding the loss of the subjectivity of the patient that has been autoethnographically highlighted thus far in this chapter. *The Birth of the clinic* traces the evolution of the Classical view of medicine through the anatomo-clinical model, exploring the shifts in the role of the doctor, and the location and meaning of disease. Nonetheless, I do not argue that *The Birth of the clinic* is a parallel text to that of *Madness and civilization* (1965). As Gutting (1989) rightly notes, these texts are different in historical scope as *The Birth of the clinic* (Foucault, 1974) is limited to Classical medicine and focuses primarily on clinical and anatomo-clinical medicine. Further, *The Birth of the clinic* is written independently of – and without reference to – *Madness and civilization.* (Gutting, 1989). For the purposes of this chapter, I will introduce the historical and conceptual shifts outlined by Foucault, culminating in the modern clinic. I do so with a particular eye to the shifting relationship

to the patient as subject, listening always for the implications of this for my

understanding of the neuropsychologist.

*The Spacialization of Illness***:**

Foucault (1974) introduces the task of understanding the medical project by

highlighting what has come to be taken for granted as the space in which disease exists.

Foucault reminds the reader that other conceptualizations of disease have occurred in the

past, and will likely occur again in the future, thus accenting its contingency. What is

natural in the current conception of illness and medicine has not always been so, and will

not always be so.

> For us, the human body defines, by natural right, the space of origin and of
>
> distribution of disease: a space whose lines, volumes, surfaces, and routes are laid
>
> down, in accordance with a now familiar geometry, by the anatomical atlas. But
>
> this order of the solid, visible body is only one way – in all likelihood neither the
>
> first nor the most fundamental – in which one spatializes disease. There have
>
> been, and will be, other distributions of illness. (p. 3)

Although the current conceptualization of disease makes it seem only natural that illness

exists in a body whose properties have been anatomically mapped. Yet, this is not the

only possible understanding of illness or the body, and there are implications for such an

understanding.

According to Foucault one such consequence of this understanding of illness and

the body is that doctors and patients are merely tolerated as inevitable disturbances by

medicine. The goal of medicine is to reduce the disturbances caused by doctors and

patients as much as possible in order to make space for the disease itself. Minimizing the

impact of patients and doctors is done with the goal of allowing the disease to express

itself. Nothing is to interfere with the natural expression of the disease.

> In the rational space of disease, doctors and patients do not occupy a space as of
>
> right; they are tolerated as disturbances that can hardly be avoided: the
>
> paradoxical role of medicine consists, above all, in neutralizing them, in
>
> maintaining the maximum difference between them, so that, in the void that
>
> appears between them, the ideal configuration of the disease becomes a concrete,
>
> free form, totalized at last in a motionless, simultaneous picture, lacking both
>
> density and secrecy, where recognition opens of itself onto the order of essences.
>
> (p. 9)

The bodies of patients and physicians are initially rendered invisible in the service of

diagnosing. In this conception of medicine, the physician must eliminate the presence of

the individuality of the patient in order to locate the disease and to permit the disease to

show itself.

Such an understanding of disease as anatomically located and configured,

particularly as lesions, is a relatively new one, emerging from a process that began in the

nineteenth century. The decision to view lesions as spatially located is a new and

particular means of understanding illness, emerging in the nineteenth century.

Understanding lesions in such a manner relates to a privileging of the gaze. What can be

seen is privileged over all else.

> The space of *configuration* of the disease and the space of *localization* of the
>
> illness in the body have been superimposed, in medical experience, for only a

relatively short period of time – the period that coincides with nineteenth-century

medicine and the privileges accorded to pathological anatomy. This is the period

that marks the suzerainty of the gaze, since in the same perceptual field, following

the same continuities or the same breaks, experience reads at a glance the visible

lesions of the organism and the coherence of pathological forms; the illness is

articulated exactly on the body, and its logical distribution is carried out at once in

terms of anatomical masses. The 'glance' has simply to exercise its right of

origin over truth. (p. 3, 4)

The gaze becomes equated with the truth.

Foucault argues that this – and other – conceptions of disease have tremendous

implications for the way in which medicine is practiced and understood. And, since this

understanding is contingent, one can explore – as Foucault does – the societal forces that

have shaped this understanding as well as the force that this understanding of medicine

exerts on society, and – in particular – the body. With this in mind, Foucault traces the

history of medicine from the Classical age to the Anatomo-Clinical medicine.

Classical Medicine:

Foucault (1974) begins with an exploration of medicine in the Classical era,

which he says was marked by a belief in 'essential' non-bodily diseases whose

presentation can be obscured by the patient's body itself. The doctor's task was to

separate out the essence of the disease from the patient's idiosyncrasies. The disease had

its own essence and trajectory. Medical knowledge was primarily theoretical, seeking to

place the particular disease within a non-causal categorization system.

Just as the genealogical tree, at a lower level than the comparison that it involves and all its imaginary themes, presupposes a space in which kinship is formalizable, the nosological picture involves a figure of the diseases that is neither the chain of causes and effects nor the chronological series of events nor its visible trajectory of the body. (p. 4)

The disease had an essence that was unrelated to the patient's body. Because of this, the roles of the physician and patient were minimized – both could get in the way of the process of the disease, and needed to stay away to minimize their impact. The doctor and patient were tolerated only as disturbances:

In the rational space of disease, doctors and patients do not occupy a space as of right; they are tolerated as disturbances that can hardly be avoided: the paradoxical role of medicine consists, above all, in neutralizing them, in maintaining the maximum difference between them, so that, in the void that appears between them, the ideal configuration of the disease becomes a concrete, free form, totalized at last in a motionless, simultaneous picture, lacking both density and secrecy, where recognition opens of itself onto the order of essences. (p. 9)

In the Classical era, doctors and patients attempted to stay out of the way of the expression of classifiable disease so that the disease could express itself. An understanding of disease was unrelated to the specific expression of that disease in the patient's body. Further, the hospital was an undesirable space as it – like the patient and doctor – ran the risk of interfering with the essence of the disease. In the Classical era, the aim was to provide a natural environment in which the disease was free to express its

155

essential identity. "Like civilization, the hospital is an artificial locus in which the transplanted disease runs the risk of losing its essential identity" (p. 17). Doctoring ideally occurred in the home, where the disease could express itself with minimal interference. Classical medicine worked to minimize the (disruptive) influence of the doctor and patient, privileging a theoretical and classificatory (non-bodily) understanding of diseases.

The emergence of clinical medicine:

The (French) Revolution attempted to bring about a shift in medicine. At this time, the faculty of medicine which had emphasized this classificatory understanding was replaced by the Royal Society of Medicine, marking a change in understanding to one in which medical knowledge can constantly be revised.

> What now constituted the unity of the medical gaze was not the circle of
> knowledge in which it was achieved but that open, infinite, moving totality,
> ceaselessly displaced and enriched by time, whose course it began but would
> never be able to stop – by this time a clinical recording of the infinite, variable
> series of events. (Foucault, 1974, p. 29)

This also corresponded with the belief that disease (and thus doctors) could be eliminated, demonstrating a change in understanding of the doctor's role from one who eliminates disease to one who enforces health. Disease was conceptualized as a (potentially unnecessary) deviation from health. The disease itself was no longer respected as a natural phenomenon that should be given space. Instead, disease was a deviation from the norm of health that should – and potentially could – be eliminated.

156

Medicine became concerned with normality rather than health. The interventions and

theories of medicine came from physiological knowledge and a standard of functioning

that was considered to be normal.

> Nineteenth century medicine, on the other hand, was regulated more in
>
> accordance with normality than with health; it formed its concepts and prescribed
>
> its interventions in relation to a standard of functioning and organic structure, and
>
> physiological knowledge – once marginal and purely theoretical knowledge for
>
> the doctor – was to become established (Claude Bernard bears witness to this) at
>
> the very centre of all medical reflection. (p. 35)

This shift transformed the meaning of medicine, altering it into something that has a

positive meaning and involves social control. Here emerged the medicine of normality.

The shift in meaning correlates to a change in the place of theoretical knowledge

to a valuation of practical knowledge. These shifting values led to the birth of the clinic.

This altered what qualified one to be a doctor, shifting to a valuation of medical

competence as opposed to theoretical knowledge. Training thus involved direct contact

with patients in the clinic setting.

> Cantin suggested that once the rudiments had been taught, the candidate doctors
>
> would be sent either to a hospital or to the countryside, where they would attain
>
> practical experience as assistants to already qualified doctors; for very often what
>
> is needed is an extra pair of hands, and patients rarely need qualified doctors. (p.
>
> 35)

 Practical, not theoretical, knowledge became the criteria of evaluation for competence.

And, indeed, doctors were evaluated for competence, with the government taking an

interest in 'protecting' citizens from unskilled doctors. Medicine began to enforce

normalcy in the body but also came up with new standards for the practice of medicine.

"Protective bodies sprang up spontaneously against this state of affairs" (p. 67). Out of

desires to regulate the competency of doctors and to care for the poor, the clinic emerged.

The clinic was a new entity: "To all appearances, it was simply reviving, as the only

possible way of salvation, the clinical tradition that had been developed in the eighteenth

century. In fact, what was involved was something quite different" (p. 68). This new

clinic was not like the old. This new clinic was part of a pedagogic system.

> In that autonomous movement and the quasi-clandestinity that abetted and
>
> protected it, this return to the clinic was in fact the first organization of a medical
>
> field that was at once composite and fundamental: composite because in its
>
> everyday practice, hospital experience resembles the general form of a pedagogic
>
> system; but fundamental, too, because unlike the eighteenth century clinic, it is
>
> not a question of an encounter, after the event, or a previously formed experience
>
> and an ignorance to be dissipated. (p. 68)

In contrast to Classical medicine, clinical medicine understood disease according to the

signs and symptoms (which are not differentiated) of the disease as they appear on the

surface of the patient's body. The disease is reducible to its observable signs. The

disease is the totality of its symptoms and is thus entirely visible. The gaze of the doctor

then became an essential ingredient in the medical project. The language of medicine no

longer involved speech and instead relied entirely on the gaze.

> The silencing of university speech (*la parole universitaire)* and the abolition of
>
> the professorial chair made it possible, beneath the old language, in the obscurity

of a partly blind practice, driven this way and that by circumstances, for a

language without words, possessing an entirely new syntax, to be formed: a

language that did not owe its truth to speech but to the gaze alone. (p. 69)

It was the gaze itself that replaced even language. The clinic occupied a special place,

important as it was for the coherence of this new social and medical structure: "The clinic

figures, then, as a structure that is essential to the scientific coherence and also to the

social utility and political purity of the new medical organization" (p.70). The clinic was

a space in which doctors were trained and where the poor were treated, with the poor

being used in order to train doctors and revive the medical science. This combination –

the use of the poor to advance medical knowledge – led to moral difficulties. Patients,

having arrived at the hospital out of necessity due to poverty and asking for help as

subject, were to be transformed into object for the sake of medical knowledge from

which others would benefit.

The most important moral problem raised by the idea of the clinic was the

following: by what right can one transform into an object of clinical observation a

patient whose poverty has compelled him to seek assistance at the hospital? He

had asked for help of which he was the absolute subject, insofar as it had been

conceived specifically for him he was now required to be the object of a gaze,

indeed, a relative object, since what was being deciphered in him was seen as

contributing to a better knowledge of others. Furthermore, while observing, the

clinic was also carrying out research. (p. 83)

The patient's – particularly the poor patient's – subjection to the physician's gaze became

an integral aspect of medicine, one that largely defined the practice of medicine. The

gaze of the physician, healing though it may be, is also violent, and appropriates the patient's body. The patient's body is displayed as a spectacle rather than comforted in its pain. Pain itself becomes a spectacle. The illnesses of some are transformed into the experiences of others.

> But to look in order to know, to show in order to teach, is not this a tacit form of violence, all the more abusive for its silence, upon a sick body that demands to be comforted, not displayed? Can pain be a spectacle? Not only can it be, but it must be, but virtue of a subtle right that resides in the fact that no one is alone, the poor man less so than others, since he can obtain assistance only if others intervene with their knowledge, their resources, their pity, since a patient can be cured only in society, it is just that the illnesses of some should be transformed into the experience of others; and that pain should be enabled to manifest itself.
>
> (p. 84)

The body of the patient is subjected to the gaze of the physician. This gaze was not the gaze of classificatory medicine, but one that operated in a very different and violent manner. It is not just any gaze holding the patient in sight, but a gaze that carries the weight and authority of a medical institution. It is a gaze that can decide and intervene, and one that is attuned to deviance and calculates.

> But the medical gaze was also organized in a new way. First, it was no longer the gaze of any observer, but that of a doctor supported and justified by an institution, that of a doctor endowed with the power of decision and interventions. Moreover, it was a gaze that was not bound by the narrow grid of structure (form, arrangement, number, and size), but that could and should grasp colours,

160

variations, tiny anomalies, always receptive to the deviant. Finally, it was a gaze

that was not content to observe what was self-evident; it must make it possible to

outline chances and risks; it was calculating. (p. 89)

The gaze now fixed on signs and symptoms, and it was these that comprised the illness.

The doctor's gaze was a fundamental aspect of medicine, and the doctor's gaze was

believed to be able to see the totality of the disease. The symptoms become disease itself.

"There is no longer a pathological essence beyond the symptoms: everything in the

disease is itself a phenomenon; in that respect, the symptoms play a simple role, primary

in nature" (p. 91). Signs and symptoms, then, are the disease itself. The difference

between signs and symptoms is that the sign points to – says – the symptom. "Signs and

symptoms are and say the same thing, the only difference being that the sign *says* the

same thing that *is* precisely the symptom" (p. 93). It is this saying that is of utmost

importance. Clinical medicine relied on an interaction between seeing and saying, of

translating symptoms into language. This process of seeing and saying – the process of

translation – was the essence of this kind of medicine. Disease only exists, in this

formulation, in what can be seen and therefore stated. The description transforms the

disease. It is what can be seen and therefore articulated.

> The descriptive act is, by right, a 'seizure of being' (*une prise d'etre),* and,
>
> inversely, being does not appear in symptomatic and therefore essential
>
> manifestations without offering itself to the mastery of language that is the very
>
> speech of things. In the medicine of species, the nature of a disease and its
>
> description could not correspond without an intermediate stage that formed the
>
> 'picture' with its two dimensions; in clinical medicine *to be seen* and *to be spoken*

immediately communicates in the manifest truth of the disease of which it is

precisely the whole *being*. There is disease only in the element of the visible and

therefore statable. (p. 95)

Thus, disease can be – and must be, for clinical medicine – translated into language. The

clinical gaze 'hears' what is seen in symptoms immediately. This bridges the gap

between clinical medicine and research. Research is about speaking what is seen.

The clinical gaze has the paradoxical ability to *hear a language* as soon as it

perceives a spectacle. In the clinic, what is manifested is originally what is

spoken. The opposition between clinic and experiment overlays exactly the

difference between the language we hear, and consequently recognize, and the

question we pose or, rather, impose. (p. 108)

This dialogue between seeing and saying is the link to the domain of research. It is this

process that determines what questions are asked or imposed.

Clinical medicine gave birth to the clinic through its emphasis on clinical,

practical knowledge. Clinical medicine made use of the gaze of the doctor, which saw,

and then transferred what was seen into language. The clinic was born through clinical

medicine, and disease was reducible to signs and symptoms.

*Anatomo-Clinical Medicine***:**

Eventually, clinical medicine gave way to anatomo-clinical medicine. As

opposed to clinical medicine, anatomo-clinical medicine calls upon lesions rather than

symptoms. In other words, symptoms are no longer viewed as the route to understanding

disease. Rather, symptoms are viewed as useful only insofar as they lead the clinician to

the discovery of the lesion that is said to be causing the symptoms. Lesions become the only true sign of disease. Symptoms are only significant to the extent that they reveal the presence of lesions. Thus, the surface of the body is disregarded in favor of the underlying anatomical problem (lesion) causing the symptom. This rather dramatically shifts the doctor's relationship with the body of the patient. Symptoms refer to a living body, but the ultimate referent of the lesion is the corpse. "A clinic of symptoms seeks the living body of the disease; anatomy provides it only with the corpse" (Foucault, 1974, p. 134). The corpse as referent involves a third layer of the gaze. It is the corpse, not the living body, that is of concern in anatomo-clinical medicine. The medical gaze does not stay with the surface of symptoms but seeks to penetrate into the body of the patient, to find secrets hidden deep within the tissue of the patient's body.

> The medical gaze must therefore travel along a path that had not so far been opened to it: vertically from the symptomatic surface to the tissual source; in depth, plunging from the manifest to the hidden; and in both directions, as it must continuously travel if one wishes to define, from one end to the other, the network of essential necessities. (p. 135)

The third dimension of the gaze is characteristic of anatomo-clinical medicine. It is the introduction of the lesion and this third dimension that defines anatomo-clinical medicine. The gaze adds a third dimension. "The medical gaze, which, as we have seen, was directed upon the two-dimensional areas of tissues and symptoms, must, in order to reconcile them, itself move along a third dimension. In this way, anatomo-clinical range will be defined" (p. 134/135). Anatomo-clinical medicine is defined by the lesion.

Anatomo-clinical medicine, with its emphasis on lesions rather than symptoms, incorporates death in medicine – and in the body of the patient – in a new way. Death is an integral part of anatomo-clinical medicine, much more than other forms of medicine. Death is incorporated into medicine. "Death is now no more than the vertical, absolutely thin line that joins, in dividing them, the series of symptoms and the series of lesions" (Foucault, 1974, p. 141). Death is no longer cut off from medicine, part of a different dimension. It is rather joined with life and disease, both technically and conceptually. Death is now used to comprehend life.

> Life, disease, and death now form a technical and conceptual trinity. The
> continuity of the age-old beliefs that placed the threat of disease in life and of the
> approaching presence of death in disease is broken; in its place is articulated a
> triangular figure the summit of which is defined by death. (p. 144)

Anatomo-clinical medicine did more than incorporate death in its understanding of disease. Death, no longer the absence of life, offers understanding of life and of disease. Death itself elucidates disease.

> Instead of being what it had so long been, the night in which life disappeared, in
> which even the disease becomes blurred, it is now endowed with that great power
> of elucidation that dominates and reveals both the space of the organism and the
> time of the disease. (p. 144)

The perspective of death offers a new understanding of disease, one which has a location that can be mapped. It is this land of death – the corpse – that provides an understanding of life, and of disease. The corpse can be mapped, it can shed light on life, but a

164

particular kind of life. Death makes disease able to be mapped. It is the corpse that brings understanding of the living body.

> From the point of view of death, disease has a land, a mappable territory, a subterranean, but secure place where its kinships and its consequences are formed; local values define its forms. Paradoxiacally, the presence of the corpse enables us to perceive it living – living with a life that is no longer that of either old sympathies or the combinative laws of complications, but one that has its own roles and its own laws. (p. 149)

Death, for anatomo-clinical medicine, is the very source of disease. Death is not a stranger to life, it is manifest within life, and it is the cause of disease. Death is present in life and it causes disease.

> Earlier, death appeared as the condition of the gaze that gathered together, in a reading of surfaces, the time of pathological events; it enabled the disease to be articulated at last in a true discourse. Now it appears as the source of disease in its very being, that possibility internal to life, but stronger than it, which exhausts it, diverts it, and finally makes it disappear. Death is disease made possible in life (p. 155/6)

Because of its relationship to death, disease exists bodily within the diseased, permitting disease to become spatialized and individualized. Disease itself dissects the body.

> On the basis of death, disease is embodied in a space that coincides with that of the organism; it follows its lines and dissects it; it is organized in accordance with its general geometry; it is also inflected towards its singularities. From the moment death was introduced into a technical and conceptual organon, disease

was able to be both spatialized and individualized. Space and individual, two

associated structures deriving necessarily from a death-bearing perception. (p.

159)

In anatomo-clinical medicine, death is present as the bringer of disease. Its relationship

to disease permits disease to dissect the body. It is death that brings truth. For anatomo-

clinical medicine, it is in death that perception can grasp life and disease. It is death that

enlightens.

In anatomical perception, death was the point of view from the height of which

disease opened up into truth; the life/disease/death trinity was articulated in a

triangle whose summit culminated in death; perception could grasp life and

disease in a single unity only insofar as it invested death in its own gaze. (p. 158)

In death, the clinician can grasp the truth of the disease. It is the visible lesion – that

which is sought after during autopsy – that characterizes disease, whether or not

symptoms are manifest. "Now, in an anatomo-clinical perception the symptom may quite

easily remain silent, and the significant nucleus with which one believed it to be armed

prove to be non-existent" (p. 159).

All in all, anatomo-clinical renders visible what had previously been invisible.

The emphasis on lesions and the incorporation of death shows what had previously been

hidden away. "What was fundamentally invisible is suddenly offered to the brightness of

the gaze, in a movement of appearance so simple, so immediate that it seems to be the

natural consequence of a more highly developed experiences" (Foucault, 1974, p. 195).

Because of this new visibility, the emphasis on symptoms fades away. Disease is

individual and spatial; it is visual and can be located in the corpse.

Birth of the Clinic and the Neurobehavioral Unit*:*

The values and understanding of the self that are characteristic of anatomo-clinical medicine, as described by Foucault (1974), offer a new understanding of the loss of subjectivity on the neurobehavioral unit. Elements of clinical medicine remain, but I argue that anatomo-clinical medicine is the dominant means of operation on the unit. (I make intentional use of the term "dominant", calling upon it to express both its mainstream acceptability and a particular relationship to power.) In this section, I argue that my performance on the neurobehavioral unit was characteristic of the anatomo-clinical medicine, and explore the practical implications of this understanding.

*The Birth of the clinic (*Foucault, 1974) is a narrative of the historical evolution of medicine, one that traces the shifting understanding of medicine and the corresponding shifts that cause and are caused by these beliefs. Simply stated, the era of anatomo-clinical medicine has arrived. Indeed, it is less that neuropsychology has reinvented its identity, technique, and assumptions in light of the emergence of an anatomo-clinical medicine and corresponding understanding, but rather that neuropsychology largely emerged in such a context. Emerging following World War I, neuropsychology was born into a context in which discovery of lesions were central to medicine. Thus, neuropsychology emerged in the historical context of anatomo-clinical medicine. As I outlined on page --, neuropsychology's understanding of anatomo-clinical medicine was initially rather crude – it sought to establish simply whether or not one had a lesion. I argue that the subsequent changes in neuropsychology – and the eradication of the

167

subjective highlighted in this chapter – are symptoms of neuropsychology's attempts to draw ever closer to the mission of anatomo-clinical medicine.

Dissection is a major goal of anatomo-clinical medicine. Death is present in anatomo-clinical medicine, and it is death present within the body that makes this understanding coalesce. The anatomo-clinical doctor seeks out lesions. Neuropsychology does this through neuropsychological testing. The brain of the living cannot be dissected, and thus neuropsychology was faced with the task of determining whether and where lesions exist in the brains of patients. Testing thus seeks to eliminate the living patient, focusing instead on the condition of the brain. Moreover, it is the brain of the corpse – not the living patient – that functions as the ultimate referent. Neuropsychology aims, perhaps, to function as a dissection without death. It seeks to turn the living brain into the brain of the corpse.

This largely explains – illuminates, perhaps – the peculiar elimination of the subjective that is the focus of this chapter. It is precisely the patient's subjectivity that serves to remind the clinician that the patient is *not* a corpse, thus interfering with the studied search for lesions. With the discovery of lesions as the aim, the subjectivity and subjective experience of the patient have very little role in the discovery process. Perhaps, too, this begins to answer the question featured in the next chapter – Why is it, exactly, that neuropsychology defers to neuroimaging even at the expense of its own progress? Neuroimaging simply fits with the goal of dissection of the living more than neuropsychology. It dissects the living more effectively.

Placing neuropsychology within the historical era of anatomo-clinical medicine offers an explanation for why it is that the performance of the neuropsychologist seems to

168

focus so much on the elimination of the patient's subjectivity. It does not, however, articulate or explore the experience of the patient whose subjectivity attempts to be eliminated by neuropsychology. What is it like when your neuropsychologist pretends that you're dead?

Chapter Summary:

This chapter explored the ways in which my performance of training neuropsychologist served to attempt to eliminate the subjectivity of patients. As in other chapters, I did so initially through autoethnography, exploring the minimization of the psychological, minimization of the contextual, and the reduction of patients to scores. I then turned to Foucault's (1974) *Birth of the clinic* in order to further process this dynamic. In the end, I conclude that my self as training neuropsychologist worked to eliminate the subjectivity of my patients and my self as patient as a function of anatomo-clinical medicine which is concerned with lesions, and thus, the corpse.

Chapter 6: Bowing to Neuroimaging:

In this chapter I examine the next step in neuropsychology's separation of the patient from the brain: the desire to see the brain. Although this desire logically follows from the separations outlined in the previous chapter as the neuropsychologist looks further and further away from the totality of the patient, it is a desire that is necessarily unfulfilled by neuropsychology. Neuropsychology can be used to *imagine* the condition of the brain – whether or not it *should* be used for this purpose is another question entirely! – but it cannot be used to literally see the brain or images of the brain. This chapter begins by moving to descriptions of that desire, and then explores the implications of the desire – namely, the valorization of neuroimaging, the devaluation of neuropsychology, and the further obliteration of the presence of patients.

Wanting to see:

I discovered, in myself and on the unit, a fascination with images of the brain. There was a frenzy on the unit surrounding the prospect of sight! I surrounded myself with images of the brain and joined in the frantic search for glimpses of the brain. The search for images of the brain infiltrated almost all aspects of my performance as training neuropsychologist, and I found the image of the brain following me as I travel the unit.

Scene:

I often look over at the model of the brain in Dr. G.'s office. The unit is full of images, models, and scans of brains. We have posters on office walls, plastic models with removable, color-coded brain parts. There are light-up display boards on which we

can post pieces of neuroimaging. These are sort of toys for us, objects that we view with

pleasure and playfulness. I am entranced by the models of brains that litter Dr. G's

office, sometimes holding one in my hand as he and I talk. And what a symbol. As Dr.

G. and I talk I casually – cavalierly – hold a brain in my hands.

Scene:

Today's case conference was a "Big Deal." I first found out about this "case"

when Dr. G beckoned me inside his office. He handed me a plastic model of a skull with

a big chunk missing, and showed me a picture of a vibrant blue head with yellow flecks

flying all around. I chuckled, thinking that this was a new "toy" of Dr. G.'s, some plastic

model produced in bulk and marketed to medical professionals. Instead, he told me that

this is the image of the brain of a new patient. The flecks are chunks of bone and metal.

I was suddenly horrified by what I held in my hands. I wanted to hand it back.

Dr. G. was in overdrive. I felt called to match his intensity, but, shit, there's this

guy with half of his head gone! I awkwardly excused myself, having found the shock of

what I have seen temporarily jolted me out of my neuropsychologist trainee self.

I discovered that Dr. G. was not the only person extraordinarily enthusiastic about

this man and his brain. The table in the conference room was overcrowded. I found that

the excitement was contagious, and although I continued to feel overwhelmed, I also felt

energized. The conference began with Dr. G. passing around the small model of the

battered brain resting in the broken skull and a series of pictures. Some of these showed

the patient's actual brain, with pins holding his scalp open to reveal the gray tissue. I felt

slightly dizzy looking at them, both drawn and repelled. It reminded me of the feeling I

had as a kid looking at a large bug.

I felt certain that the patient required the care of this devoted team of

professionals. But I was also disturbed by the notable voyeurism that we exhibited. We

were, collectively, getting off on the display[48]. Most of us clustered in the conference

room were definitely not involved in this man's care. Furthermore, I wasn't sure what

the clinical utility was of showing the shattered skull or the pictures of the brain itself.

Dr. G. then moved on, with palpable excitement, to displaying the MRIs. Those,

at least, made a kind of clinical sense. We could see where he literally lost brain. Unlike

most case conferences, we never actually got into the testing data. We just discussed

how the man was coping, the impact of the injury on his personality, etc. I felt vaguely

disturbed by the whole thing even as I strained in my chair for a better view. The air of

excitement seemed to relate both to the severity of the patient's trauma and to the

incredible visual images that accompanied the patient's story. We were collectively

fascinated by the glimpses of this man's brain. I had the sense that we were seeing what

was "really" happening through the images of his brain[49].

Scene:

I spend time looking at the various "brains" in Dr. G.'s office. In my own office,

I stare at picture after picture of brain parts in textbooks and online. It reminds me of the

---

[48] Many of my descriptions in this chapter are somewhat eroticized. The image of the brain has become fetishized.

[49] This is a strange phenomenon. I feel comfortable looking at an image of his brain, but not at looking at this brain in itself. I feel that, seeing, the brain itself was voyeuristic – masturbatory, even! – but I felt comfortable looking at the image on his MRI. Somehow, processing his brain through this technology removed the profanity.

first time I saw an actual image of the brain – I felt naively surprised that the parts of the

brain are not actually distinguishable from one another via borders! As I look at these

models and study the pictures, I have the sense that I am seeing something very

important. Somehow, viewing this is my ultimate goal in neuropsychology. The testing

that I do feels like a sort of straining my eyes, trying to see a scan of the brain.

Scene:

  After I have placed all of the testing information into the summary sheet, I

examine it for patterns that would indicate a specific part of the brain is struggling, or if

the problems seem to be diffuse, indicating a vascular dementia. There is a way in which

I am trying to use the tests to imagine the image of the patient's brain. (One could

imagine a performance of neuropsychology that instead aims to refer to the patient's life.)

I spend time considering the implications of the testing on the patient's frontal lobes or

amygdala, rather than on the patient's ability to drive or read. Indeed, the image that

comes to mind when I look over testing materials is a brain, not a person. And yet, the

brain that neuropsychology calls me to picture is a fantasy. I am not imagining the image

of an actual brain, but a cross-section of a brain that is conveniently labeled with color-

coded parts. This is not the brain that rests in the skull at all!

Scene:

I am invited to see a "brain cutting[50]" on another unit. I have a class, and am unable to attend. However, I am lured by the invitation. The invitation holds the promise of seeing an actual brain, in person. It also offers the chance to witness the permanent altering of that brain. The goals of sight and of intervention are central here. I would like to see it, but am also grossed out by the prospect of seeing an actual brain. Somehow, I have come to see the images of MRI's and other neuroimaging techniques as more "real" than the actual brain, privileging the view through technology above all others. And yet, an MRI is not an actual brain. It is an image. I play with the term "neuroimaging." It is an image, a mirage even. It is an imagining. A neuro-imagining!

Explorations:

An air of excitement surrounds the promise of "seeing" an image of the brain[51]. The image of the brain seems to hover just around the corner when I am on the unit, and I am worked into frenzy when I am granted the promise of finally seeing. I want to see because I believe that seeing will provide answers. But why do I believe that sight[52] provides a certainty not provided by anything else? What is this obsession with seeing? What answers are provided through sight that cannot be provided by any other way of

---

[50] A brain cutting is precisely what it sounds like – the cutting of the brain! In other words, I was invited to watch neurosurgery. It also seems to be telling that the invitation is not specific – I am not invited to witness a particular procedure, or watch the potential cure of a debilitating condition take place. I am merely invited to watch the brain be cut.

[51] I use the phrase "an image of the brain" quite intentionally. Although the actual brain provides some excitement, it is the *image* of the brain produced by the technology of neuroimaging that is most fantasized about here. Indeed, the exaltation of the image rather than the actual brain is yet another form of turning away from the patient! Even when I look inside my patient, I cannot see him in his flesh.

[52] To be clear, the "sight" to which I refer is not necessarily simply a "structural" map. Increasingly, neuroimaging techniques show more than the contours of the brain. They also permit us to "see" when various parts of the brain are in action.

174

knowing?[53] What do I do with the reality that neuropsychology cannot actually permit me to see?

Bowing to Neuroimaging:

Because sight has become so elusively sought-after and I cannot achieve the goal of sight through the tools of neuropsychology, I find myself exalting neuroimaging and deferring to it whenever possible. Neuroimaging promises to offer glimpses of the ever sought-after brain. I notice myself believing that neuroimaging provides superior knowledge than that provided by neuropsychology. I also find that I am not alone in this valorization and fetishization of neuroimaging. Because the context of the brain is minimized and seeing the images of the brain is valorized as the most effective way of understanding the patient, neuropsychology minimizes its own function. Because of the promise of sight, neuroimaging seems to be taken as "trumping" whatever is seen on neuropsychological profiles.[54]

Scene:

Before I meet with a new patient, I will have searched the computerized file for neuroimaging. I can actually see an image of my patient's brain up on the screen,

---

[53] Dr. Phelps, one of the creators of the PET scan explained his invention as such: "You know, another way to approach the explanation [of the PET] is to forget abot PET initially and focus on the problem: That is to be able to take a camera and just watch. ..You know the activity is there, and you'd like to be able to build a camera that can watch it." (Dummit, 2004, p. 2).

[54] There are some exceptions to this. Some disease processes such as Alzheimer's dementia are believed to show up subtly in neuropsychological testing prior to its emergence on neuroimaging. However, I believe that my point still holds – when there is a discrepancy between the two, the information garnered from the neuroimaging is seen as more accurate. Furthermore, the kind of changes that may be detected through neuropsychological testing are seen as less convincing than those that show up on neuroimaging.

although I have not yet seen his face[55]. I am not trained in reading neuroimaging, so I look at it briefly before reading the interpretation of whoever read the imaging. I take my notes to Dr. G. and together we use this information to develop a testing battery. There is something circular about this. We begin with the information provided to us by neuroimaging and use that to determine which tests to use. Reflecting on this, it is both efficient and circular. It is efficient because it is impossible to administer all neuropsychological tests in order to capture an absolutely complete neuropsychological picture. And yet, I am putting a lot of faith in the neuroimaging to not have missed something. In essence, I am assuming that I will find what neuroimaging has already found.

Scene:

After testing a patient and scoring the results, I meet with Dr. G in supervision to make sense of the resulting summary sheet. For one particular patient, the results don't quite seem to cohere. Dr. G. and I sit around his table, staring at the summary sheet. Finally, Dr. G. asks me to show him the interpretation of the patient's MRI. He stares at it for a while, then pulls out a sheet of paper and shows me how to emphasize pieces of data from the summary sheet and de-emphasize others so that the neuropsychological testing results appear to match the neuroimaging.

I am glad to have his suggestion. Dr. G. did not ask me to alter the testing results in any way, but rather simply to highlight and de-emphasize certain points. However, the result is that Dr. G. has privileged the neuroimaging above the testing. It is the testing

---

[55] Clearly, this relates to the dynamics of previous chapters, literally putting an image of the patient's brain before his face. I cannot be called by the Other's face, because I do not face the Other (Levinas, 1969). I look through his face, to his brain, and try to decode who he is without enduring the ethical call of his face.

that must be interpreted in such a way that it is consistent with the neuroimaging rather than the reverse. In doing so, he is ascribing a higher kind of truth to the data produced by neuroimaging[56].

Scene:

When I argue a point in supervision, I do so with the words of neuroimaging, not testing data. (See, for example, my argument with Dr. G. – on p. 133 - regarding a patient who I believe to be experiencing a traumatic disorder) I do so because both Dr. G. and I are more convinced by what we believe to be the certainty of neuroimaging. Somehow, the questions of human error – did you accidentally give the patient too much or not enough time on a task, or inadvertently cue him if he was doing well or poorly through your tone of voice? – do not enter here.

I turn to neuroimaging both as a rhetorical device (I know that Dr. G. is more likely to be compelled by this language than that of neuropsychology or – especially – psychology) and because I find myself believing in the truth that it offers. I believe that the brain scan offers a kind of knowing to which I have no access through neuropsychological testing. I find myself believing in it, reassured by the relative certainty it offers.

Explorations:

Neuorpsychology has come to involve a fascination with the image of the brain. In the role of training neuopsychologist, I do not feel ambivalence about neuroimaging,

---

[56] The term "production" is a loaded term, and I use it fully aware of its implications. I believe that neuroimaging and neuropsychology are producers of types of knowledge. Each creates and markets a particular truth.

but rather, fascination. The performance of neuropsychology involves the exaltation of neuroimaging, and I find myself all too ready to worship. Upon reflection, it feels to me that I have been duped by the promise of knowledge provided by sight into surrendering the value of neuropsychology itself. Somehow, the desire to see has taken over any other concern.

Neuroimaging as Certainty:

As I reflect, it seems to me that sight has become equated with certainty. (And this is not just any sight, this is sight that has been mediated by technology and medicine!) I exalt neuropsychology because I believe that it can offer me definitive truths, a decontextualized truth. And somehow, that is what I have come to value as a training neuropsychologist.

Scene:

Sondra tells me that the nurse practitioner is on the phone for me. He asks me to send him a file on a patient that I saw approximately a month prior. The man had been referred to test for a learning disability. His testing profile was puzzling, as he had odd pockets of impairment. A few days later, Dr. G. tells me that an MRI revealed a tumor, and that the nurse practitioner has been working with the patient. My reaction is of concern, yes, but also the sense that a mystery has been solved. I felt puzzled by the results of testing and then felt reassured by the "certainty" of neuroimaging.

Scene:

A patient, who had been referred to me to determine whether or not his cognitive difficulties could be reasonably attributed to his bipolar disorder, mentioned in our interview that he had a stroke a few years back. I was surprised, because I did not remember anything about it in his chart. After he left, I revisited his chart and discovered that his very recent MRI showed no sign of a stroke. I took this as firm evidence that he has not had one, and make a note that he erroneously believes that he has had a stroke. I consider putting this in my report as evidence of a "delusion," but decide that he may have been simply misinformed. It does not seem to be conceivable that he had a stroke that was not captured on the MRI, or that the radiologist interpreting the MRI could have made an error.

Scene:

In neuropsychology case conference, several neuropsychologists disagree about the meaning of the results of neuropsychological testing. I am bored and a bit irritated with the meeting. I want to rush ahead and ask what the neuroimaging said. It is as if I feel that they have the answer to their question in front of them, but are playing a game in which they debate to see who ends up with the right answer! Eventually, they do turn to the neuroimaging. I am relieved, for I want the answer!

Explorations:

I – along with others on the unit – treat neuroimaging as an unquestionable truth. I permit it to reshape information found from neuropsychological testing, and I use it to determine whether or not patients are providing accurate information. Indeed, I devalue

179

the way of knowing of the neuropsychologist and defer to neuroimaging. In the role of

the training neuropsychologist, this only seems to make sense.   I hold to the notion that

neuroimaging provides me with a "real" truth, a truth that can see through the human

error of testing and the ability of patients to compensate for deficits[57]. Memories of my

experiences as a patient with neuroimaging managed to break through this fantasy and

shock me out of my love affair with neuroimaging.

The Patient's View of Neuro-imaging:

In the midst of my admiration for neuroimaging, it did not occur to me to ask

patients what sense they made of neuroimaging. Indeed, my admiration of neuroimaging

prevented such questions from occurring to me! It is my role as patient that douses me

with skepticism and anxiety. I think of my own family, and the vague understanding that

– as one clinician bluntly put it – "the back of [our] heads are out of whack." There is

certainly a kind of certainty that comes from neuroimaging – the knowledge that the

problems that we have are not imaginary or the result of something that could be

controlled by willpower alone. But even though it offers assurance by visibly providing

evidence, this supposed certainty is also frightening. It seems that this "certainty" wipes

out any of my attempts to compensate for whatever it is that is happening in my brain. I

feel caught by it. I feel that a brain scan can set "me" off to the side and look at my brain

without me. That feels frightening and violating. I have the sense that a scan could tattle

on the inner workings of my brain. The fear of "being caught", featured in Chapter 2, is

prominent here, and I worry that I can no longer "pass." Indeed, neuroimaging is

---

[57] Of course, I am critical of this statement! As I will further explore, the statement involves a particular – indeed, peculiar – understanding of deficit. It is one in which deficit exists apart from a patient's daily reality, and lived strengths and weaknesses. It is, rather, a deficit that exists in the brain itself.

sometimes portrayed as bypassing human censorship and compensation to get at "the real truth." The "truth" provided by neuroimaging feels immutable. When I had my own MRI, I found that I was able to reduce this anxiety by allowing my professional role to mingle with my patient role[58]. My subjectivity could only re-emerge by shifting roles. I could only come to be again by becoming the one who evaluated myself.

I fear neuroimaging (neuroimagining) because it has no space for me. The ecological validity of much of neuropsychological testing – the degree to which the testing approximates the demands and resources of a patient's everyday life – is debatable. In my patient role, I worry about neuorimaging's imposition of a particular kind of truth. I fear this kind of truth even as I question its importance. Does it truly matter what shows up on a brain scan if I am able to live the way I would like?

Explorations:

I realize that my patient role grants neuroimaging just as much power as the neuropsychologist grants it. It is simply a different interpretation of this power – one that is full of fear, not adoration. It is only when I am back in this role that I think to question the function and purpose of neuroimaging. It is interesting that, in the role of neuropsychologist, I feel a sexualized charge to neuroimaging while in the role of patient, I feel a sense of control, violation, and betrayal.

Questioning Neuroimaging:

Once my experiences as a patient permitted me to reconsider the seemingly limitless promises of neuroimaging, it became possible for me to reflect on the promises

---

[58] See Chapter One.

made by neuroimaging. I became able to examine the philosophical assumptions underlying neuroimaging. I realized that the decision to look at images of the brain is one that is philosophically loaded.

Although neuroimaging is largely exalted in contemporary Western medicine, there are those within and outside the field of neuroimaging who are skeptical of the promises of neuroimaging. These critiques can be roughly divided into three categories: the epistemological (Are the philosophical assumptions underlying neuorimaging sound?), the empirical (Are the interpretations of the data of neuroimaging empirically sound?), and the ethical (When and how is it ethical to make use of neuroimaging?). Of course, it is somewhat false to distinguish these critiques. Epistemological sloppiness can lead to interpretations of neuroimaging data that are not empirically sound which in turn creates ethical problems for those who struggle to apply it despite its imperfections. (For example, Illes and Racine, 2005, critique neuroimaging via empirical and ethical grounds.) Nonetheless, distinguishing between these categories of criticism is useful for the purposes of this discussion.

Epistemological Critiques:

I begin with the epistemological critique of neuroimaging as it challenges the very philosophical assumptions inherent in imaging the brain, providing the broadest strokes of critique. This critique deconstructs neuroimaging, questioning the philosophical assumptions inherent in the decision to image the brain. Indeed, this critique challenges the seeming belief of many neuroimaging researchers that the only logical place to look for answers to complex questions regarding selfhood is in the brain.

182

The belief that images of the brain offers important information regarding the human condition in addition to basic diagnostic questions, rests upon many assumptions about the brain, the self, and the interaction between the brain and self. Neuroimaging rests upon a materialist understanding of humanity: "Since the mid- 1980s, brain mapping research has rekindled and reconfigured a materialist approach to the understanding of mental function and dysfunction (Beaulieu, 2002, p. 54). Much of neuroimaging emerges from the belief that the mind is the brain, and thus that an examination of the brain is the examination of the mind[59]: "New to neuroethics will be the need to tackle responsibly—with the inevitable and omnipresent working hypothesis (or the "astonishing hypothesis" to quote Crick, 1997) — that the mind is the brain" (Illes & Racine, 2005, p. 12). It is this belief that transforms the images of the brain into something meaningful. "Acceptance of the notion of biological determinism—in this case, that brain activity determines who you are and how you will behave—is highly controversial" (Eaton & Illes, 2007, p. 394). (Eaton and Illes are pointing to a philosophical controversy, not a controversy that is necessarily found within the field of neuroimaging.) Depending on the philosophical and culturally situated conception of self, neuroimaging – images of the brain – may or may not provide answers to questions of self-hood. For example, Tingley (2006) questions neuroimaging's ability to provide useful information for political science:

> Beyond the complexity of studying politics this way is the equally important
> question of whether or not information on how, or why, the brain operates in this
> or that way is helpful in explaining behaviors that are of interest to political
> scientists. Observing a pattern of brain activity ''x'' alongside behavior ''z'' does

---

[59] Certain kinds of diagnostic imaging are an exception to this general rule.

not necessarily give us a better understanding of why ''z'' happened, or why

departures from ''z'' happened, in the context of the political questions we are

interested in. (Tingley, 2006, p. 5)

In other words, Tingley argues that neuroinmaging can provide information correlated to

certain behavior, but that this is not necessarily useful for those seeking to understand

human behavior in an applied context. Sohrabi and Brook (2005) use this argument in

their comparisons of neuroimaging to phrenology:

The localization approach in neuroimaging is an attempt to find where a cognitive

function is located in a specific area of the brain, which seems to be similar to an

old effort, called phrenology, to relate the skull bumps to specific mental

faculties. Using neuroimaging just to find "where" a function occurs doesn't tell

us much about "what" that function is and "how" it happens. (Sohrabi and Brook,

p. 2244)

It is not disputed that a particular phenomenon is occurring in the brain and is captured

via neuroimaging, but rather that the meaning of that phenomenon captured via imaging

is not inherent in the image. The image itself does not provide an explanation for the

correlation. It is possible that it is a thought process, behavior, or emotion that causes

activation in the brain, rather than the reverse. Similarly, it is possible that cultural forces

constructing identity encourage particular categories of people to think and behave in

certain ways, thus causing neurological differences.

However, a framework in which neuroimaging provides truth rarely

acknowledges its contingency[60]. Rather than acknowledging that there are philosophical

---

[60] I say "rarely" as those considered in this section (Eaton & Illes (2007), Fins (2005), Illes & Racine
(2005) Sohrabi & Brookes (2005), etc.) do reflect on the assumptions underlying neuroimaging. For

assumptions behind the decision to use neuroimaging, what kinds of questions are asked

when looking in the brain, and the way that the images are rendered meaningful via

interpretation, some neuroscientists using neuroimaging believe that neuroimaging

eliminates problems of interpretation and definitively answer philosophical and

theological questions: "Neuroscience may provide answers to some of the 'oldest

philosophical questions, shedding light, for example, on existence limits, and meaning of

free will" (Greely, 2002, p. 7). Indeed, some neuroimaging researchers have gone so far

as to argue that they have defeated the concept of a soul:

> The idea that there is somehow more to a person than their physical instantiation
>
> runs deep in the human psyche and is a central element in virtually all the world's
>
> religions. Neuroscience has begun to challenge this view, by showing that not
>
> only perception and motor control, but also character, consciousness and sense of
>
> spirituality may all be features of the machine. If they are, then why think there's
>
> a ghost in there at all? (Farah, 2005, p. 39)

Neuroscience may believe that it has found grounds with which to challenge the

existence of a soul, but it only does so if one follows the assumptions behind

neuroimaging – namely that what happens in the brain is caused by biology alone (or

biology interacting with environment.) Furthermore, as will be explored in the next

section, this attitude assumes not only that neuroimaging is a valid means of exploring

---

example, Fusar-Polia & Broome (2006) explicitly reflect on the path that cognitive science took towards neuroimaging, including the philosophical path taken:
Cognitive science had some guiding tenets initially that include a focus on information processing, a lack of interest in affective and noncomputational thought, and agnosticism regarding the material that instantiates thought (traditionally cognitive scientists are linked with the philosophical position of functionalism: mental states are multiply realizable and are identified in terms of causal or functional role in mediating between sensations and behaviour). Second, the powerful early influences on the development of cognitive science, namely artificial intelligence and linguistics, have somewhat declined to be replaced by the increasing relevance of neuroscience (p. 610).

questions of free will and the existence of a soul, but that the interpretations of

neuroimaging are unquestionable due to their scientific nature. Indeed, whereas some

consider the pursuit of knowledge about human nature and the mind praiseworthy, others

can consider the intimacy of the human mind to be outside the province of science (Illes

and Bird, 2006). The validity of the interpretation of neuroimaging – the sense that is

made of neuroimaging – is the topic of the next segment of the critiques on

neuroimaging.

Empirical Critiques:

The empirical critique of neuroimaging challenges neuroimaging's ability to

deliver what it has promised, questioning the empirical validity of the interpretation of

neuorimaging. The epistemological critique has made it clear that neuroscience

constructs a self whose mysteries can be unlocked via images of the brain. Yet, the

images in themselves, however mysterious and inviting, do not provide answers. The

images must be interpreted to be of use, and this interpretation may be controversial.

And yet, according to a study by Beaulieu (2002) in which neuroscientists using

neuroimaging were questioned regarding their understanding of the function and purpose

of neuroimaging, neuroimaging researchers do not emphasize the images themselves, but

the data derived from the images that is central to understanding: "To see a picture as

transparent, as the activity in the brain, is not an appropriate way of seeing;

measurements must be understood in terms of their quantitative production, not simply in

terms of the phenomena they represent" (Beaulieu, 2002, p. 50)**.** Thus, it is the

interpretation that is seen as central to understanding. Yet, interpretation is no easy task:

"Further, these trends bring to the foreground what would appear to be a strict epistemological challenge at the core of neuroethics—proper interpretation of neuroimaging data" (Illes and Racine, 2005, p. 6). Yet, the psychological, cognitive and behavioral implications are not necessarily clear. Take, for example, the knowledge that a particular area of the brain corresponds to lying, and that it activates when asked a particular question:

> Even if a scan could accurately determine that a person is actually lying, providing the answer to the inevitable 'what' question (i.e. what is the person lying about) will be far more elusive. In this case, usefulness is limited, at best. At worst, the risk of false positives is enormous, because even a low false-positive rate could have important consequences for an individual accused of criminal intent. (Illes and Bird, 2006, p. 515.)

Even these measurements must be interpreted and translated into something that is meaningful, and the criteria for doing so may be unclear. As neurotechnologies are increasingly applied in diagnosing and treating disease, disagreements may arise concerning definitions of brain health, and acceptable thresholds and ranges of human motor and cognitive behavior. "For example, imaging that can detect increasingly small differences in cognitive processing can lead to disputes about whether these variations are within the normal human range or are hallmarks of mental disease" (Eaton and Illes, 2007, p. 394). Even the so-called simple task of diagnosis can be difficult in relation to neuroimaging:

> Although some structural changes (e.g., discrete tumors or lesions) can be

unambiguously identified, other structural abnormalities can be much more subtle. In such cases, one would like to compare a scan image from the individual in question with a normative template. This can be difficult for three reasons. First of all, there are few templates of ''normal'' brains against which one could compare an individual sample. Second, it is unclear which brain measure should be used as a normative standard. Should it be size? If so, should one use overall volume or rather specific measures of certain brain regions or nuclei? Should it be the ratio of white matter to grey matter? Neurons to glia? Or should it be the size of the ventricles? There may be no single measure that can serve as a gold standard. Third, the decision whether a given sample is ''normal'' or ''pathological'' is statistical, not absolute. This is because a normative template would consist of the average multiple brains, so that any given brain structure is an averaged representation whose shape will vary along a normal distribution in each dimension. To compare a test sample against the normative template means to determine whether its measures are significantly different from the normal distribution. This leads to the fourth and final point. The decision whether a given brain structure falls within the normative range will likely vary from one brain structure to another, so that any given brain may qualify as ''normal'' by one measure but not another. (Canli and Amin, 2002, p. 424).

Simply put, interpreting the images produced by neuroimaging technology is no simple task. In other words, neuroimaging may be able to show that a particular brain part is large, small, active, or inactive, but it does not tell us how or why that part of the brain is doing what it is doing. "These [PET] images travel easily and are easily made

meaningful. Because they are such fluid signifiers, they can serve different agendas and different meanings simultaneously" (Dumit, 2003, p. 4).

> With the increase in knowledge and ability to do functional imaging, the potential for misconstruing association and causation is heightened further. Functional imaging allows for the visualization of metabolic changes that occur in the brain simultaneously with the production of behavioral tasks. Because the imaged change occurs with the behavioral change, it is assumed that the two are associated. (Hinton, 2002, p. 464)

In addition to the practical barriers to determining whether or not a particular brain falls within the category of 'normal,' Eaton and Illes (2007) note that it is extremely difficult to gather a normative database for these purposes: "Another central question focuses on the point at which a brain database is sufficiently large, representative, and both medically and culturally sound to deliver valid assessments of individual cognitive function" (Eaton, and Illes, 2007, p. 395). These difficulties are exacerbated in pediatric neuroimaging, when the interpreter must be able to account for developmental differences and changes:

> Interpretation of an individual's neuroimaging data relies on availability and understanding of good normative data, as well as thoughtful evaluation of the individual's specific behavior and clinical concerns. To interpret scans of children, knowledge of normal development—and its ever changing presentation—is crucial. (Hinton, 2002, p. 459)

Interpretation of neuroimaging, even for the relatively simple task of diagnosis, is no easy task. Functional imaging only heightens the difficulties of interpretation. It is difficult to

interpret neuroimaging, and different researchers may interpret the same data differently. It is these interpretations that are presented as the completed research, and they tend to be viewed as scientifically true, and "above" interpretation.

Not only must data be interpreted, it is interpreted through a particular cultural lens, shaping both what is looked for and the sense that is made of what is found:

> Interpretation of neuroimaging studies are not only bound by scientific frameworks, but also cultural and anthropological ones. Consider concepts such as "moral emotions" that are based on assumptions that some emotions are moral and others not. They illustrate the cultural aspect of the interpretation challenge, which is based on the fact that the self is defined in diverse ways. (Illes and Racine, 2005, p. 13)

The sense that is made of these images is culturally bound, relating deeply to culturally situated values and understanding of the self:

> However, with new and still-evolving insights into our neurobiology and previously unquantifiable features of profoundly personal behaviors such as social attitude, value and moral agency, the difficulty of carefully and properly interpreting the relationship between brain findings and our own self-concept is unprecedented. (Illes and Racine, 2005, p. 5)

Fine (2008) explores the problems of this in her critique of books such as Brizandine's (2006) "The Female Brain," in which the difficulties faced by working mothers are blamed on neural connections particular to the female brain (Fine, 2008). Fine argues that this is reminiscent of now-scoffed at beliefs regarding the brain and gender:

Nineteenth century medical opinion proposed that girls who overtax their brains

might never reproduce. Twenty-first century neurosexism warns that women who

reproduce risk overtaxing their brains. It is, perhaps, a little less progress than

many working mothers would have hoped for. (p. 71)

Thus, this technology is being interpreted in such a way that it is in concordance with the

values of patriarchy. Interpretation renders data meaningful, and inherently involves

values.

What I term the empirical critique of neuroimaging questions the answers that

neuroimaging supposedly offers. The basis for this critique rests on the assertion by

neuroimaging that it is unbiased and provides objective information regarding the brain.

The empirical critique questions that the knowledge presented by neuroimaging is not

necessarily true.

Ethical Critiques:

A final category of critique of neuroimaging focuses on whether we *should* make

use of neuroimaging, and if so, under what circumstances and with which safeguards.

Those concerned with the ethics of neuroimaging raise concerns regarding the myriad

aspects of life that are changed, or potentially changed, by neuroimaging. The ethical

dilemmas sparked by neuroimaging cover large areas of territory both in terms of the

terrain (from the hospital bed to the courtroom) and the nature of the ethical concern

itself.

From a twenty-first century partnership between bioethics and neuroscience, the

modern field of neuroethics is emerging, and technologies enabling functional

neuroimaging with unprecedented sensitivity have brought new ethical, social and

legal issues to the forefront. Some issues, akin to those surrounding modern

genetics, raise critical questions regarding prediction of disease, privacy and

identity. However, with new and still-evolving insights into our neurobiology and

previously unquantifiable features of profoundly personal behaviors such as social

attitude, value and moral agency, the difficulty of carefully and properly

interpreting the relationship between brain findings and our own self-concept is

unprecedented. (Illes and Racine, 2005, p. 5)

The epistemological and empirical critiques can precipitate an ethical crisis when one

considers the myriad of areas over which neuroimaging increasingly holds domain.

This trend conceivably introduces possibilities—or at least desires—for

using brain maps to assess the truthfulness of statements and memory in law,

profiling prospective employees for professional and interpersonal skills,

evaluating students for learning potential in the classroom, selecting investment

managers to handle our financial portfolios, and even choosing lifetime partners

based on compatible brain profiles for personality, interests and desires. (Illes and

Racine, 2005, p. 6)

Recalling that neuroimaging is reliant on sometimes controversial interpretation and

questionable philosophical assumptions, one must consider the power that neuroimaging

has over our lives.

Empirical concerns aside, neuroprivacy becomes pressing in the face of

neuroimaging. "Nonetheless, we are warned about the perils of neural privacy" (Fins,

2005, p. 57). There are privacy issues that are unique to neuroimaging, due to

neuroimaging's belief that it can read thoughts and predict future behavior. Furthermore,

192

there are concerns that scans will not be used for their intended purposes. "Should diagnostic imaging become reliable, the possibility of inferring current or prior psychiatric illness from images taken for other purposes will also become a concern" (Farah and Volpe, 2004, p. 37). Privacy cannot be assured, despite attempts at protection of data. In addition, those completing assessments may discover information that they did not intend to find, thus inadvertently violating privacy.

> Even with the most sophisticated protections in place, repeated access to online databases for monitoring therapeutic progress will strain mechanisms for information privacy. It is unlikely that all testing will yield only intended information or information that is only about the medical parameter in question. Information that a person would prefer to keep private—personality traits, emotions, memories and sexual preference— may be gleaned from an assessment. This capacity invites misuse of information. Unauthorized disclosure can be especially injurious if socially problematic thinking can be detected in patients who have been able to control their associated behavior. The fact that cocaine craving, for instance, can be detected in brain scans is one illustration of this possibility. (Eaton and Illes, 2007, p. 395)

Perhaps the biggest ethical critique of neuroimaging is the empirical one: if neuroimaging does not do what it has promised, and it is believed to provide information about the health, psychology, thoughts, and future behaviors of people, an ethical tragedy has taken place.

Given the limitations of neuroimaging, and its continued need for ecological information regarding patients' functioning for interpretation, the degree to which

neuropsychology has submitted to the power of neuroimaging becomes even more mysterious. Neuroimaging, while a useful tool in the right context, is fallible and represents particular cultural and philosophical assumptions. Like all other interpreted data, interpretation involves subjective meaning-making. The fantasy of neuroimaging offers a certainty regarding questions of selfhood that it seems to be unable to supply. Thus, it seems that neuropsychology's bowing to neuroimaging is a defensive maneuver and collusion with omnipotent fantasies.

Impact of the Obsession:

I have already alluded to the many implications of the obsession with sight and thus neuroimaging that I encountered in my role as training neuropsychologist. I turn now to more explicitly explore the question of the impact of this obsession. I ask myself who benefits from this arrangement and who is harmed. Asking this question helps to illuminate the power structure propelling the dynamic.

Rendering neuropsychology obsolete:

This obsession with sight and thus neuroimaging leads neuropsychology to work to render itself obsolete. Many of my questions regarding the function of neuropsychology[61] simply would not have been pertinent prior to the advent of neuroimaging. Something has happened alongside the birth of neuroimaging that has caused neuropsychology to strain to see something that it cannot. In doing so, it values

---

[61] See Chapter 1. It is not that these questions would be entirely resolved, as I still critique the performance of neuropsychology and the impact of that performance on patients. Neuroimaging seems to have upped the ante on the dynamics already present in neuropsychology. I believe that the possibility of new performances would emerge more easily should neuropsychology not be turning on itself.

the knowledge of the medical gaze that is provided by the technology of neuroimaging alone, essentially arguing that the kind of knowledge that it produces is not of much value compared to that of neuroscience.

Advancing Capitalism:

I ask myself who benefits from this emphasis on neuroimaging and sight.   What force is here that is so strong that it can compel a profession to turn against itself and promote another above it? Capitalism is certainly at least part of the answer. The equipment for the neuroimaging technology is expensive, and the procedures themselves cost much more than a neuropsychological evaluation. The process itself requires expensive, highly skilled labor. The technology is, frankly, impressive. Patients most certainly feel that they are getting a bang for their buck – the machines are impressive! Insurance companies are persuaded to put out the big bucks, and the more mystique is added to the Neuroimaging as so obviously a "scientific" project that it is not difficult to justify the expense of treatment. Overall, neuroimaging fits into a capitalist system better than neuropsychology does. Yet, so far, I have made a case for the success of neuroimaging, not for neuropsychology's worshipful response!

Silencing Patients:

Patients are further obliterated by nueorimaging. During an MRI, for example, patients are to lie very still in a large tube. It seems that this is part of the allure – the "messiness" of dealing with the complexity of patient is supposedly bypassed by the utter objectivity of neuroimaging. The factors that can influence a patient's performance on

neuropsychological testing – whether or not the person is well-rested, hungry, or intoxicated – theoretically do not influence the results. I see neuropsychology's overemphasis on neuroimaging as another way to hide patients. It is a way of diagnosing that does not involve the patient's experience at all, and it leads to a kind of treatment that continues to repress the subjectivity of patients. Patients are eliminated as they are seen as less real than the scans of their brains.

Baudrillard:

Baudrillard's (1995) hyperreality deepened my understanding of the advent of neuroimaging and neuropsychology's peculiar response to it. Grounded in the post-structural tradition – perhaps, rather, *un*grounded in the post-structural tradition – Baudrillard's concept of hyperreality offers one possible explanation for the love affair with neuroimaging that I participated in on the unit. Baudrillard's *Simulacra and Simulation* examines the relationship between image and so-called reality, and thus offers a way of understanding this seemingly senseless maneuver of neuropsychology to render itself obsolete through its worship of neuroimaging. This understanding of neuroimaging and neuropsychology places the relationship between the two in the context of society's relationship to reality, faith, and truth.

Introducing the hyperreal:

To begin this discussion, I must introduce Baudrillard's (1995) concept of the hyperreal, which he argues in *Simulacra and simulation* has replaced the real. For Baudrillard, what appears as real is not real. It is, rather, a model that does not have

196

either origin or reality. It is this that Baudrillard terms the hyperreal. Baudrillard believes that something else has replaced the real. The hyperreal is abstraction far greater than the map or the mirror. The hyperreal refers to nothing. Unlike a map which relies on the preexistence of the territory being mapped, the hyperreal cannot point to its referent. The hyperreal is a model of the real with no referent.

> Today abstraction is no longer that of the map, the double, the mirror, or the concept. Simulation is no longer that of a territory a referential being or a substance. It is the generation by models of a real without origin or reality: a hyperreal. The territory no longer precedes the map, nor does it survive it. It is nevertheless the map the precedes the territory – *the precession of simulacra* – that engenders the territory and if one must return to the fable, today it is the territory whose shreds slowly rot across the extent of the map. (Baudrillard, 1995, p. 1)

Baudrillard sets out to understand how the hyperreal is 'created' and its relationship to 'reality'.

Central to Baudrillard's (1995) understanding of hyperreality is the differentiation between pretending (or dissimulation) and simulation. Pretending is false whereas simulation is not real nor is it false. Baudrillard draws upon the example of sickness: the pretender stays in bed merely pretending to be ill, whereas the simulator produces actual symptoms of the illness, creating a different problem of truth (p. 3). The pretender is not ill. The simulator is neither ill, nor well. Pretending is simply false, a kind of subterfuge, a masquerade. Simulation, on the contrary, shakes up the very notion of real versus false. "Therefore, pretending, or dissimulating leaves the principle of reality intact: the

difference is always clear, it is simply masked, whereas simulation threatens the difference between the "true" and the "false," the "real" and the imaginary" (p. 3). Simulation blurs the distinction between the real and the imaginary, shattering the notion of truth itself. This is the hyperreal, abandoning rationality and meaning. The hyperreal is simply operational. It is not really the real anymore.

> It no longer needs to be rational because it no longer measures itself against either an ideal or negative instance. It is no longer anything but operational. In fact, it is no longer really the real, because no imaginary envelops it anymore. It is a hyperreal produced from a radiating synthesis of combinatory models in a hyperspace without atmosphere. (p. 2)

The hyperreal, as merely operational, does not refer back to anything. There is no truth to which it refers. The hyperreal does not emerge suddenly; the real does not simply turn into simulacra. Rather, it undergoes a process of transformation described by Baudrillard as such:

> Such would be the successive phases of the image:
>
> it is the reflection of a profound reality;
>
> it masks and denatures a profound reality;
>
> it masks the *absence* of a profound reality;
>
> it has no relation to any reality whatsoever: it is its own pure simulacrum. (p. 6)

Baudrillard goes on to unpack these descriptions, describing each stage qualitatively, noting the distinguishable features of each one. The first stage is of a "sacramental order," and is a *"good* appearance" (p. 6). In this first stage, the image represents the 'reality'. This first stage of transformation is reminiscent of the mirror or a map – the

image refers back to a concrete object. The second stage is marked by "maleficence" and is an "evil appearance" (p. 6). Rather than imitating a profound reality it conceals and masks that reality. The third is "sorcery" as it "plays at being an appearance" (p. 6). This stage hides the absence of a reality, it exists in order to pretend to point to something that does not exist. Finally, simulation arrives. It is no longer appearance, but pure simulation (p. 6). This pure simulation is the subject of my investigation. It refers to nothing and is neither true nor false, becoming seen as more real than reality itself. . The hyperreal, then, is an image that does not refer to reality. It refers back to nothing. It confuses concepts of reality itself, landing as it does in a space between real and false. The hyperreal is an image of nothing that simulates reality. The hyperreal has a different relationship to reality than has been seen before. The hyperreal is simulation.

The Function of the Hyperreal:

I look now to explore the function of the hyperreal. In other words, I explore Baudrillard's (1995) explanation for the existence of the hyperreal. (Of course, it is rather absurd to say that the hyperreal 'exists' when it is precisely its status as existing – and existing as what – that is questioned.) I ask: 'What is the purpose of the hyperreal? How does it operate'?

The answer is both simple and profound. The hyperreal functions to hide that it does not signify anything. In other words, the hyperreal exists in order to maintain the illusion that everything else – all that is *not* hyperreal – is real. Baudrillard calls upon Disneyland as the ultimate example of this facet of hyperreality:

Disneyland exists to hide that it is the "real" country, all of "real" America that *is*

Disneyland (a bit like prisons are there to hide that it is the social in its entirety, in

its banal omnipresence, that is carceral). (p. 12)

Thus, Disneyland is not about, as it pretends, a break from the 'reality' of the rest of

society, but it rather functions as a means of maintaining the illusion that the rest of

society is *not* like Disneyland! Disneyland poses as fiction in order to cover over the lack

of reality of the rest of society. Disneyland, for Baudrillard, is "neither true nor false, it is

a deterrence machine set up to rejuvenate the fiction of the real in the opposite camp" (p.

13). Thus, hyperreality exists as a means of supporting the myth of reality; it covers over

a void in meaning. The hyperreal permits the myth of reality to persist. The hyperreal

thus covers over a void of reality and of meaning.

Indeed, the void that the hyperreal covers over is a profound one, extending all

the way to the divine.   If simulation covers up a void of reality, of meaning, the

implications are immense if God can be simulated. The hyperreal can eliminate God.

"But what if God himself can be simulated, that is to say can be reduced to the signs that

constitute faith?" (p. 5). If this is true, then simulation reveals that there is no God, only

the signs and images of God. As Baudrillard notes, it is precisely this fear that motivated

the Iconoclast's fears of the use of images of God. The Iconoclasts understood the

danger of simulacra, the way that simulation can efface God.

This is precisely because they predicted this omnipotence of simulacra, the faculty

simulacra have of effacing God from the conscience of man, and the destructive,

annihilating truth that they allow to appear -- that deep down God never existed,

that only the simulacrum ever existed, even that God himself was never anything

but his own simulacrum -- from this came their urge to destroy the images (p.4)

Hyperreality is dangerous, as it exposes a lack of meaning, and prevents meaning from

returning. Thus, it is vital that hyperreality work properly, that Disneyland successfully

maintain the myth that the rest of society is real, that icons function successfully as God.

If hyperreality is questioned, the vast array of beliefs – false beliefs – upon which society

is dependent, crumble. Reality and truth itself crumble.

For Baudrillard (1995), reality has been replaced by the hyperreal which is neither

real nor false, but which conceals that the rest of so-called reality is not real either. The

hyperreal functions in order to protect society from losing a deep sense of meaning. The

hyperreal prevents truth from crumbling.

Neuroimaging as hyperreal*:*

It strikes me that neuroimaging is simulacra; it is hyperreal. Before unpacking the

implications of neuroimaging as hyperreal, it is useful to start from the beginning and

trace the transformation of images culminating in the hyperreal as it pertains to

neuroimaging.   In this scenario, the self is the 'profound reality' in question. It is the

"self" to which the related images (supposedly) refer. Experience is the first level of the

transformation; it is our experience that makes us believe that we have a profoundly real

self. It is the reflection of the profound reality of self-hood. The self is seen as sacred.

Represented in image, the self may appear as a photograph of the person. This

photograph represents the person as a whole, the self of that person. Neuropsychology

emerges as the second stage of image.   Neuropsychology masks and denatures a

profound reality of self-hood, insofar as neuropsychology begins to be mistaken for the self. It is profane. The image of neuropsychology is that of the structural summary – connected, supposedly, to the self, but no longer accounting for profound subjectivity. Neuropsychology violates the self by trying to look *through* it. Structural imaging, the third phase, masks the absence of a profound reality by its turn towards the brain as the self. Finally, neuroimaging emerges as simulacra. Neuroimaging has become more real than the brain, and more real than the self. It refers to nothing, and exists to hide the emptiness of what came before.

Implications of Hyperreal Neuroimaging: Maintaining Belief in a Self.

The implications of neuorimaging as the hyperreal are immense, challenging, as it does, the existence of an essential self. In this formulation, neuroimaging functions to maintain the myth of the self. If one believes that neuroimaging is simulacra, it follows that the self – an essentialized, singular self – is nothing more than myth. Neuroimaging is a map which refers back to nothing, keeping us from realizing that there is nothing towards which to refer! Thus, neuroimaging functions to maintain the myth of an essential self.

The simulacra of neuroimaging pretends to offer truth. Neuroimaging has made claims previously reserved for a god, promising that sufficient faith will lead to revelations of ultimate, unchanging, unquestionable truth regarding the self. Human nature will be revealed through brain scans, and the future – behaviors, thoughts, emotions, and diseases -- can be predicted through proper interpretation of these scans. This is, arguably, the Church of Neuroimaging. And here emerges neuropsychology's

complicity. Neuropsychology must be complicit, or the entire church (of which

neuropsychology is a part!) crumbles.   The self cannot be found; the self is nothing more

than the image of neuroimaging. It is not only the neuroscientific project that requires

neuropsychology's complicity in maintaining the illusions of simulacra. As Shweder

(1991) notes, the broader psychological project is similarly complicit, having long

(attempted to) fashion itself in the image of positive rationalism, and thus also searching

for a fundamental, essentialised self. According to Shweder, psychology itself is wedded

to a kind of pseudoempiricism and pseudodeductionism that limits psychology to a search

for fundamental truths. Thus, the psychological aspect of the definition is similarly

bound to simulacra as part of its very survival.

Chapter Reflections:

In my role as training neuropsychologist, I became obsessed with, addicted to,

and enamored with the promise of sight. I find myself lusting for the image of the brain,

and turning to neuroimaging for the promise of gratification. Lurking within the promise

of neuroimaging is a promise of certainty and an indisputable knowledge free from

human error. This dream is a façade, and it provides nothing more than a particular kind

of knowledge, one that has limitations in the illumination that it can provide. I found that

my relationship with neuroimaging further divorced me from patients and from myself in

the role of patient. I found that, the more I invested in neuroimaging, the less I even

noticed that I was silencing my patients.

Neuroimaging has become hyperreal. It is treated as the "real" truth, treated with

the illusion that the images it produces illuminates a self that does not exist. Images of

the brain, as well as neuroimaging, have become iconic. The neurobehavioral unit itself became a sort of shrine. I found myself treating these images with reverence mixed with awe and occasional skepticism. I believed the promises of neuroimaging (despite skepticism) and felt tantalized by the promise of finally seeing what neuroimaging had to offer. Yet, I never understood precisely what it was that neuroimaging promised to show. It seems that, in fact, these images showed nothing.

There is a way that this chapter offers hope for neuropsychology. Neuropsychology is promoting its competition and continually reducing its own role, potentially in the service of maintaining an essentialized self. Perhaps another performance of neuropsychology could redeem the profession, refocusing its efforts on the unique strengths of neuropsychology, and acknowledging the construction of selves. The following chapter will begin to explore what a new performance of neuropsychology might look like.

Chapter Seven: Towards a different performance

By the end of my nine month long rotation on the neurobehavioral unit, I had begun to form a critical sense and understanding of the ways I was called, pressured, and positioned to a certain performance of neuropsychology. It is abundantly clear that this calling, or calling forth, was challenging and riddled with conflict, such that I also began to struggle with the possibility of – if not the creation of - a new performance, another way to be, do, and be done by neuropsychology, so to speak. I felt that my performance of neuropsychology trainee was harmful to my patients, and that it harmed my self-as-patient. I was sick of the tensions within my body that I discuss in chapter two, and I felt that I was letting my patients down.   I struggled with my performance of training neuropsychologist and tried to find a new, more liberatory performance. The disability rights movement provided me with much information and inspiration, freeing me to see new possibilities. This chapter describes some of these attempts at an alternative, or another (an other) kind of performance, at the performance of something different, after which it moves to my fantasized ideal performance of neuropsychology. I do not see even my supposedly idealized performance as a perfect one, nor do I see my fantasized performance as one that escapes all of the dynamics of oppression or ethical dilemmas presented in this dissertation. Indeed, I remain trapped by the constrictions of my various roles, and the second part of the chapter will explore the limitations of my attempts to integrate my various roles. The constructed self that is writing this dissertation is comprised of the selves presented in this project, and is bound by the same limitations. It is only in turning to the disability rights movement and observing the interactions of my selves in relation to neuropsychology that can begin to permit me to imagine a new

205

performance. The queering of a performance is always initially awkward, and I see my

attempts as valuable despite their obvious imperfections. In the third segment of this

chapter, I take on the role of director, choreographing a new – albeit still imperfect –

performance.

Attempting A Different Dance:

As much as I had tried to perform a neuropsychologist-in-training differently, I

discovered that I was only very rarely able to break free from the habitual, the normative,

or the expected performances. For the most part, I felt that my attempts to queer the

performance of neuropsychology were awkward and unseemly, taking on the quality

more of momentarily breaking character rather than shifting the interpretation of a

character. I turn in this section to describe the sole time that I felt able to sustain a

different performance of the neuropsychology trainee, which occurred in my work in

cognitive rehabilitation. I tell a story in which, despite some real strides towards

liberation, I became frightened of my new performance and was unable to sustain it, very

likely hurting the patient along the way.   This tale highlights the range of performances

possible for the neuropsychologist whilst also emphasizing the resistance that can emerge

in the context of a new performance.

Preparing to Dance:

Near the end of my nine-month long rotation on the neurobehavioral unit, I have

been assigned to do memory therapy[62] (also called cognitive rehabilitation) with a man in

---

[62] This means that I have been asked to teach him skills that will help him to "compensate" for the changes
in his memory resulting from this traumatic brain injury.

his thirties who has traumatic brain injury (TBI) and fairly severe post-traumatic stress disorder related to the circumstances leading to the TBI. I am being supervised by a different neuropsychologist for this case, and she has provided me with books and packets from which to select lessons and exercises. She has me photocopy standardized worksheets and homework assignments to give him. Before I have even met this patient, I have selected a brief curriculum targeted towards the client's specific memory "deficits" as dictated by his neuropsychological assessment.

Despite the high level of structure provided by my supervisor for this case, I am primed to try a different performance. I am approaching the end of my rotation and am less fearful of supervisory responses to my performance of the role of neuropsychologist. Unlike much of my assessment work, cognitive rehabilitation offers me a chance to meet with the same patient several times. And, even though I am to follow a curriculum, I am not expected to write a report, and thus have a bit more freedom in terms of my work. There is no report with standardized testing to report on what the patient and I 'accomplished'. With all this in mind, I set out to perform a bit differently. I turn now to describe the dance that occurred when I attempted to perform differently. I term this a 'dance' for several reasons. I imagine it as a sort of tango, in which the interactions between the patient and myself constituted the performance. My habitual performance on the unit felt more like a play in which I was the lead, and my patient a supporting character. Further, it is a different kind of dance, as I 'dance' between this new performance and the old.

The Dance:

After I invite Steve – and his distraught mother– into my office, my questions veer from my typical rapid-fire 'fact finding' to experiential questions. This is my first attempt at a different performance, and the shift is dramatic. I transition from the quantitative to the qualitative. I slow down and ask him to describe exactly what he does, and how he thinks and feels as he does it when he finds himself struggling. I am trying to pinpoint exactly where he is running into trouble with his memory. I sense the impact of my different performance in the level at which I am engaged with Steve. I feel less like I am sitting back and interacting primarily with my clipboard and more like I am leaning forward and engaging. Steve seems to be impacted by my performance as well. This small shift in performance to one in which I wrestle with the mysteries of his struggles serves as an intervention in itself – he, too, is considering what does and does not work and is beginning to glean patterns. As the end of our first session approaches, we have not cracked open the carefully established curriculum. Before he leaves, I remember my supervisor, and hand Steve some of the homework worksheets and informational packets. The stacks of paper I give him include an explanation of his type of memory difficulties, a chart for him to put in his attempts to cope, and a chart for him to put in his difficulties. These all sort of followed from our discussions as we worked, although I felt slightly embarrassed by the childish tone of the worksheets. And, because he is afraid that he will forget the contents of our meeting, he and I type up a summary of our session. I give him a few copies, and save the sheet so that I can print him more later.

Steve returns a week later for our second session of cognitive rehabilitation. He's 15 minutes late, and he's pissed off about it. Still visibly upset, he apologizes for his

tardiness and tells me that he had to smoke and calm down before he could come in, and

that he had pulled off the road to calm down on the way. I offer him another minute to

chill out, and he leans his head down into his lap for a minute, before sitting up and

saying; "Okay." Once he sits up again, I wait to see what he decides to discuss. As I

wait, he hands me the sheets where he tracked his problems. I look at them, but ask him

to talk me through them, wanting us to collaborate on his struggles. I am attempting a

more collaborative performance in which I see change as coming from our interactions

rather than simply from the information that I provide. Listening to him talk, it seems

that he has a pretty elaborate system going for himself, but somehow it's just not

working. He has calendars and planners working in a system, but he still misses

appointments if his family does not remind him. I continuously ask him to clarify what

exactly is going wrong with his attempts at adaptation. After I listen I ask questions that

are designed to clarify the exact nature of his problems. Once I feel that Steve and I have

a strong sense of where he is struggling, I begin to work with Steve to help him find

solutions. We decide that it might help for him to set his cell phone so that it rings two

hours before an appointment, an hour before, and 30 minutes before. We figure out how

to use a tape recorder to 'reinforce' what's on his wall calendar.   We talk about him

asking for pictures of particular family members so that he can remember their names.

We talk about having a central location for his belongings, notes on the front door, other

simple little tricks. This session seems to get both of us amped up. He and I are engaged

in the process of figuring out ways to make his environment work for him. This time, I

don't give him a hand out, acknowledging more explicitly that I have changed my

approach. Instead, I type up another sheet of what we came up with, and print out several copies.

When he returns a week later, he is late again, but fired up. He sits down breathlessly in my office and describes how his friends came over and helped him to develop more solutions. He shows me a bag that a friend made for him and explains the system that they devised. I'm excited that he has found a way to engage the people in his life in this project of adapting his surroundings. I am glad that this process has helped his friends to engage with him and his changes, rather than to avoid them. I am also pleased because they know his patterns, preferences, and living situation far better than I ever will, given my limited role in his life. Plus, it seems that this process is making him need me *less* rather than more. He and his friends have been empowered to address his struggles[63].

And yet, since we last met, I began to feel anxious about "neglecting" the role of neuropsychologist. Even though my work with this patient has taken a good deal of effort from me, involving an (attempted) understanding of the function of memory, his personal and family dynamics, issues of power and oppression, and a constructed disabled role, I feel like I have been slacking off. Somehow, I am duped by the structure of the neuropsychological unit. I feel like we have done some very good work together, but the "markers" of success – such as completed worksheets – are missing. I begin to

---

[63] I need to be cautious and not overly "Pollyana-ish" here. He continues to greatly suffer from the cognitive and psychological changes that he is experiencing. However, I see his work with his friends as beginning to cross the bridge of isolation that is so often a result of either disability or post-traumatic stress disorder. It is clear that his friends came up with some excellent tricks for making his environment work for him. It is also clear that he feels cared for. I wish to distinguish being "cared for" from being "taken care of." His friends are caring for him in the service of his empowerment. This form of care supports, rather than denies, his agency. Such support does not minimize the cognitive changes that he has experienced nor does it see him as the totality of those changes. I am reminded of Sinason's (1992) distinction between primary and secondary 'handicap,' arguing that many of the so-called problems of developmental and degenerative disorders stem from the beliefs and desires of non-handicapped persons.

210

devalue our excellent work, viewing it through the eyes of the neurobehavioral unit itself. Suddenly, instead of an invigorating and liberating experience for my patient I begin to feel that he and I have been wasting time just visiting. My special supervision for this case is approaching, and I let my anxiety override the needs of my patient and turn away from him towards the next step of the memory therapy curriculum: 'internal memory cues.' So I pull out the standardized, photocopied sheets, and dutifully introduce stereotyped suggestions such as: "Cluster information into smaller chunks" or "associate new information with old information." I have returned to the role of detached professional, and feel him pulling back as I leave him through my worksheets. He pushes his bag of memory tricks under his seat and dutifully listens to me. I feel guilty, and I know that I am abandoning him but I continue on. I feel intense pressure to do so, but I do not understand this intensity. He is quite patient with me, but politely notes that he learned these things back in school. He is clearly bored and tires quickly. My guilt gets in the way of pressing on, but I still insist on sticking to my agenda saying: "Look, why don't I just give you this sheet and we can review it next time?" He happily agrees.

A week later, I am sitting in my office, waiting for him to arrive. I'm just sitting around, expecting him to be late (again) but to eventually arrive. He doesn't. As I give up and pull out some testing materials to work with, it occurs to me that he has given up on me after I let him down by reverting to my typical performance of training neuropsychologist.

A few days after he missed a session, I check my voicemail and discover a message from Steve saying goodbye to me, explaining that he has felt so angry lately that he wasn't certain that it was safe for him to leave the house. He tells me that his anger

211

was meaningless, that he had just been feeling angry for a while for no particular reason[64]. I pick up the phone and call him back, leaving a message that I'd still like to see him when he felt up to it. A week later, he schedules an appointment.

Staggering into the office, he is unshaven, bleary-eyed, tearful, and pale. I step into psychology mode and listen. He talks about suicide, and I encourage him to go inpatient. He tells me that this hospital flips him out, but agrees to call another place where he had been inpatient before. I don't want to overwhelm him as he is so on edge, and feel that we should focus on support rather than the next step of the curriculum. I tell him so and he agrees. We use the brainstorming that had been helpful before to come up with activities, foods, sleep routines that wouldn't trigger his post-traumatic stress disorder. We are again allies in working to improve what might be called his "cognitive functioning". As Steve leaves, I say goodbye. I never see him again.

Critiquing the Dance:

Reflecting on my attempts at a different dance, I feel that this new performance did manage to be different –more liberatory – in some important ways. This new performance was a dance between two people. I felt as though the expertise of my training was being used to serve Steve – a service he found useful. I, too, was liberated from the tensions I so often felt on the unit, and in (parts of) my contact with Steve it did not feel impossible to be both professional and patient. And yet, this new performance was also a failure; it was one that remained trapped by the traditional performance. It

---

[64] Only in retrospect do I realize that his anger may have been connected to me, and my decision to turn away from him and what had brought him hope in the previous session. This will be explored in the next section.

was also a performance that harmed. This section explores both how this performance succeeded and where – and why – it failed.

I begin by reflecting on what this new performance did offer. It strikes me, first off, that this dance offered a different kind of assessment of Steve, engaging him in the treatment in a different way. Although he entered the treatment relationship with an already-completed neuropsychological assessment in tow, the beginning of our work together involved a kind of collaborative assessment in which he and I worked together to assess the nature of Steve's problems. Performing this way shifted many of the dynamics highlighted in this dissertation. At the times that I was collaborating with Steve, I did not create as much of a false barrier between us, and I emphasized rather than eradicated his subjectivity. My performance called for Steve to engage with me. Far from demanding Steve to be a living corpse, I asked Steve to interact. In contrast to my other performances, I felt that I was moving closer and closer to Steve's personality and life, as opposed to attempting to eliminate them as factors. Rather than eliminating Steve's body, I found that more bodies – those of his family and friends – were drawn in. I found that this granted Steve a kind of expert status. Furthermore, Steve was in charge of identifying his problems[65].This performance was both assessment and intervention. The goal of intervention permitted a shift in the dynamics of assessment. It was no longer possible for me to 'contaminate' the 'reality' of Steve's organic (brain) deficits via

---

[65] It was, of course, easier to facilitate this given that the purpose of our work together was cognitive training rather than assessment. I will address the difficulties of this in terms of assessment work later in this chapter. I should note that the idea of the patient self-assessing is complicated for particular kinds of problems that are noted precisely for the affected person's lack of awareness of them. All sorts of ethical problems stem from this – issues of that person's safety and the safety others must be balanced with their right to autonomy.

intervention. I felt that these aspects of my attempts at performing differently were useful for him.

Nonetheless, I was not able to entirely break free of my habitual performance and felt myself suddenly (and cruelly) reverting back to my habitual performance of the training neuropsychologist. Most concretely, and representing concerns most immediately present, I did so out of fear of a bad review from my supervisor on this case. I found myself worrying that, despite everything that I felt that I accomplished in my first meetings with Steve, that my supervisor would question what, exactly, I had done. The lack of 'evidence' regarding our meetings concerned me. Part of the difficulty was one of translation. The 'language' of neuropsychology is quantifiable and standardized. My work with Steve did not fit into that framework. I viewed Steve's interactions with his friends that resulted in an even more personalized system of memory cues as well as strengthened friendships as strong evidence of the success of our work together, but I was concerned that my supervisor would not. I was concerned that my work would, therefore, be viewed as 'untrained' or 'unskilled'. It was out of this concern related to my evaluation that I reintroduced the 'curriculum' at various times in our work together. When I turned towards it, I turned away from Steve and challenged our alliance.

There is another sense in which I seemed to feel afraid of the change in my performance, and thus dropped it precisely when Steve began to demonstrate the success of this changed performance! I abandoned him at a crucial moment – the one in which he began to feel empowered separately from me entirely. It seems to be enormously significant (despite my difficulty in recognizing this) that the moment I decided to turn back to my habitual performance was the one in which he began to make use of the offer

to re-enter his life. And it crushed him when I did it. He next reported frightening rage, followed by near suicidal depression. Reflecting, it seems that I had an investment in maintaining my habitual performance of the neuropsychologist. This reminds me that, as much as I envisioned myself as one who tried to alter my performance, my conscious desire to perform differently was not enough for me to overcome the problematic aspects of my performance of neuropsychology.

The times in which I explicitly attempted to break free and try a different performance of the training neuropsychologist (such as my work with Steve) occurred when I was not working with patients in an assessment capacity. This is no coincidence, but rather points to the particular difficulties that I felt were involved in shifting my performance while in the role of the assessor. I found that it was surprisingly difficult to even attempt such a shift when I was working in an assessment capacity. It seems that understanding this particular difficulty may provide valuable information for beginning to understand how to break out of the problematic aspects of these entrenched performances.

I find myself saddened as I reflect on my interactions with Steve. I have already addressed the ways in which these interactions with Steve represented my personal limitations in attempting transformation. My interactions with Steve demonstrate the frightening intensity with which the structure of the neuropsychologist operates. Armed with the insights of my multiple positions as well as theory, I was still no match for the intense backlash of the role of the neuropsychologist. It was almost as though the role of the neuropsychologist saw my resistance and fought back.

It is this disturbing experience with Steve that leads me to turn next to a fantasized performance of neuropsychology. The new performance to which I have referred throughout this section seemed to be impossible. The forces sustaining the current performance of neuropsychology prohibit a radical queering of performance. I found that the backlash was largely an internal one although it involved fantasies of external retribution by the supervisors on the unit. At this point, I find it possible to imagine – but not perform – a new libratory neuropsychologist. As a starting point on the path to queering the performance of the neuropsychologist, I create a fantasy of a new performance.

Imagined Performances:

I shift now from the performances that I actually performed on the unit to those performances that I am able to imagine a neuropsychologist performing. This is both my acknowledgement of the power of the current performance of the neuropsychologist that prevents transformation and my hopes for the future. Although my attempted new performance did not succeed, my ability to imagine a new performance creates the possibility of such a performance in the future. This task of imagination is a difficult one, as I realize that I am so used to the stage settings of this current performance that I can barely imagine what another staging of the show of neuropsychology might look like. I imagine myself in the role of director, trying to imagine a liberatory performance. And here, I combine autoethnography with a kind of (fantasized) performance ethnography. I find that I land in something between prescription, fantasy, and personal quest.

Setting the Stage:

I walk onto the stage – entering stage right by using my key in the big door to the unit – and fling open the door to my office. With relish, I discard the sickly-pink exam table. I chip up the bathroom tile and toss it aside as well. I stare at the desk, ambivalent, but decide that it needs to leave, too – something about it seems both rundown and bureaucratic. Out it goes. As I think about what to fill the office with me, it dawns on me: this new performance doesn't take place in my office. It doesn't take place on a hospital unit at all. I decide to break free. I busy myself smashing down walls, shoving filing cabinets full of tests off into the abyss, and scattering plastic models of brains behind me as I shove everything off stage. Eventually, I am alone on the bare stage.

There. That's better. But now what?

I stand still.

I don't struggle with what to put in place of the office and the unit. I wonder if it would be too tragically cliché for me to build a suburban living room, as I drag an overstuffed couch on stage. I speculate that it represents some unconscious classism in addition to its painful triteness. I push it back off stage. I decide that this new performance cannot have a "Leave it Beaver" quality. I realize that it's an impossible task to conjure up all the possible places where this new performance of neuropsychologist could occur – a client's workspace, home, the library, the grocery store, or the neuropsychologist's office should another scenario be experienced as intrusive. I realize that it is impossible to represent all possibilities, so I slap together a haphazard living room that does not feel like the Cleaver family lives in it.

I move on to props. I decide that whoever I cast as the neuropsychologist will need a bag of stuff. I settle on a tan bag, because a black bag feels too "doctorly" for this new play. (I begin to worry, though, that if I'm not careful I could be writing a script of concealment – I cannot just write a play that *hides* the medicalized aspects of neuropsychology without transforming them, or the play becomes even more sinister than it was before!) I think of what to put in the bag. Pens, of course, and a notebook. A day planner. A chart for patients – wait, I don't like that word! More on that later! – to chart their difficulties and attempts at adaptation. Extra copies for family and friends. A few tape recorders and plenty of blank tapes. Vouchers for bulletin boards, PDAs, and other potential tools. I realize that, as my actors begin to perform, I will come up with more tools for the bag.

I take a step back, and realize that I have rushed ahead. In order for a liberatory performance of neuropsychology to occur, does not one need a liberatory classroom to precede it? I leave my earlier creation, but I erect a classroom stage left. I arrange desks in a circle, and call for a professor and handful of students. I add a chalkboard. I decide to kick the professor and student back outside, making sure that they do not limit themselves to the performances that are available within the confines of a classroom.

Cast of Characters:

It is time to settle on characters. The play will require neuropsychologists, other professionals, patients, and family members. (And again I catch myself. I am not sure that I should cast "patients" in my new play. And yet, I am not sure who else to cast – collaborators, partners, or clients? I feel that I should develop some term that is entirely

new, but I feel at a loss. I am not sure if I should cast neuropsychologists at all. Should

we adopt new names?) I decide to keep the names of those in the role of professionals

and to ask those in the role of what had been called patients to decide what they would

like to be called. For now, I will refer to the person in the role of the one who is

receiving services as "Joanne," and I will refer to her partner as "Stephanie." I will call

the person functioning in the role of neuropsychologist "Susan." I do this for simplicity's

sake, reminding myself that I am both Joanne and Susan[66]. I decide to cast myself as

both, deciding that I am free to do whatever I would like in my fantasized performance.

Even as I do so, I again recognize how trapped I am as the director. I have

neglected to cast those creating the oppression of those with disabilities. I then cast

government officials, and various citizens. I gather up a cast of millions to demonstrate

the oppression.

Act One:

Susan, a woman who has been drawn to the field for its anti-ableist work, is

sitting in a classroom attending a doctoral level class as part of her training in

neuropsychology. She and her classmates are discussing literature from the disability

rights movement. In her coursework, Susan is encouraged to reflect on her personal

motivations for entering the field. She discovers within herself a slew of ableist beliefs.

Even her classmates with so-called disabilities find themselves harboring some of these

attitudes. The process of training is largely designed to attune students to ableism as it

---

[66] Importantly, there will not be the great divide between Joanne and Susan as their has been in previous performances. Therefore, it is less preposterous for me, Kristen, to play both at the same time.

appears culturally, as part of the profession, and within each student. The entire curriculum is based on insights from the disability rights movement.

In addition to studying their own beliefs (conscious and unconscious) regarding people with what have been referred to as disabilities, Susan and her classmates study the barriers to equality. They explore the myths of ableism, trying to see through these myths so that the natural results of these myths no longer seem like the only logical option. They become much like anti-racists, acknowledging that the oppressor lurks within, and struggling to get free. Those who have been Othered as disabled and those who have not all see an ethical call to break free of ableism. The classroom is comprised of those with and without so-called disabilities. The mix within the class is so important because of dual pulls. One pull is for those without so-called disabilities to see themselves as doing some sort of charitable work through engagement with those with disabilities. The other pull is to cast those with so-called disabilities into the role of helper of others with so-called (dis)abilities and assume that they do not have other interests. Classroom work does, of course, explore both of these pulls.

The field experience components of training included work with persons oppressed by ableism and work geared towards the elimination of ableism. To that end, they work on raising awareness of ableism, the education of other professionals, government advocacy, and working with businesses/employers to work on advocacy issues. The attitude throughout is not that those with so-called disabilities are broken and need to be fixed, but rather that there are societal problems that prevent those with so-called disabilities from participating in society as fully and freely as would otherwise be

possible. This scene includes a montage of students bustling about in various capacities, both on and off campus.

As the director, I need to make some choices. I decide to spend my time depicting the neuropsychologist in her interactions with a person with so-called disabilities. I make this choice because it relates most directly to the performance of neuropsychology performed on the unit. I acknowledge, however, that this shows a limitation in my thinking. Perhaps the neuropsychologist would not devote much of her time to working with so-called patients. But for now, I call intermission.

Act Two, Scene One:

The curtain rises to focus on Joanne, a woman in her early sixties who has experienced a traumatic brain injury in a car accident. She had been given the contact information for Susan – a neuropsychologist – when she left the hospital. Joanne has decided to contact Susan after talking things over with her husband. The two of them have tried to adapt to the changes in Joanne after her stroke, but they both find themselves feeling exasperated. They cannot seem to make the environment work for Joanne. Joanne has struggled to concentrate, especially at work, and her boss has become increasingly exasperated with her. She and Stephanie have been uncharacteristically bickering. Joanne finds that others don't seem to understand her struggles and finds her emotions spiraling. After Joanne was released from the hospital, Susan left a message introducing herself, explaining what she offers, and encouraging Joanne to call if she feels that it would be of use. Susan left her cellphone number.

When Joanne called Susan, Susan offered to host Joanne in her office or to visit her at home (or at work, if that's what Joanne preferred.) Susan noted that Joanne is free to invite anyone that she would like to the visit, or to come alone. Joanne decides that, since she feels anxious in cars after her accident, she would prefer that Joanne visit her in her home. (And the clichéd suburban living makes resurgence. I realize that it may be the best that I can do.)

Scene Two:

Susan arrives at Joanne's house. Joanne has decided to meet with Susan alone first, and then to invite her partner in for the end of the meeting. Susan invites Joanne to tell her story. Joanne discusses her experiences with the brain injury, describing what happened to her, how she felt immediately after, and the difficulties that she has experienced since then. Joanne leads the discussion, with Susan asking open-ended questions that invite Joanne to elaborate on her story. Joanne is emotional, explaining that she feels like she has lost a part of herself through her injury.

When Joanne has finished telling her story, Susan asks Joanne how she can be helpful. Joanne asks Susan to help her to be able to fill her old roles. Susan suggests that they make a list of the specific roadblocks that Joanne is encountering in doing so. (Her phrasing is intentional – she is working from a framework from which Joanne's difficulties stem from the environment's failure to adapt to her changes rather than from a deficit in Joanne herself. At this point, Joanne invites Stephanie to join the meeting. Joanne begins by listing what she recalls of what has been happening, touching on her

irritability, her difficulty keeping her appointments straight, and her new-found struggles following recipes or balancing the check book.

Susan asks the couple to describe – and show her – the ways that they have tried to adapt the environment. She asks detailed questions about the success or frustration of each attempt. Susan then gets to work with the family, trouble-shooting each attempt, developing new techniques, and providing the family with technology – tape recorders, PDAs, alarm clocks – she works with the family to develop a system designed to meet Joanne's needs.

Scene Three:

Susan returns a third time. This time she has returned to check in with Joanne and see if her environment is now optimally suited to her needs. Susan is aware that, in an ableist society, the environment will *never* be fully suited to Joanne's needs. Susan reflects on her advocacy work – which encompasses about half of her time - and is critical of the ableist assumptions in her work with Joanne, worrying that perhaps her questions of Joanne point to a continued ableism. Yet, she also acknowledges that, given the existence and prevalence of ableism, it is important to ensure that Joanne has received all of the individualized assistance that she can. Joanne tells Susan that she feels that her environment – social and physical – has adapted a great deal to her needs. Susan reminds her that she can call at any time to check in.

And here I end the play.

Explorations:

This "play" takes on the feel of the cheesily fantastical. Of course, this *is* a fantasy. The fairy-tale quality makes sense when one considers that this play is my fantasy of what a liberatory performance could look like. It will be stilted and awkward until performers try it out and refine the script. The cheesy and stilted quality is still further evidence of how trapped I am by ableism, despite my work on this project. Furthermore, I have painted a best-case scenario. How would this change if Joanne was not in a supportive relationship, if she lacked health insurance after her injury, or if her finances could not tolerate her absence from work, has not been addressed. All of these concerns would complicate Joanne and Susan's work together and would limit the effect that this individual work could have.

I should note that I have ignored difficult issues of funding. I do not answer questions of funding and survival. I do not explain how this new neuropsychologist will be paid or who will fund this project. I am deliberately ignoring these concerns as they may tie me needlessly to the conventional. In this new performance, it is quite likely that an entirely different funding source makes more sense. I do not want to be limited to hospital grants and patient's insurance when it is possible that a new performance would call for different funding sources entirely. This relates to my decision to include Susan's training. In order for a single neuropsychologist to enact a truly different performance, structural support must be in place in terms of funding, education, and public acceptance. This is not an excuse for neuropsychologists to refrain from creating new performances, but is a call for neuropsychologists to strive to systemic change that reaches even beyond the bounds of the profession itself.

Implications:

The implications of my fantasized performance are many. Some implications are also limitations, as they are prerequisites for these performances to be permitted to exist. Others are more of a mutual influence. For example, making the curriculum more attuned to disability rights would likely increase the number of persons with disabilities entering the field. Conversely, an increase in the number of persons with disabilities entering neuropsychology would (likely) shift the profession's relationship to disability. My fantasized performance cannot exist without a reduction of ableism on a societal level as well as a pervasive awareness of ableism that is attended to in the curriculum of the training neuropsychologist. Similarly, this new performance would advance the disability rights movement. Thus, I am aware that all of the aspects of my fantasized performance are necessarily in dialogue with other changes.

There are some predictable implications and resulting shifts that would follow from this fantasized performance. The shift of my fantasized performance would require a different means of funding for neuropsychology, as it is unlikely that the current managed care environment would be interested in paying for neuropsychology in this (less overtly medical) vein. Similarly, neuropsychology would become more clearly distinct from neuroimaging, both in aim and its relationship to a larger medical project. As opposed to the medical project and neuroimaging, neuropsychology would involve a careful attunement to the experienced life of the patient. The bodies and subjectivities of patients and professionals would re-emerge. Rather than taking information from standardized tests, neuropsychologists would turn towards the lives of patients for

225

information regarding diagnosis. Diagnosis would always be made with the explicit aim of improving the life of the patient. The anatomo-clinical model and its emphasis on the corpse would be abandoned in exchange for a relationship between the neuropsychologist and the person requesting services. The relationship becomes the basis of the work, and training would emphasize the relational aspect of the work.

My fantasized performance may be disturbing in some sense. Much of the mysterious power of the professional must be surrendered. This new neuropsychologist has a very different relationship to knowledge and power, one in which power is more explicitly acknowledged and shared with the patient. Similarly, the neuropsychologist must surrender some of his/her expert status in exchange for a relationship that acknowledges the expertise of the patient.

Limitations:

I believe that, should my fantasized performance occur, there will be other even more liberatory performances that will become possible to imagine. What I am able to fantasize is limited by my perception. I am constructed, and am limited by the boundaries of my constructed self. A different performance, a different construction of the neuropsychologist would permit different fantasies of what is possible. I am certain that I am unable to imagine the 'most' liberatory performance that is possible. Indeed, if neuropsychologists and patients were constructed differently, there would no longer be a need for a new performance. It is difficult – absurd, even – to discuss the limitations of what I can see. I am not aware of what I cannot imagine.

However, I have the sense that I have failed to radically disrupt the separations of patients and professionals. I find myself continuing to use those problematic terms, and acknowledge that I continue to fall upon variations of the anatomo-clinical medical model for my framework. I have not yet been able to break free. Thus, in many ways, this fantasized performance represents the mere beginning of possibility rather than a satisfactory solution.

Chapter 8: Conclusions:

I struggle to conclude this dissertation, as this project aims to be one of ever-expanding possibility. I find that it is difficult to conclude without cutting off further possibilities or sedimenting a performance that I wish to leave in transition. In this concluding chapter, I revisit the themes highlighted in the dissertation. I take the reader through reflections on the dissertations' impact on my identity/performed selves, as well as insights that are accessible to me only upon contemplation of the project as a whole. Finally, I offer one more glimpse at the possible future performances towards which I hope this project reaches.

Reflections on the Neuropsychologist:

This projected unpacked interlocking dynamics that serve to construct the identities and performances of the neuropsychologist and patient. I take time now to step back and reflect on the overall structure of the neuropsychologist that I discovered, along with the resulting position of the patient. This section serves as a snapshot of the dynamics discovered via this dissertation.

The role of the neuropsychologist and patient are in a particular relationship to one another. The constructed identity of the neuropsychologist requires that the patient must be kept separate from the neuropsychologist, with the neuropsychologist exalted as the standard of normalcy to which the patient is constantly compared. The neuropsychologist is valorized and seen as the standard of normalcy, whereas the patient is seen as flawed. Not only does the neuropsychologist compare the patient to the

standard of normalcy that is represented by the neuropsychologist, the patient comes to evaluate himself in the same manner. The patient comes to scrutinize his performance and contrast it to that of the neuropsychologist, trying to match the performance. Thus, the power of the neuropsychologist stems from its status in contrast to the patient. Much as the asylum doctor of Foucault's (1965) *Madness and civilization,* the neuropsychologist is a thaumaturge, drawing power from its symbolic significance of the position of neuropsychologist itself. I discovered, then, that the power of the neuropsychologist did not stem from the knowledge of the neuropsychologist, but rather the position itself. The patient attempts to emulate the neuropsychologist, coming to evaluate him/herself from an outside perspective.

In addition to – and a part of – the separation of neuropsychologist and patient and the accompanying exaltation of the neuropsychologist and devaluing of the patient, I discovered that the subjectivity of the patient was actively minimized. Psychological influences were actively de-emphasized, and were treated as either irrelevant or another neuropsychological symptom. The role of the neuropsychologist also worked to strip the patient of a life and cultural context. What happened outside of the brain was seen as irrelevant. The patient came to be totalized by the scores found on neuropsychological testing, with all else eliminated and ignored. The life and experience of the patient was stripped away, treated as a confounding variable, until all that was left was scores. The patient him/herself was treated as interfering with neuropsychology. The anatomo-clinical phase described by *The Birth of the clinic* (Foucault, 1974) highlights this dynamic. The neuropsychologist treats the patient as a corpse of sorts, using testing as a kind of autopsy on a living brain to try to imagine tumors and lesions.

Neuropsychology reduces the patient to scores, and yet, neuropsychologists turn to neuroimaging to provide what is considered to be a more definitive truth. Sight is valued above all else. Neuroimaging provides a superior autopsy of the living, offering actual images of the brain. These images were treated as though they offer a real truth that cannot be challenged, and neuropsychology bowed to neuroimaging, permitting it to take over what had otherwise been the domain of neuropsychology. The images provided by neuroimaging are a kind of hyperreality, coming to be seen as more real than the actual brain or person.

Thus, the constructed role of the neuropsychologist emerged as one that separated patients and professionals and worked to reduce the patient to scores representing the brain, all while submitting to neuroimaging. These roles adopted by the neuropsychologist and patients have consequences, particularly for the patient. The current performances are harmful to patients and limit the effectiveness of the neuropsychologist.

New Performances:

Although I discovered many problematic aspects of my performance of the neuropsychologist, I also found many places of rupture where a new performance could begin to emerge. These new performances, just beginning to peek through, offer hope. Still on the horizon, these performances only became visible to me through the process of embodying multiple positions and reflecting in a rigorous manner.

Writing as Intervention:

The writing of this dissertation itself functioned as an intervention of sorts. The process of writing transformed my position as patient and as neuropsychologist. While feeling increasingly paranoid about my self as patient on the unit, I found that the writing process served not only to decrease my paranoia over my status as patient, but also lessened my identification with the patient role altogether. The process of writing transformed my self as patient out of a passive position. Asking for my self as patient to reflect and contribute to the process necessarily shifted my constructed identity. The habitual construction of the patient's role keeps the patient in an unknowing and passive position, which writing served to shift. Writing queered the performance. In this new, active, reflecting performance, I no longer felt like a patient. "Patient" came to mean something different, and was not recognizable. My self as neuropsychology trainee had to shift as well, as the critical reflection that is a part of this dissertation is incompatible with the habitual performance. The neuropsychologist's performance requires that the assumptions of superiority and the value to seeing are unquestioned. This dissertation, then, served as an intervention, unmasking my self as neuropsychologist trainee and empowering my self as patient to see. This dissertation, then, is a beginning attempt at the queering of neuropsychological performances.

Towards the Future:

I strain to see the future, to imagine performances which have not yet been performed. As I end this dissertation, my self as neuropsychology professional and self as patient sit together, striving in the awkward stages of transformation. My self as

neuropsychology trainee and self as patient sit staring at one another warily but

hopefully. They cautiously begin to talk, trying to figure out who they are, how they

have come to be, and who they shall become. As my patient self watches, my self as

neuropsychology trainee tucks away testing material and prepares to listen. My self as

patient begins to articulate and advocate for herself, no longer content to passively follow

the neuropsychologist. Instead, my self as patient begins to identify her own needs, using

the expertise of my self as neuropsychology trainee for her own goals. My self as

researcher steps away, leaving them to continue their process of self-construction.

References

Alsop, C. (2002). Home and away: Self-reflexive auto-/ethnography. *Forum: Qualitative Social Research.* 3(3), Art. 10, http://nbnresolving.de/urn:nbn:de:0114-fqs0203105.

Anderson , L. (2006). Analytic autoethnography. *Journal of Contemporary Ethnography.* 35(4), 373-395.

Atkinson, P. (2006). Rescuing autoethnography. *Journal of Contemporary Ethnography.* 35(4), 400-404.

Baudrillard, J. (1995). *Simulacra & simulation*. Ann Arbor, MI: University of Michigan Press.

Beaulieu, A. (2002, Winter). Images are not the (only) truth: Brain mapping, visual knowledge, and iconoclasm. *Science, Technology, & Human Values*. 27(1), 53-86.

Block, J. W. (2002). *Copious hosting: A theology of disability for persons with disability.* Harrisburg, PA: Continuum International Publishing Group.

Brambati, S. M., Termine, C., et al. (2006). Neuropsychological deficits and neural dysfunction in family dyslexia. *Brain Research.* 1113(2006), 174-185.

Brizandine, L. (2006). *The Female brain.* New York, New York: Random House Inc.

Brooks, R., 2002, "The Merger of Flesh and Machines" in Brockman, J., ed., *The Next Fifty Years: Science in the First Half of the 21st Century,* New York, New York: Vintage Books.

Buchanan, A. Brock, D, Daniels, N., & Wikler, D. (2000). *From chance to choice: Genetics and justice.* Cambridge: Cambridge University Press.

Butler, J. (1999). *Gender trouble: Feminism and the subversion of idenity.* (Second edition.) New York: Routledge.

Butler, M. A. & Bennett, T. L. (2003). In search of a conceptualization of multiple sclerosis: A historical perspective. *Neuropsychology Review.* 13(2), 93-112.

Canli, T. & Amin, Z. (2002). Neuroimaging of emotion and personality:Scientific evidence and ethical considerations. *Brain and Cognition*. 50(2002), 414–431. Retrieved on 4/3/08 from ScienceDirect.

Chambers, E. (2000). Applied ethnography. In *Handbook of qualitative research, Second edition.* New York: Sage Publications, Inc. Denzin & Lincoln, eds., 851-869.

Charmaz, K. (2006). The power of names. *Journal of Contemporary Ethnography.* 35(4), 396-399.

Chaytor, N. & Schmitter-Edgecombe, M. (2003). The ecological value of neuropsychological tests: A review of the literature on everyday cognitive skills. *Neuropsychology Review.* 13(4), December, 181-197.

Chaytor, N, Schmitter-Edgecombe, M., & Burr, R. (2006). Improving the ecological validity of executive functioning assessment. *Archives of Clinical Neuropsychology.* 21(2006), 217-227.

Collinson, J. A. (2005). Emotions, interaction, and the injured sporting body. *International Review for the Sociology of Sport.* 40(2), 221-240.

Couser, G. G. (2005). Disability and (auto)ethnography: *Riding* (*and writing*) *the bus with my sister. Journal of Contemporary Ethnography.* 34(2), 121-142.

Crick, F. (1995). *The Atonishing hypothesis: The Scientific search for the soul.* New York, New York: Touchstone.

Cushing, P., & Lewis, T. (2002). Negotiating mutuality and agency in care-giving relationships with women with intellectual disabilities. *Hypatia.* 17(3), 173-193.

Damato, R. C., Crepeau-Hobson, F., Huang, L. V., & Geil, M. (2005). Ecological neuropsychology: An alternative to the deficit model for conceptualizing and servinc students with learning disabilities. *Neuropsychology Review.* 15(2), 97-104.

Danforth, S. (1997). Deconstructing disability. *Remedial & special education*. 18(6), 357-367.

Davis, L. J. (1999). Crips strike back: The rise of disability studies. *American Literary History.* 11(3), Autumn, 500-512.

Denny, R., & Wynkoop, T. (2000). Clinical neuropsychology in the criminal forensic setting. *The Journal of Head Trauma Rehabilitation* 15(2), 804-828.

Department of Justice, (1990). Americans with Disabilities Act of 1990. http://www.ada.gov/pubs/ada.htm.

Derrida, J. (1973). *Speech and phenomena and other essays on Husserl's theory of signs.* Evanston, Illinois: Northwestern University Press.

Dumit, J. (2003). *Picturing personhood: Brainscans and biomedical identity.* Princeton, NJ: Princeton University Press.

Eaton, M. & Illes, J. (2007, April). Commercializing cognitive neurotechnology—the ethical terrain. *Nature Biotechnology*. 25(4), 393 – 397.

Ellis, C. S., & Bochner, A. P. (2006). Analyzing analytic autoethnography: An

autopsy. *Journal of Contemporary Ethnography.* 35(4), 429-449.

Erevelles, N. (2000). Educating unruly bodies: Critical pedagogy, disability studies, and

the politics of schooling. *Educational theory*. Winter, 2000, 50(1), 25-47.

Ecklund, E. & Torres, I. (2005). Unawareness of deficits in Alzheimer's Disease and

other dementias: Operational definitions and empirical findings.

Neuropsychology Review. 15(3), 147-166.

Errevelles, N. (2000). Educating unruly bodies: Critical pedagogy, disability studies,

and the politics of schooling. *Educational Theory.* 50(1), 25-48.

Ettorre, E. (2006). Making sense of my illness journey from thyrotoxicosis to health: an

autoethnography. *Auto/Biography* 14, 153-175.

Farah, M. (2005). Neuroethics: the practical and the philosophical. *Trends in*

Cognitive Science. 9(1), 34 – 40. Retrieved on 4/1/08 from ScienceDirect.

Farah, M. & Wolpe, PR. (2004). Monitoring and manipulating brain function:

New neuroscience technologies and their ethical implications. *The Hastings*

Center Report. 34(3), 35 – 45.   Retrieved on 4/7/08 from ResearchLibrary.

Fine, C. (2008). Will working mothers' brains explode? The popular new genre of

neurosexism. *Neuroethics*. 1, 69 – 72.

Fins, J. (2005). The Orwellian threat to emerging neurodiagnostic technologies.

The American Journal of Bioethics. 5(2), 56 – 58. Retrieved January 27, 2008

from Informaworld.

Fischer, C. (1994). *Individualizing psychological assessment.* Hillsdale, New Jersey:

Lawrence Erlbaum Associates, Inc.

Foucault, M. (1974). *Birth of the clinic.* New York, New York: Vintage Books.

Foucault, M. (1975). *Discipline and punish: The birth of the prison.* New York, New York: Vintage Books.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason.* New York, New York: Vintage Books.

Fusar-Poli, P & Broome, M. (2006). Conceptual issues in psychiatric neuroimaging. *Current Opinion in Psychiatry.* 19, 608–612. Retrieved on 4/10/2008 from Journals@Ovid.

Geertz, C. (1973). *The interpretation of cultures: Selected essays by Clifford Geertz.* New York, New York: Basic Books.

Gelber, S. (2005). A hard-boiled order': The reeducation of disabled WWI veterans in New York City. *Journal of Social History.* 39(1), Fall, 161-180.

Gergen, K. (2001). *The Saturated self: Dilemmas of identity in contemporary life.* New York, New York: Basic Books.

Glannon, W. (2006). Background briefing: Neuroethics. In *Bioethics.* 20(1), November, 37-52.

Goodman, A. (2001). *Biological diversity and cultural diversity from race to radical biphoniculturalism.* Hoboken, NJ: Wiley Blackwell. Susser and Patterson, Eds.

Granskog J. (2003). Just 'tri' and 'du' it: The variable impact of female involvement in the triathlon/duathlon sport culture. In A. Bolin and J. Granskog, (Eds.) *Athletic intruders: Ethnographic research on women, culture, and exercise.* Albany, NY: State University of New York Press, 27-52.

Greely, H. (2002). *Neuroethics*? Health Law News. Health Law & Policy Institute, University of Houston Law Center. July 2002(5).

Gutting, G. (1989). *Michel Foucault's archeology of scientific reason: Science and the history of reason.* New York, New York: Cambridge University Press.

Hahn, T., & Belt, T.L. (2004) Disability identity and attitudes toward cure in a sample of disabled activists. *Journal of health and social behavior.* 45(December), 453-464.

Hammersley, M. (1992). *What's wrong with ethnography?* New York, New York: Routledge.

Heaton, R. K., & Pendleton, M. G. (1981). Use of neuropsychological tests to predict adult patients' everyday functioning. *Journal of consulting and clinical psychology.* 49(6), 807-821.

Hehir, T. (2007). Confronting ableism. *Educational Leadership.* February, 2007: 64(5), 8—14.

Hehir, T. (2002). Eliminating ableism in education. *Harvard Educational Review.* Spring 2002: 72(1), 1—32.

Heinrichs, R. W. (1990). Current and emergent applications of neuropsychological assessment: Problems of validity and utility. *Professional psychology: Research and practice.* 21(3), 171-176.

Hinton, V. (2002). *Ethics of neuroimaging in pediatric development.* Brain and Cognition. 50(2002), 455 – 468. Retrieved on 04/07/2008 from ScienceDirect.

Hurst, R. (2003). The international disability rights movement and the ICF. *Disability and Rehabilitation.* 25(11-12), 572-576.

Illes, J. & Bird, S. (2006).*Neuroethics: a modern context for ethics in neuroscience.*

Trends in Neuroscience. 29(9), 511 – 517. Retrieved on 3/28/08 from

ScienceDirect.

Illes, J. & Racine, E. (2005). *Imaging or imagining? A neuroethics challenge informed

by genetics*. American Journal of Bioethics. 5(2), 5 – 18.

Jago, B. J. (2002) Chronicling an academic depression. *Journal of Contemporary

Ethnography.* 31(6), 729-757.

Kulynych, J. (2002). *Legal and ethical issues in neuroimaging research: human subjects

protection, medical privacy, and the public communication of research results.*

Brain and Cognition. 50(2002), 345 – 357. Retrieved on 04/07/2008 from

ScienceDirect.

Kulynych, J. (2007). *Psychiatric neuroimaging evidence: A high-tech crystal ball?*Stanford

Law Review. 49(5), 1249-1270 Retrieved on 04/07/2008 from JSTOR.

Legris, J., van Reekum, R. (2006). The neuropsychological correlates of borderline

personality disorder and suicidal behavior. *Canadian Journal of Psychiatry:* Mar

2006; 51(3), 131-142. Proquest Psychology Journals.

Levinas, E. (1969). *Totality and infinity: An exercise on exteriority.* Pittsburgh, PA:

Duquesne University Press.

Lewis, L., & Sinnett, R. (1987). An introduction to neuropsychological assessment.

Journal of Counseling and Development. 66(November), 126-130.

Lezak, M.D., Howieson, D. B., Loring, D. W., Hannah, H. J. & Fischer, J. S. (2004).

Neuropsychological Assessment, Fourth Edition. Oxford University Press.

Lifton, R. (1986). *Nazi doctors.* New York: New York: Basic Books.

Lincoln, Y. & Denzin, N. (2000). The Seventh moment: Out of the past. In *Handbook*

of qualitative research, Second edition. New York: Sage Publications, Inc.

Denzin & Lincoln, eds., 1047-1065.

Livingston, K. (2000). When architecture disables: Teaching undergraduates to perceive

ableism in the built environment. *Teaching Sociology.* July, 2000: 28(3), 182—

191.

Lorde, A. (1997). *The Cancer Journals.* San Francisco, California: Ann Lute Books.

Macapinlac, H. (2006). Positron emission tomography of the brain. *Neuroimaging*

Clinics of North America. 16(2006), 591-603.

Mahowald, M. B. (2004). Prenatal testing and disability rights/Testing women, testing

the fetus: The social impact of amniocentesis in America. *Hypatia.* 19(3), 216-

221.

Malhotra, R. (2001). The politics of the disability rights movements. *New Politics.* 8(3).

McCarthy, H. (2003). The disability rights movement: Experiences and perspectives of

selected leaders in the disability community. *Rehabilitation Counseling Bulletin:*

46(4), 209-223.

Miller, A. (1997). *The Drama of the gifted child: The Search for the true self.* New York,

New York: Basic Books.

Mullens, M. E. (2006). MR spectroscopy: Truly molecular imaging; Past, present and

future. *Neuroimaging Clinics of North America.* 16(2006), 605-718.

Patterson, A., & Satz, A. (2002). Genetic counseling and the disabled: Feminism

examines the stance of those who stand at the gate. *Hypatia.* Summer, 17(3),

118-142.

Prince, M. J. (2004). Disability, disability studies and citizenship: Moving up or off the

sociological agenda? *The Canadian Journal of Sociology.* 29(3), 459-467.

Reger, M., Welsh, R. K., et al. (2004). The relationship between neuropsychological functioning and driving ability in dementia: A meta-analysis. *Neuropsychology:* 18(1), 85-93.

Rourke, B. (2005). Neuropsychology of learning disabilities: Past and future. *Learning disability quarterly:* 28(2), 111-114.

Satah, U., Streufurt, S., & Eslinger, P. (2006). Measuring executive function deficits following head injury: An application of sms simulation technology. *The Psychological Record:* 56(2), 181-190.

Sayce, L. & Perkins, R., 2002, They should not breed: Feminism, disability, and reproductive rights. *Off Our Backs,* Nov-Dec 2002, 18(7).

Scullion, P. (1999). Conceptualizing disability in nursing: some evidence from students and their teachers. *Journal of Advanced Nursing.* March, 1999, 29(3), 648-658.

Semrud-Clikeman, M. (2005). Neuropsychological aspects for evaluating learning disabilities. *Communications Disorders Quarterly.* Summer: 26(4), 242—247. Proquest Psychology Journals.

Shweder, R. (1991). On pseudoempiricism, pseudodeductionism, and common sense. *Psychological Inquiry.* 2(4), 366—371.

Sinason, V. (1992). *Mental handicap and the human condition: New approaches from the Tavistock.* London: Free Association Books.

Sohrabi, A & Brooks, A. (2005). *Functional neuroimaging and its implications for cognitive science: Beyond phrenology and localization.* Proceedings of the twenty seventh annual meeting of the Cognitive Science Society, Stresa, Italy,

2244-2249 Retrieved 4/15/2008 from:

http://cognitio.uqam.ca/2005/proc2005.pdf#page=48

Smith, L., Foley, P., & Chaney, M. (2008). Addressing classism, ableism, and heterosexism in counselor education. *Journal of Counseling and Development.* Summer, 2008: 86(3), 303—309.

Sparkes, (1995). Writing people: Reflections on the dual crises of representation and legitimation in qualitative inquiry. *QUEST.* 47(2).

Stuss, D. & Levine, B. (2002). Adult clinical neuropsychology: Lessons from studies of the frontal lobes. In *Annual review of psychology*; 53, 401—453. ProQuest Psychology Journals.

Sullivan, K. (2004). Neuropsychological assessment of mental capacity. *Neuropsychology review.* 14(3), 131-142.

Tedlock, B. (2000). Ethnography and ethnographic representation. In *Handbook of qualitative research, Second edition.* New York: Sage Publications, Inc. Denzin & Lincoln, eds., 455-486.

Titchkosky, T. (2000). Disability studies: The old and the new. *Canadian Journal of Sociology.* 25(2), 197-224.

Tingley, D. (2006). *Neurological imaging as evidence in political science: a review, critique, and guiding assessment.* Social Science Information. 45(1), 5–33.

Tomaszewski Farias, S., Harrell, E., Neumann, C., & Houtz, A. (2003). The relationship between neuropsychological performance and daily functioning in individuals with Alzheimer's disease: Ecological validity of neuropsychological tests. *Archives of Clinical Neuropsychology.* 6(Aug 2003), 655-672.

Vidich, A. J. & Lyman, S. M. (2000). Qualitative methods: Their history is sociology and anthropology. In *Handbook of qualitative research, Second edition.* New York: Sage Publications, Inc. Denzin & Lincoln, eds, 37-84.

Wappett, M. (2002). Self-determination and disability rights: Lessons from the women's movement. *Journal of Disability Policy Studies.* 13(2), 119-124.

Weinstein, C., Fucetola, R., & Mollica, R. (2001). Neuropsychological issues in the assessment of refugees and victims of mass violence. *Neuropsychology Review*, 1(3), 131-141.

Wheatley, E. E. (2005). Risk, reflexivity and an elusory body: Transformations in studying illness. *Journal of Contemporary Ethnography.* 34(1), 68-100.

Willinek, W., & Kuhl, C. (2006) 3.0 T neuroimaging: Technical considerations and clinical applications. *Neuroimaging Clinics of North America.* 16 (2006), 217-228.

Wilson, B. A. (2000). Compensating for cognitive deficits following brain injury. *Neuropsychology Review.* 10(4), 233-243.

Wood, R. L., & Liossi, C. (2006). The ecological validity of executive tests in a severely brain injured sample. *Archives of clinical neuropsychology.* 21, 420-437.