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Beyond Clinical Reduction: Levinas, the Ethics of Wonder and the Practice of Autoethnography in Community Mental Health Care

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By Catherine Racine

Abstract

The central claim of this thesis is that wonder has the capacity to interrupt the institutional entrancement of the clinician to exert a gravitational pull on her awareness. This can "awaken" her from the normalized perspective of clinical praxis, and a clinical environment that defiles the vulnerable help seeker while contributing to the clinician's moral disengagement or paralysis. In making this claim, our inquiry revisits many well-rehearsed ethical questions about the therapeutic relationship, the construct of mental illness and its care, the politics of power within the institution of community mental health care, and the supposed and real dangers of emotional intimacy in the clinical relationship. These questions also point uncomfortably—devastatingly—back to why and how the ethics of educated and dedicated clinicians can be diluted, for which the possible "cure" of wonder is being sought here.

Wonder represents but one aspect of our ethical analysis in this interdisciplinary study. We turn in equal measure to an emerging strand of moral research, called autoethnography, and to the radical ethical vision of Emmanuel Levinas who informs our final understanding of wonder. In this inquiry, autoethnography takes the form of a short story in chapter 2 and as a series of personal epiphanic vignettes thereafter. Autoethnography affectively illuminates the theory being presented here and evokes the horrifying imperative of our ethical quest that calls for radical institutional change, albeit enigmatically. It is in Levinas' ethical vision, however, that the clinician may discover the astonishing holiness and relationality at the heart of the clinical relationship and all this implies. This perfection, apprehended through the stunning approach of the vulnerable help seeker, extends an ethical invitation to the beleaguered clinician that she can hardly resist, but that she will almost inevitably fail to answer.

Beyond Clinical Reduction:
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Acknowledgements

Dedication

In memory of my parents Muriel and Bruno Racine, and for Alex W.'s shining example.

Chapter 1.
Introduction

The event in the Nitobe Garden presented a dilemma that emerged from an awe-full sense of presence, a third thing that was shocking but devastatingly tender and familiar. It was an overflowing rapture that made me yearn to offer I-knew-not-what to a near stranger in paltry exchange for all that was being given—had been given—apparently from the beginning, from forever.[1]

1.1 Introduction

The central claim of this thesis is that wonder has the capacity to interrupt the institutional entrancement of the clinician to exert a gravitational pull on her awareness. One that is sufficient to "awaken" her from normalized perspectives of clinical praxis and the clinical environment that defile the vulnerable help seeker and contribute to the clinician's moral disengagement or paralysis.[2] This claim revisits many well-rehearsed ethical questions about the therapeutic relationship, the construct of mental illness and its care, the politics of power within the institution of community mental health care, and the dangers of emotional intimacy in the clinical relationship. These questions also point uncomfortably—devastatingly—back to why and how the ethics of educated and dedicated clinicians become diluted within the context of their work, for which we are seeking the possible "cure" of wonder. We wish to understand to what extent wonder may affect the clinician's capacity to recognize and resist her culturally informed understanding of "mental illness," and the praxis of "mental health care" within the institution.

Can an orientation to wonder increase the ethical sensitivity and capacity of community mental health clinicians? In what ways might we expect wonder to act on the awareness *and* behaviour of the clinician? How does one orient one's self to wonder? Can wonder be learned and taught? If our ability to see the world with wonder connects us to the imagination and creativity, how might this affect the clinician's perception of the other person? What *is* wonder and how does it work? Is it an emotion, a state, an experience, an external phenomenon, a relationship or, is it a linguistic construct as close to us as the air we breathe? Is it a type of consciousness or quality of enlightenment? Is wonder the same as

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[1] See: The Nitobe Garden (5.1.2)

[2] O.S. Haque and A. Waytz, 'Dehumanization in Medicine Causes, Solutions, and Functions', *Perspectives on Psychological Science,* 7 (2012), pp. 179-80.

awe? Is it embodied, transcendent or both? Most of all, is wonder capable of elevating the vulnerable other to a position of such importance and meaning that the likely response of the clinician is one of reverence, esteem and love that might be demonstrated through ethical action?

I intend to show how the "approach"[3] of wonder confronts and disturbs the clinician with evidence of her engagement in an indefensible clinical enterprise underscored by legal authority and the many privileges it bestows.

1.2 The origins of this study

My academic involvement with this question began almost 20 years ago while completing a Master's degree in counselling psychology. My dissertation focussed on what I then identified as a "mystical experience," following a remarkable event alluded to in the epigraph of this introduction.[4]

From early in my MA studies I could see the troubling social inequalities within an overly simplistic and idealistic counselling model that locked into larger conversations about pathology and institutionalized—culturalized—norms and controls. These intersected disturbingly with the difficult and painful circumstances of people's lives, which despite the predictable emotional distress they caused still resulted in diagnoses of mental illness.[5] The cracks in the arguments of praxis, the medicalization of oppression and the real horror and history of mental health care, while not new, came into sharp focus. It was the event described in *The Nitobe Garden*, however, that confirmed beyond doubt my moral uneasiness for it illuminated the vulnerable help seeker as the answer to *my* greatest yearning as a clinician. This changed everything but then again, only to a point.

Aspects of this phenomenal encounter have recurred throughout my years of working in the field of mental health care although never with the raw force described in *The Nitobe Garden*.[6] The encounter was so life altering that months afterwards it appeared that something had changed. I recognized myself one day in an offhand remark made by a stranger who

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[3] The term "approach" is used throughout the work of Emmanuel Levinas to qualify his notion of the Face and the Other. I use it here to allude to the Levinasian definition of wonder I claim in chapter 5.

[4] C. Racine, 'Mystical Experience of a Counsellor: An Autobiographical Journey', (University of British Columbia, 1996).

[5] For a thoughtful argument on this matter see: S. Williams, 'Reason, Emotion and Embodiment: Is 'Mental'health a Contradiction in Terms?', *Sociology of Health & Illness*, 22 (2000).

[6] See: The Nitobe Garden (5.1.2).

suggested that I seemed to have had a "conversion experience".[7] I felt deeply in love and loved in return with an ultimacy and intimacy I have never recaptured with the same intensity or for that duration of time.

In significant ways, this event and my study of it ended my education in counselling psychology before its completion, and my career before it began for I no longer believed in what I was doing. The lengthy education I was completing failed to address the glaring issues of disenfranchisement, injustice and loneliness that too often formed the baseline of those I would earn a living helping. My Master's dissertation concluded that unless I was actively engaged in community building and justice making for those who came for help with their stories of abuse, oppression and abandonment, I too would be contributing to their burden. But this still did not dissuade me from the best part of fifteen years of front line work with the "mentally ill" that has been rewarding *and* traumatizing as well as morally distressing, leaving my initial conclusions intact. For, there can be little doubt that the mental health professional, *not* the vulnerable help seeker, is by far the primary beneficiary of the therapeutic relationship.

I might be accused of pursuing an academic question that my education and clinical work would seem to have already answered. Yet the question driving this thesis still stands and the imperative remains unanswered: What *must* I do, *can* I do, in the light of this wonder-full other? This question floats in the wake of individual, professional and systemic failure, and in the indifference and violence born of the reductive clinical environment and my collusion in it. My failure, *this* failure to respond adequately to the ethical call of wonder must not preclude an attempt to discern its greater meaning, and to radically challenge and change the status quo and to go further.

1.3 From the mystical to the wonder-full
Two years into this thesis, I shifted my focus from the mystical to the *wonder-full*, having originally planned to continue the work I had started in my Master's dissertation.[8] This was not a simple shift but it has allowed me to trace the development of my work over time and

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[7] William James discussed conversion and offered descriptive and analytic narratives to account for this experience. Of interest is the notion of "self-surrender" as opposed to a "volitional" approach to this extraordinary event. See: W. James, *The Varieties of Religious Experience* (Cambridge, MA: Harvard University Press, 1985), pp. 228-39.
[8] See: C. Racine, 'Loving in the Context of Community Mental Health Practice: A Clinical Case Study and Reflection on Mystical Experience', *Mental Health, Religion & Culture,* 17 (2014).

to defend my original construal of this "opening" as a mystical experience. As we shall see, the "mystical" is arguably already colonized in clinical praxis and unable, or less able, to reflect the focus of this study on the ethical *relationship*.

1.3.1   Naming the event in the Nitobe Garden

The event in the Nitobe Garden had no name within the sphere of counselling practice. I called it the "third thing" until Walter Stace's *Mysticism and Philosophy* identified it as an "extrovertive mystical experience". [9] This "type" is emotional, typically spontaneous, experienced through the senses—or in more contemporary terms, "embodied"— where, as Stace observes, *a unity* is "seen through a multiplicity". [10] By which he means that opposites appear *identical* to each other while maintaining their own substance and individual identity. This description confirmed my own experience of seeing another as my *self* not just as "a series of words," by which Stace presumably means not as an illusion or metaphor, but as something I "physically saw" which had been "shocking". [11] In contrast is the intellectual or speculative "introvertive" type, acquired "calmly" through spiritual practice and inward looking, "in the darkness and silence," where "the One" is perceived and is "united with it". Although these "types" are differently apprehended, either one enables an individual to realize the "Unity of the One". [12]

The issue of self-authentication is still controversial, however, even among mystical scholars. [13] Yet, *The Nitobe Garden* certainly describes a "wonder-full" event in terms defined by philosopher Martyn Evans, [14] or feminist theologian Mary-Jane Rubenstein, whose work we will discuss later in this inquiry. It could also qualify as a "peak experience" defined by

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[9] The extrovertive and introvertive types, defined by Stace, generally conform to kataphatic or apophatic mysticism respectively. The former refers to an emotional or spontaneous type, the latter to an intellectual or cultivated type. See: W.T. Stace, *Mysticism and Philosophy* (London: Macmillan, 1961), pp. 44-65.

[10] Ibid. p. 61.

[11] Ibid. p. 65.

[12] Amy Hollywood contends that separating the apophatic and kataphatic types pits the rational intellect against the subjective and affective, which are better understood as a continuum along which an individual may move in either direction. Stace's own bias for the "calm" more evolved expression of extrovertive mystical experience reflects the ongoing pre-eminence of scientific rationalism. See: A.M. Hollywood, 'Beauvoir, Irigaray, and the Mystical', *Hypatia,* 9 (1994).

[13] For a description of four current theoretical approaches to mysticism see: L. Nelstrop, K. Magill, and B.B. Onishi, *Christian Mysticism: An Introduction to Contemporary Theoretical Approaches* (Surrey, England: Ashgate, 2009), pp. 1-20.

[14] H.M. Evans, 'Wonder and the Clinical Encounter', *Theoretical Medicine and Bioethics,* 33 (2012).

humanist psychologist Abraham Maslow[15] or conversely, as some kind of pathology or dissociative state.[16] What is certain is that this coup-de-foudre has no simple niche or definition within the clinical encounter.

1.3.2 Dumbing down the mystical

Evelyn Underhill's seminal work on mysticism[17] and William James' analysis of religious experience[18] further corroborated my original construal of *The Nitobe Garden* as a "mystical" experience. These were among the first contemporary works on mysticism produced mainly between 1890 and 1970, a period that coincided with the emergence of the psychology of Freud, Jung, and James himself.[19] As I was to appreciate only much later, these pioneering authors had distilled and interpreted but a fraction of the literature emerging from the Christian mystical tradition. This left our contemporary understanding of the mystical stripped of much of its historical and political significance, leaving it all too predictably and worryingly reduced to an anomaly for one's private enjoyment.[20]

The focus on the mystical as "experience" remains problematic in clinical literature because this kind of apprehension was often understated—or not even mentioned—in the accounts of early mystics. The origins of mysticism emerge from the work of an unknown writer named Dionysius the Areopagite, who produced a body of texts composed in the fifth or sixth century that continues to inform our interest in mysticism today. Dionysius is wrongfully accused, Mark McIntosh asserts, of moving the early practice of mystical theology to our more modern understanding of an individual ecstatic experience we call "mystical". This is not to be confused with the real meaning of ekstasis (ecstasy), which was "a standing outside oneself to be all the more available to the beloved".[21] The rapturous

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[15] A.H. Maslow, *Religions, Values, and Peak-Experiences* (Columbus: Ohio State University Press 1964), pp. 59-68, 84-96.

[16] The concern about mis-diagnosing religious or spiritual states as pathology, was addressed by a group of researchers who called for greater sensitivity and training for "spiritual emergencies". See: D. Lukoff, F. Lu, and R. Turner, 'From Spiritual Emergency to Spiritual Problem: The Transpersonal Roots of the New DSM-IV Category', *Journal of Humanistic Psychology,* 38 (1998).

[17] E. Underhill, *Mysticism: A Study in the Nature and Development of Man's Spiritual Consciousness* 5th edn. (London: Methuen, 1914).

[18] W. James, 'The Varieties of Religious Experience', pp. 413-68.

[19] D. Cupitt, *Mysticism after Modernity* (Malden, MA: Blackwell, 1998), p. 26.

[20] Grace Jantzen takes particular exception to James' approach to mysticism as an "experience" and criticises his work for its lack of depth and context. See: G. Jantzen, 'Mysticism and Experience', *Religious Studies,* 25 (1989), 295-302.

[21] M.A. McIntosh, *Mystical Theology: The Integrity of Spirituality and Theology* (Oxford: Blackwell 1998), p. 49.

beauty of Dionysius' language still offers a clue to the remarkable appeal of the mystical to psychology and the project of mental health:

> The divine longing (theios erõs) is Good seeking good for the sake of good. That yearning (erõs) which creates all the goodness of the world preexisted superabundantly within the Good and did not allow it to remain without issue…this divine yearning brings ecstasy so that the lover belongs not to the self but to the beloved.[22]

Mysticism was, however, part of a larger, communal and coherent context and focussed on a life-long commitment to rigorous spiritual practice and asceticism. The path to the knowledge of God was through the arduous journey of purgation, illumination and contemplation, or union, with God. A more accurate description of "mysticism" might be understood as "contemplation," which "in earlier eras referred to the most intimate and transforming encounter with God," while the term "mysticism" is described as "something of an academic invention"[23]. Other accounts describe mysticism as "a part or element of religion…as a process or way of life…an attempt to express a direct consciousness of the presence of God".[24] Mysticism also describes a quality of consciousness that "allows us to see the mystical element of religion as a process, a form of life, and not merely as a matter of raw experience, even of some special kind".[25] Another scholar adds that affective mysticism represents "a particular form of discourse…a source for doing theology…a certain type of knowing…a kind of intersubjectivity, and a set of texts from a variety of traditions requiring a complex hermeneutics".[26]

1.3.3   *Misappropriating the mystical in clinical praxis*

In stark contrast is the clinical perspective of those researchers who deserve considerable credit for attempting to negotiate mystical experience into clinical literature in order to address their own concerns about its reduction in praxis. These are also early days in the development of such scholarship, consequently, we find mystical "experience" being

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[22] Ibid.

[23] Ibid. p. 11.

[24] B. McGinn, *The Foundations of Mysticism* (New York: Crossroad, 1991). pp. xv-xvi.

[25] B. McGinn, 'Mystical Consciousness: A Modest Proposal', *Spiritus: A Journal of Christian Spirituality,* 8 (2008).p.50.

[26] J.K. Ruffing, in *Mysticism and Social Transformation,* ed. by J.K. Ruffing (New York: Syracuse University Press, 2001). p. 1.

"operationalized"[27] by researchers who unwittingly, if not unwillingly, continue to dilute and decontextualize this one aspect of mysticism.[28] Such is the case in Ralph Hood's mysticism scale, based on Stace's work,[29] and in newer versions of similar scales where researchers use words like "exceptional" to describe this experience.[30] Other clinical literature still uses William James' four main characteristics[31] to identify mystical experience in individuals who might otherwise be at risk of being mis-diagnosed,[32] nor is this an insignificant concern when the larger community is deprived of such a vision.[33]

Still other research shows the divided and polemical scholarship on the issue that tends to fall roughly into three camps: Those who do not recognise any overlap between the pathological and the spiritual, those who pathologize *any* spiritual experience, and those who tend to see all pathology as spiritually based.[34] The latter would include proponents like psychiatrist R. D. Laing and others like him connected to the anti-psychiatry movement. The problem is that neither spiritual experience nor its psychopathology or even "psychosis," as these researchers contend, are sufficiently well defined. Indeed, these terms change in significance and meaning from one context to another.[35]

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[27] This is a term used "[i]n research design, especially in psychology, social sciences, life sciences, and physics" to define "a fuzzy concept…to make the theoretical concept clearly distinguishable or measurable…in terms of empirical observations". See: <http.//en.wikipedia.org/wiki/Operationalization.> [accessed 30 July 2016], (para. 1 of 14). This term is also disparaged by Martyn Evans. See: H.M. Evans, 'Reflections on the Humanities in Medical Education', *Medical Education,* 36 (2002). p. 509.

[28] The constraints imposed on such research by the dominant research paradigm are discussed by researchers who appear to bend over backwards to defend their use of *any* qualitative measures in their "scientific" work. See: N. Kohls, A. Hack, and H. Walach, 'Measuring the Unmeasurable by Ticking Boxes and Opening Pandora's Box? Mixed Methods Research as a Useful Tool for Investigating Exceptional and Spiritual Experiences', *Archive for the Psychology of Religion/Archiv für Religionspychologie,* 30 (2008).

[29] See: R.W. Hood, Jr., 'The Construction and Preliminary Validation of a Measure of Reported Mystical Experience', *Journal for the Scientific Study of Religion,* 14 (1975). For an example of literature informed by this measure see: K.R. Byrd, D. Lear, and S. Schwenka, 'Mysticism as a Predictor of Subjective Well-Being', *The International Journal for the Psychology of Religion,* 10 (2000).

[30] N. Kohls and H. Walach, 'Exceptional Experiences and Spiritual Practice: A New Measurement Approach', *Spirituality and Health International,* 7 (2006).

[31] Ineffability, noesis, transiency and passivity.

[32] See for example: F. Ng, 'The Interface between Religion and Psychosis', *Australasian Psychiatry,* 15 (2007); C.C.H. Cook, 'Psychiatry and Mysticism', *Mental Health, Religion & Culture,* 7 (2004). Also: S. Mohr and others, 'The Assessment of Spirituality and Religiousness in Schizophrenia', *The Journal of nervous and mental disease,* 195 (2007). For more discussion and literature on this subject see also: S.J. Ziguras and G.W. Stuart, 'A Meta-Analysis of the Effectiveness of Mental Health Case Management over 20 Years', *Psychiatric services,* 51 (2000), 110-11.

[33] C.C.H. Cook, 'Psychiatry and Mysticism', p. 154.

[34] The terms "spiritual" and "mystical" are often used interchangeably in the literature.

[35] M. Jackson and K. Fulford, 'Spiritual Experience and Psychopathology', *Philosophy, Psychiatry, & Psychology,* 4 (1997).

Psychological research on mysticism also fails to recognize the political analyses of those postmodern philosophers whose interest in early mysticism pointedly explores an apprehension capable of transcending the subject-object distinction.[36] This distinction is one we wish to address in our inquiry, for it concerns the seemingly intractable issue of how to extricate the "object" from the reductions of the "subject". In this case, the object is the vulnerable help seeker and the subject is the clinician who observes, distances, labels, objectifies and in some real ways *owns* the object of her scrutiny.

I am suggesting that the cataclysm described in *The Nitobe Garden* was, twenty years ago, reasonably construed within psychological praxis as a "mystical experience". An emerging thread of "transpersonal" psychology,[37] investigating the nature of consciousness as it relates to "self-discovery and transformation,"[38] further corroborated my understanding. At that time, several researchers in this field were also attempting to introduce "mystical experience with psychotic features" (MEPF)[39] into the DSM IV[40] to stop this "experience" from being pathologized.[41] Transpersonal psychology now appears to have been assimilated by the current explosion of research on spirituality, religion and health—including mental health—by a growing legion of researchers worldwide.[42]

Divested of its religious historical context, social and culture roots and spiritual practice connected to community life, our notion of the mystical has been significantly eroded and reduced. Equally, the canon left behind by those wanting to put their "mystical" apprehensions into language is conspicuously absent in the clinical literature. Consequently,

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[36] This is analysed by theologian Grace Jantzen, whose feminist analysis draws on a number of post-modern thinkers, especially Luce Irigaray, to formulate an argument for the divinization of the immanent and embodied that is relevant to our concerns about the vulnerable-help seeker. See: G. Jantzen, *Becoming Divine: Towards a Feminist Philosophy of Religion* (Manchester University Press, 1998).

[37] For a good synthesis of this field, see: D. Raab, 'Transpersonal Approaches to Autoethnographic Research and Writing', *Qualitative Report,* 18 (2013), p. 2.

[38] Ibid. p. 17.

[39] D. Lukoff, F. Lu, and R. Turner, 'From Spiritual Emergency to Spiritual Problem: The Transpersonal Roots of the New DSM-IV Category', p. 26. See also: D. Lukoff, 'The Diagnosis of Mystical Experiences with Psychotic Features', *Journal of transpersonal psychology,* 17 (1985), pp. 160-66.

[40] The DSM is The *Diagnostic and Statistical Manual* of *Mental Disorders*, published by the American Psychiatric Association (APA) and is the diagnostic "bible" of psychiatry.

[41] D. Lukoff, F. Lu, and R. Turner, 'From Spiritual Emergency to Spiritual Problem: The Transpersonal Roots of the New DSM-IV Category', p. 26.

[42] American psychiatrist Harold Koenig's phenomenal contribution to the classification and meta-analyses of hundreds of studies of research related to the field of spirituality, religion and mental health has undoubtedly put this field of endeavour on the map. H.G. Koenig, D.E. King, and V.B. Carson, *Handbook of Religion and Health* (New York: Oxford University Press, 2012); H.G. Koenig, M.E. McCullough, and D.B. Larson, *Handbook of Religion and Health* (New York: Oxford University Press, 2001).

the focus on mystical "experience" in psychological literature is exceptionally problematic. Ever more tightly tied to the *patient* and pathology, or its absence, mysticism's vital ethical and political implications have been lost to us.

1.3.4 The possibilities of wonder

By relinquishing the mystical in favour of wonder, I hope to avoid any interpretation of the "event" under consideration as a self-centred consumable or even an anomalous "experience" of interest to the help seeker *or* the clinician. I also hope to sidestep the contentious discussion connecting mystical experience with pathology now occurring in the burgeoning field of spirituality, theology and mental health. Other related debates I wish to avoid include the turf wars between clinicians and clerics engaged in territorial disputes about spirituality and religion. Where, for example, such questions as to who may or may not pray with or for a patient are creating a furore.[43] These issues are important but have no place in our study, for the interests of that field are largely focussed on recognizing and mobilizing the impact of spirituality and religion on the well-being of the help seeker. In contrast, this study comprises an ethical inquiry arguing *against* the legitimacy of community mental health care as an institution. This is an argument that calls for a radical re-ordering of the construct of mental illness and the urgent need for the clinician to recognize and *resist* the profound injustice in which she colludes.

The work of philosopher Martyn Evans also influenced my decision to shift from the mystical towards wonder, for I discovered my own concerns and argument for mysticism reflected in his work on *Wonder and the Clinical Encounter*.[44] Informed by clinical ethics and philosophy allied to the medical humanities and my own interests, Evans' scholarship and his compelling invitation offered another way forward:

> No one has attempted any sustained analytic discussion on the clinical relevance of wonder, nor exploration of the ethical or aesthetic aspect of wonder in relation to medical practice from the perspective of either the clinician or the patient.[45]

The work of physician and specialist in narrative medicine, Rachel Remen, further supported my shift from mysticism to wonder.[46] Remen has written on wonder and

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[43] At one conference I attended, an irate mental health chaplain informed a psychiatric nurse that if she could administer spiritual care, then hospital chaplains should be allowed to administer hypodermic medication.
[44] H.M. Evans, 'Wonder and the Clinical Encounter'.
[45] Ibid. p. 124.

contributed to the development of values-based medical curricula for American doctors. Her work clearly supports an investigation of wonder as something of specific value to mental health professionals' practice and ethical education.[47]

The challenges of developing a definition for wonder with clinical and ethical relevance are still complex, but even if—like "mystical experience"--the notion of wonder has become banal in contemporary vernacular, it is also less arcane. Moreover, wonder is gaining traction in the medical humanities at the University of Durham, which additionally reflects and supports the ethical, political and autoethnographic interests of this study.[48] Of particular benefit to our study is that unlike the mystical, wonder appears – for now – to have eluded the defilement of science's reductive grip, while hopefully remaining enigmatic enough for our purposes.[49]

1.4 The body of this inquiry

I have divided the thesis into two sections. The first half illustrates and grounds the ethical issues of concern and defends the autoethnographic approach taken in the thesis. The second half offers an ethical analysis of these concerns through a discussion of wonder and the work of Emmanuel Levinas. The following sections offer a brief synthesis of each of the eight chapters.

1.4.1   Chapter 2. James' Story

The occurrence narrated in *The Nitobe Garden* reached its moral culmination many years later through a career-altering clinical relationship with a troubled youth whose story takes up the whole of chapter 2. James' circumstances and my response to him allowed me to finally "see" the extent to which I was—or had become—morally hobbled in fearing, fleeing, oppressing and reducing a defenseless youth.

James' story provides the bridge between my Master's work and this thesis by introducing the main themes related to social justice, the transcendent, love in clinical care and

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[46] Remen writes movingly about her own wonder-full experience as a woman living with Crohn's disease. See: *The Holy Shadow* in: R.N. Remen, *Kitchen Table Wisdom: Stories That Heal* 10th edn. (New York: Riverhead Books, 2006), pp. 245-51.

[47] B. Kligler and others, 'Core Competencies in Integrative Medicine for Medical School Curricula: A Proposal', *Academic Medicine*, 79 (2004), 523-24.

[48] See website: <https://www.dur.ac.uk/cmh/> [accessed 30 July 2016].

[49] I am grateful to Professor Martyn Evans for suggesting the term *defilement* to describe the outcome of scientific reduction on the ineffable and the vulnerable help seeker.

responsibility for the help seeker. The narrative was developed over a period of several years, first as a conference paper and later as a published article.[50] In terms of Michael Taussig's brilliant Marxist deconstruction of mental health care, the transformation of theory to reality, of human to commodity, of oppression to pathology, and suffering to symptom, is fully illuminated in *James' story*.[51]

1.4.2   Chapter 3. Three opponents of wonder

There are many ethical obstacles in the practice of community mental health care and I focus on three in chapter 2 to highlight what I perceive as the most prominent. The first, *medicalization*, describes the eroding boundaries of psychological normalcy and well-being that are becoming increasingly reduced and subsequently manufactured and imposed as illness and pathology. The second, *asymmetry*, describes the fundamental inequality of the clinical relationship that subordinates the vulnerable help seeker to the clinician and the institution. Lastly, *dehumanization,* describes the types of institutional and social discrimination suffered by the vulnerable help seeker in every facet of her life.

These three factors also contributed to my decision to employ the term "vulnerable help seeker" that is used throughout this study to identify the person who might be variously identified as the patient, the client, the service user, the mental health consumer or even the stakeholder. This term acknowledges the work of theorists, like Frank Reissman, who argued persuasively for a reconfiguration of the services paradigm to address the problem of asymmetry and its "sequelae". This would certainly include the sobering concern of "iatrogenic difficulties" to which the help seeker is predictably exposed.[52] Reissman claimed that resistance to change is great because an industry like community mental health care is "based on systemic knowledge and scientific methodology". Hence, professional help becomes "*a commodity to be bought, sold, promoted and marketed,*" evidence of which is "always there—and typically ignored".[53] This leaves the help seeker vulnerable not only to the emotional suffering and circumstances of her life, but to the clinical environment to which she must turn for help.

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[50] C. Racine, 'Loving in the Context of Community Mental Health'.

[51] See: M.T. Taussig, 'Reification and the Consciousness of the Patient', *Social Science & Medicine. Part B: Medical Anthropology* 14 (1980).

[52] F. Riessman, 'Restructuring Help: A Human Services Paradigm for the 1990s', *American Journal of Community Psychology*, 18 (1990), p. 222.

[53] Ibid. p. 226.

1.4.3   Chapter 4. Autoethnography: An invitation behind the mask

A clinician may not easily admit that the relationship considered so essential to the "therapeutic alliance" and the interests of the vulnerable help seeker is equally, or possibly *more*, important to her in terms generally related to ideas of kinship, tenderness, intimacy, cherishing—love. Not, that is, without impugning her ethics and judgement, or risking her position and professional entitlement. This, however, is precisely what I propose may be best examined through the autoethnographic lens employed throughout this inquiry.

In re-orienting this inquiry towards the wonder-full, I turn to memoir and narrative to examine the sense of professional guilt that emerged so predominantly in *James' story*. Professor Martyn Evans' use of personal vignette in his work also supported my decision to employ this approach, as did the increasing legitimacy of narrative in ethical research, given the power of self-reflexivity to mediate the problems of representation.[54] It was autoethnography's unapologetically political and moral orientation, however, that finalized my choice.

1.4.4   Chapter 5. Wonder and the turn towards the divine

The chapter on wonder initially appeared to demand a daunting synthesis of 2000 years to trace the origins of European philosophical thought through the rise of religion, the origins of mysticism, the enlightenment and finally the domination of the scientific. I have reduced my ambitions to five sections that examine the notion of wonder from various angles. The chapter begins with a brief introduction to wonder's genealogy before moving on to its etymology and the examination of a limited number of emerging themes. These are analysed in a section on praxis and wonder that explores the congruence of wonder to the therapeutic relationship. I also consider a number of definitions forwarded by contemporary scholars who are attempting to revive and re-define wonder, although their perspectives also diverge significantly. The chapter concludes with a preliminary clinical definition for wonder that critically engages with the work of Martyn Evans.

1.4.5   Chapter 6. Levinas and the wholly/holy other

In Emmanuel Levinas, I have found a teacher whose ethical vision confirms the value of this study and my own lived experience. Levinas raises our understanding of responsibility to a

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[54] A defense of the vignette as a legitimate form of autoethnography is examined in: M. Humphreys, 'Getting Personal: Reflexivity and Autoethnographic Vignettes', *Qualitative Inquiry*, 11 (2005).

level previously unconsidered, the accuracy and power of which are astonishing. This responsibility does not constitute the imposition of a morality argued through the logic of justice, fairness and mutuality. Instead, it "approaches" through the tender and imperious call of *desire* from this vulnerable "other" that overwhelms me. Levinas himself remains empty-handed on *how* to implement his ethics of first philosophy. Yet, his vision confirms a perspective of the vulnerable help seeker as i*nfinitely* elevated beyond the objectifying grasp of the clinician.

Here, then, is the final justification of an argument for wonder that Levinas helps us claim and which confirms what it can mean to be rendered incapable of referring to the self and its self-interested project, if only briefly. Levinas evokes the thrall of wonder that interrupts the "I" in its acquisitive and appetitive pursuit of knowledge and its own self-project. He does so by confronting—in this case—the clinician with the ultimate paradox of the vulnerable help seeker who incredibly and disarmingly welcomes *her*, serves *her*, heals *her*.

1.4.6   Chapter 7. The possible or impossible of Levinasian praxis

It is ironic that mental health professionals, not infrequently and with considerable frustration, may wind up trying to convince the distressed and inwardly focussed help seeker that her symptoms and diagnoses—no matter how dire—are actually secondary in importance to living her life. Thus, the help seeker can be admonished for failing to take adequate responsibility for learning and adhering to sensible and consistent regimes of self-care including, of course, compliance to medication. Such is the institutional sleight-of-hand that re-creates an individual in its own image only to reprimand her for being inadequate.

In this penultimate chapter, we examine a number of approaches to consider what Levinas' project might look like "in practice". We begin with an analysis of the work of Canadian humanitarian Jean Vanier and his life-long engagement in living with and supporting the interests of intellectually disabled adults. I also explore the overlap between Vanier's and Levinas' vision to illustrate an approach to care that recognizes the enormous significance of the vulnerable help seeker *to the helper*.

The last half of this chapter focuses on the emergence of Levinasian thought in the therapeutic dialogue and explores the salience of his work for this purpose. Some of these approaches show promise, but the problem of theorizing Levinas' ethical formulation and

the ongoing debate of how we can adequately interpret his ethical vision, leaves the successful application of his thought in some question.

1.4.7   Chapter 8. The politics of need and desire

The earnest search for a solution to the problem of clinical reduction and the issues of asymmetry, medicalization and dehumanization is an intriguing one. All the more so when it leaves the clinician believing that her ability to show the vulnerable help seeker more authentic kindness, compassion or, in Rogers' terms, *empath*y, is sufficient to the task. Yet, any attempt to bridge the disturbing gap between the clinician and the help seeker appears to be consistently and resolutely beyond reach.

In our concluding chapter, I examine and interpret this issue in some detail by casting back through our inquiry to discover the presence of a fascinating artefact. It attests to the apparently indomitable resilience of clinical reduction that ethicists and researchers continue to oppose and subvert, although still unsuccessfully. This is the artefact discovered in the conflation of abuse with even the possibility of intimacy which leaves the clinician forever thwarted. For, as we shall see, even the culture of community mental health care that argues so fluently for the ethical protection of the vulnerable help seeker must inevitably put its own considerable interests *first*.

Chapter 2.
James' Story

Vulnerability doesn't mean that anything personal goes. The exposure of the self who is also a spectator has to take us somewhere we couldn't otherwise get to. It has to be essential to the argument, not a decorative flourish, not exposure for its own sake.[1]

When we met, James was almost 19 and profoundly suicidal. He had been hospitalized when he told his father his fantasy of killing both his parents and then himself. He watched violent films, played violent video games with his friends, slept half the day and abused marijuana. Unable to concentrate or cope, he dropped out of a computer program at a local technical college, and was unemployed and living at home with his father and brother. By the time our work began, he had spent twenty days in the adult psychiatric ward of a large local hospital. This is a long time for a young man to spend watching adults play out the shattering consequences of the kind of future one might prefer to avoid. He had also experienced his first coercive treatment when he was sedated and placed in isolation at the beginning of his hospital stay.[2]

I remembered the room well from a visit to the emergency psychiatric department of the same hospital. A colleague had taken me to meet one of the referring psychiatrists as part of my orientation when I started working in community mental health. The psychiatrist had shown me the "quiet room" with a single hospital bed mattress lying forlornly on the bare floor of a small, dim, windowless room that locked. Not long after our tour, it was apparent that the "quiet room" now occupied a distressed woman, and she screamed for the duration of our interview. She screamed as though she was being tortured. I startled slightly in my chair with each fresh explosion of harrowing sound that filtered through the door of the office where we sat, while the psychiatrist continued talking as though nothing was happening and my colleague suppressed a small smile. It was a whiff of Bedlam I will never forget. Not infrequently, people I worked with who had spent time in that room expressed

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[1] R. Behar, *The Vulnerable Observer: Anthropology That Breaks Your Heart* (Boston: Beacon Press, 1996), pp. 13-14.
[2] The human rights violations of the "mentally ill," according to some, include the issues of forced hospitalization, isolation and physical or chemical restraints. For arguments supporting these practices see: S. Klag, F. O'Callaghan, and P. Creed, 'The Use of Legal Coercion in the Treatment of Substance Abusers: An Overview and Critical Analysis of Thirty Years of Research', *Substance Use & Misuse,* 40 (2005). For arguments opposing these practices see: M. Sjöstrand and G. Helgesson, 'Coercive Treatment and Autonomy in Psychiatry', *Bioethics,* 22 (2008).

such horror at the possibility of being sent back there that they would refuse hospital assistance.[3] Of course, they were not always given a choice.

Clinical files were doled out at team meetings twice a week when new cases were presented by intake nurses and, sometimes under duress, assigned to clinical staff already staggering under caseloads beyond their capacity.[4] I had established a minor reputation for taking cases no one else wanted and offered to take James' following the long silence in the room after his file was presented—no one wanted it and it was a very difficult file. There were many reasons for my magnanimity, especially my relief at being back in the role of therapist and my desire to prove my legitimacy by working with those among the least favoured in clinical practice.[5]

My first job in this community mental health centre had been intake. It was demanding work and essentially a triaging position that required I separate out those who qualified for service from those who didn't. The reality was much more complicated and deeply fraught because the primary task of intake was essentially that of gatekeeper. The intake clinician stood between those desperate souls trying to be accepted for service and the various, and often fluid, "mandates" of the various teams within the Centre that had to be constantly negotiated.

Further complicating the picture was the priority given those who were being discharged from hospital to our community mental health centre. The demand for care far exceeded our capacity. My intake colleague and I were refusing up to seventy percent and more of all requests for service while attempting to support those we turned away, either by counselling them on the phone or seeing them if they showed up in person at our door.

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[3] Many more were discharged directly from psychiatric emergency to our centre than were admitted for hospitalization. Not infrequently, clinicians urged patients to return to hospital if, in the opinion of the clinician, they had been prematurely discharged from hospital.

[4] For an analysis of the response of health workers to trauma see: S. Collins and A. Long, 'Too Tired to Care? The Psychological Effects of Working with Trauma', *Journal of Psychiatric and Mental Health Nursing,* 10 (2003). Two types of burnout are identified as emotional exhaustion and depersonalization, the latter being related to "feeling cynical about clients' success". See: S.W. Kraus and C.H. Stein, 'Recovery-Oriented Services for Individuals with Mental Illness and Case Managers' Experience of Professional Burnout', *Community mental health journal,* 49 (2013), p. 8. See also: C.H. Stein and S.A. Craft, 'Case Managers' Experiences of Personal Growth: Learning from Consumers', *Community mental health journal,* 43 (2007), p. 184.

[5] See: D. Markham, 'Attitudes Towards Patients with a Diagnosis of Borderline Personality Disorder': Social Rejection and Dangerousness', *Journal of mental health,* 12 (2003). For a brief description of epidemiology, diagnosis and causal factors see: K. Lieb and others, 'Borderline Personality Disorder', *The Lancet,* 364 (2004), pp. 453-55.

Suggestions would be given, resources and phone numbers offered and some kind of plan suggested, which would be carefully documented. If the individual showed up again or deteriorated and came back through their physician's office or the hospital, or if they complained to the manager about being refused service, there had to be a paper trail. This would confirm that the institution and clinician were not responsible, or irresponsible, and *had* done what was legally defensible despite the refusal of service.

Intake was traditionally a nursing stronghold that had been challenged by a maverick manager at our Centre who believed a change of the old guard was needed. He had hired me as clinical counsellor along with a social worker to take over the two intake positions shortly before his retirement. The backlash was brutal and the rift between nursing staff and other clinical professionals became ever more acrimonious. It was a situation for which my intake colleague and I were scapegoated for being in positions we—apparently—had no right to hold.[6]

Three months after later, the day my probation period was over, I wanted to bring a cake to work to celebrate with my new colleagues but thankfully never did. That was the day I read with incredulity an email that the nurses had circulated to every staff member concerning a meeting to discuss their collective outrage about the recent intake hires—my social worker colleague and myself—to which they had invited the head of their nursing union. The meeting room was jammed the afternoon of the meeting, the door closed, the halls empty, while the two-woman intake team got on with a job that would have been better managed with an additional staff member. The meeting and the cries of incompetence about a non-nursing intake team failed to move the manager and he dug in his heels. A number of the nurses later suggested he was so out of touch he was likely dementing. Dementing? What were they saying about me? I knew what some of them were saying about the patients I presented at intake meetings, and not only the nurses, other clinical staff as well.

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[6] Literature investigating conflict within multidisciplinary teams shows how professional groups assert and protect their professional identities and theoretical approaches. See: B. Brown, P. Crawford, and J. Darongkamas, 'Blurred Roles and Permeable Boundaries: The Experience of Multidisciplinary Working in Community Mental Health', *Health & Social Care in the Community*, 8 (2000). Given the preponderance of nursing staff in mental health teams, other professionals may report feeling isolated or silenced because they are outnumbered. According to one study: "An intriguing finding is the readiness for some clinicians to establish for themselves a mandate to critique their colleagues ... by exploiting a perceived position of power to expose these perceived faults in practice". See: A. Jones, 'Multidisciplinary Team Working: Collaboration and Conflict', *International Journal of Mental Health Nursing*, 15 (2006), p. 26.

Coming into a government paid job from the non-profit sector had almost doubled my salary over-night but the price was steep. I ruefully remembered my joy a few weeks in when I approached the manager to express my pleasure with the work and the fascinating challenges it provided. His measured smile and quizzical response, "Wait a while," had proved all too prophetic. Several years later I was finally given a counselling job on the ASTAT team, and two nurses were moved back into their "rightful" positions on intake.[7] My social worker colleague had long since moved on to safer pastures in another team within our centre. It was an immense relief for me and a reclamation victory for the nurses. Even the messiest cases failed to daunt me after that and I may well have aligned myself with the most unwanted, having made it through the fire of my own professional ostracization. James himself was nothing if not an outsider.

During his hospitalization, James had been assessed by a psychiatrist, tested by a psychologist and been later referred to the outpatient Early Psychosis Intervention (EPI) program, for yet another psychiatric assessment with a specialist in psychotic illness. James met the mandate for the program, having never been prescribed antipsychotic medication, and was sent for follow-up with the EPI social worker who worked on our team. The hospital work-up he had received was intensive and extensive but ultimately vague. The sheer volume of documentation, filled with conflicting assessments and narratives speculating about an 18 year-old young man with no previous history of mental illness, was bewildering. This psychiatric hash would follow him the rest of his life and be damning should he ever need to defend himself legally or find himself dealing with any number of situations requiring evidence of a mental health history. Beyond that, what would it do to his sense of self?[8]

When James was discharged from hospital he had been advised to go home and monitor himself for signs of psychosis. This is remarkable advice given the assumption that a labile 18 year-old using recreational drugs, and suicidal, would be capable of determining such

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[7] ASTAT: Adult Short Term Assessment and Treatment (Team).
<http://www.health.gov.bc.ca/library/publications/year/misc/Continuum_Community MHAServices.pdf,>
p. 5. [accessed 30 July 2016].
[8] The mental health consumer/survivor movement identifies the traumatic impact of being "treated" as a mental patient as so damaging that there can be no "return to a pre-illness state". L. Davidson and others, 'Recovery in Serious Mental Illness: A New Wine or Just a New Bottle?', *Professional Psychology: Research and Practice*, 36 (2005), p. 481.

symptoms let alone responding to them responsibly by seeking out medical help. When we met, James still had no idea what he should be looking for symptomatically. I remember the shadow of fear on his face when he asked me what he should be looking for and I outlined my own understanding of psychosis, especially its connection to marijuana abuse in youth.[9]

The combined diagnoses from the three respected specialists who had assessed him were all but meaningless. They ranged widely from major depression and anxiety to prodromal or early psychosis through to borderline or possibly antisocial personality disorder or features, complicated by marijuana abuse. His interest in speaking about philosophical matters had also been duly noted, and patronized, as intellectual posturing. Following his hospital stay James never did follow up with the EPI clinician on our team. Instead, he stopped his medications and dropped out of a system too overwhelmed to notice or care, only to re-emerge three months later when he became suicidal once again. This brought him back to hospital and to our mental health centre where he was assigned to me. By then he had also started to use LSD regularly with his girlfriend, a fact he willingly shared to my enormous chagrin for it added more risk to this already suicidal youth and his predisposition to psychosis.

James intimidated me from our first handshake. He was tall, raw boned, ashen, unkempt. He was aloof, emotionally flat and answered questions in monosyllables with a fixed gaze and glacial disdain. James had felt neither understood nor valued from his first encounter with the mental health system. Our initial meeting was another opportunity for him to confirm what he already knew about a chaotic and ineffective service. He'd been asked the same questions too often by too many people and invaded, observed, assessed, judged, labeled and incarcerated with too few results. He scoffed at questions about how homicidal he might actually be and denied a history of self-harm but admitted spending time as a boy

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[9] A meta-analysis of research on cannabis as a risk factor for schizophrenia, or schizophrenia-like symptoms, indicates a "three-fold" increase in pathology. See: D.M. Semple, A.M. McIntosh, and S.M. Lawrie, 'Cannabis as a Risk Factor for Psychosis: Systematic Review', *Journal of Psychopharmacology*, 19 (2005), p. 191. One study of 216 people showed that, three months following discharge from hospital for psychotic illness, one fifth of the cohort was non-compliant with medication, the strongest predictor being substance misuse. See: M. Olfson and others, 'Predicting Medication Noncompliance after Hospital Discharge among Patients with Schizophrenia', *Psychiatric Services*, 51 (2000), p. 221.

tearing the wings off bees to watch their behaviour. He blandly claimed his suicidality was insignificant which alarmed me greatly given the deadly statistics.[10] I hoped he was bluffing.

Halfway through our first meeting I knew beyond all doubt that I did not want to work with James. He scared me half to death but finding someone else to work with him would be tricky. He was a hot potato given the lack of follow-up he'd received that had enabled him to slip away only to be brought back through our doors via the hospital for a second time, and now he was really high-profile. Not just because he was at such high risk but because our centre had failed to keep tabs on him and there was no more margin for error—we would be liable if anything happened to this kid.

A community mental health centre can be likened to a M.A.S.H. unit with limited resources and staffing, and incoming wounded attended by whoever can handle the next casualty.[11] If a help seeker didn't like the clinician she had been assigned she would be likely pathologized, viewed as demanding or shown the door but never offered the luxury of another choice. Nor could a clinician easily pass on a file. It simply wasn't done and I had never attempted to negotiate such a manoeuvre, but this was different. Being afraid of a client would be a frank admission of professional inadequacy, although the "danger card" could be played but not easily in this case as James had not actually done anything, yet.

There was little love lost between the line manager and a great many of us who reported to her. She was in over her head and might have thrived as a bedside nurse but was not well suited to her job in this pressure-cooker and managed her anxiety by micromanaging the rest of us. I approached her and casually explained my wish to transfer the file. Without missing a beat she looked up coolly from her desk and told me I was welcome to trade the

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[10] Following accidental death, suicide is the leading cause of death among young men worldwide, the numbers being likely "substantially underestimated". See: A. Pitman and others, 'Suicide in Young Men', *The Lancet*, 379 (2012), p. 2383-84. Interestingly, "psychiatric diagnosis is a weak predictor of suicide," although attempts by psychiatric patients are generally "interpreted as irrational" and related to their clinical profile. Attempts in non-clinical populations are differently interpreted; a "temporary imbalance of mind" being only one of many possibilities. These authors also suggest that, "psychiatric patients might, for very good (rational) reasons, feel devalued and disabled". They also claim that attributing suicide to mental illness hides the larger social issues and the responsibility for "a range of public policy factors…in relation to primary prevention". This includes the need to address "the lax prescribing of psychiatric drugs by the medical profession [that] increases suicide rates". See: A. Rogers and D. Pilgrim, *A Sociology of Mental Health and Illness* (Maidenhead, England: Open University Press, 2010), p. 208. Suicide among borderline patients may be as much as 50% higher than in the general population. See: K. Lieb and others 'Borderline Personality Disorder', p. 453.

[11] MASH designates the Mobile Army Surgical Hospital; an allusion to the film and popular American television series based on a novel of the same title: R. Hooker, *Mash: A Novel About Three Army Doctors* (New York: HarperCollins, 1997).

file with whoever on the team might be willing pick it up. Checkmate. I tried half-heartedly to talk to a couple of colleagues about a trade but knew it wouldn't fly. Everyone was maxed out and nobody was going to pick up a file like this. I talked to two trusted colleagues about the matter and decided to try again, there remained one faint hope.

Typically, psychiatric nurses were assigned people with a history of schizophrenia or bipolar disorder with mania—those who were or had been floridly psychotic. Such patients were higher up the ladder of pathological legitimacy as opposed to those dealing with "acute situational stressors" who were generally seen by the counsellors. [12] I pressed my advantage and informed my line-manager that James' case was not a good fit because it meant "working outside of my scope of practice". This was double-speak intended to remind her of those professional limitations of the institutional hierarchy from which she benefitted more as "medical" staff than I did and that were to my ethical credit to respect. To disregard them placed her in an ethically compromising bind.

I stood in my line-manager's office looking over her shoulder while she flipped through James' file. "It's a dog's breakfast," she said, and grudgingly agreed to pass the file on to a nurse who unexpectedly left the following week for another position. The file bounced back to me, there was nothing to be done, but psychosis was the least of my worries. Here was an unknown teenager with no previous psychiatric history and an inconclusive diagnosis following a lengthy stay in hospital. Against his will, he had been certified and hospitalized for expressing an interest in killing his family and himself and according to one assessment, might have an "anti-social or borderline personality disorder". [13]

James was now using LSD in addition to having a long-standing marijuana habit and could deadpan a seasoned professional for an hour with spine-tingling effect. He knew exactly

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[12] The ranking of mental illness in order of importance and legitimacy is complex and a key issue concerns personal control. Psychosis, for example, is viewed as beyond an individual's control and consequently more legitimate than even the most devastating emotional fall-out suffered by those dealing with acute situational stressors—including historical trauma and loss. This legitimacy is further supported by the "medical" nature of "serious and persistent mental illness" (SPMI) and its treatment with anti-psychotic medication.

[13] Anti-social personality disorder is one of the best predictors of violence, particularly when diagnosed with substance abuse. Even then, "accurate prediction is impossible" especially in the case of a poorly defined diagnosis like James,' while psychosis itself is *not* a strong predictor of violence. These authors also note the spectacular inaccuracy of mental health professionals in predicting dangerousness. The possibility of human rights infringement is a given with such predictions along with the implications of social control and policing that "some professionals worry… is incompatible with a caring and therapeutic role". See: A. Rogers and D. Pilgrim, 'A Sociology of Mental Health and Illness', pp. 205-12.

how to express in few words a brooding ambivalence towards a system of care that, far from helping, had wasted his time and diminished him as a human being. He was a loose cannon I had done everything possible to avoid for fear that he might be a danger to me, find out where I lived, come to my home or kill himself on my watch.[14] There was no choice but to confront this spooky kid who was young enough to be my grandson.

James had no good reason to like me given my failed attempt to have his file transferred. I soft-pedalled my embarrassment the day I invited him into my office for our second meeting to explain that the nurse who was to have taken over his case had actually left our Centre. James eyed me levelly, silently. He had been passed around from one professional to another since his first contact with the system. Everyone had listened for there is nothing quite like a homicidal and suicidal youth to capture professional attention but he had not been heard. He stonewalled for the first several sessions and resisted my every attempt to leverage a connection. It was a standoff and the tension was palpable.

The day I dropped all pretence of professional equanimity and reached out to James to reveal myself I felt utterly reckless. I acknowledged my part in the mismanagement of his case as someone who represented the gross inadequacy of a system that sustained me at his expense. I confirmed his experience, and apologized sincerely for what he had been through and confessed I was deeply concerned he would kill himself. I admitted I had no idea how to proceed in the face of his impassive defense. I appealed to him to tell me what he needed, or thought he needed, and talked for a long time until I felt he could really see me.

My attempt had the desired effect of thawing his façade. But what was I really inviting him to do? Trust me? To what end and for whose purpose? Almost immediately, his flat-eyed impassivity fell away. I was unprepared for the speed with which he met my appeal in his eagerness to get on with the project he wanted so badly to share. Soon his sessions were saturated with references to his search for the ultimate meaning or essence of life, his growing interest in Buddhist practice and his aspirations to greatness. He wanted to be a

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[14] The death of a counsellor murdered in the parking lot of his workplace by a former client in the Vancouver area in 2005 shocked the clinical community. While such incidents are *very* rare, they stoke the historical and still widespread fear of people with mental illness, especially psychotic illness, as dangerous, even among clinicians. See: <http://www.cbc.ca/news/canada/british-columbia/mental-health-worker-killed-1.532535> [accessed 30 July 2016].

philosopher, a mathematician, a physicist, a linguist, a musician, but could hardly get out of bed in the afternoon.

His journals revealed his thoughts at that time.

> I think the reason everything is so visually appealing is because I'm seeing everything in my patterns. Life is an infinite amount of continuous patterns being projected onto our brains at the speed of light. Is there a negative infinity? If I stay alive I will eventually discover the secret of the universe because I see the patterns.

He also documented his self-loathing, rage, terror, and his desire to share his unique perspective with someone who could understand. "Is it too late for me… [w]ill uncertainty claim my mind as it has the uncertain world?"

James wasn't interested in talking about how he "felt" about symptoms or suicide, about what may or may not have been troubling him or even the story of how he had come to be where he was now. He was not interested in falling into line, playing the patient role or talking about his suffering and he didn't complain, ever. When he did speak of such things, it was always in the service of his larger interest, his obsession to know. My appeal to James had not so much resulted in increasing his trust in me as a therapist but according to his purpose, in recognizing me as possible mentor or colleague. I was someone who presumably had greater knowledge by virtue of my age and profession, someone who might support his quest because it was the only one of possible interest or merit. James was without pretense, undefended and unwilling to hide for any reason. His candor combined thoughtful maturity with innocence and urgency. It unsettled me for he never sought the advantage and he addressed me as an equal. His transparency contrasted with the opacity of the shield behind which I hid and sometimes cowered. If he was guileless, he was also intellectually and emotionally subtle, profoundly interested in his own psychological process and in sharing it with someone who might help him decode his experience.

James attended his first psychiatric interview at our Centre carrying a book by Kant, which he lacked the concentration to read. The psychiatrist was a sixty-year-old man and veteran in the field. He asked James to extemporize on his reading and waited a long time for James to answer, while I witnessed the humiliation of a fragile youth who sat dumbly in his chair looking at his feet. Only minutes before he had been animatedly describing to me his passion for philosophy. At the end of this assessment, the psychiatrist put James on a high dose of anti-depressant and a modest dose of antipsychotic.

Previous assessments from the hospital had alluded to the "pseudo-intellectuality" of this eighteen year-old youth but it was a stunning indictment of one so young whose vocational orientation, it seemed to me, spoke through his desire. From my perspective, he was earnestly seeking answers to big questions with no immediate means of finding them let alone the concentration to do so. No one had considered that he might be following the first inarticulate murmurings of a calling to philosophy or theology or psychology. Or, as Jungian therapist James Hillman might suggest, that he was practicing what he might later become.[15] James' wish to be identified as someone interested in philosophy had not been considered as a possible way out of his suffering or an innate gift that might be productively fostered.[16] Instead, it was interpreted as something phoney and insincere that needed to be rooted out, labelled and justifiably shamed. Within such an environment James' attempts to connect with something greater than himself could only be seen as suspicious, transitory or incidental, hardly life-affirming or transformative. No one had championed his impassioned inclination towards the wonder-full but it seemed his relentless pursuit of something beyond himself or its pursuit of him had been his saving grace.

I sat and witnessed James' humiliation by the psychiatrist that day without a murmur, watched his intellectual and spiritual blistering at the hands of a man three times his age. After the consultation, we walked back to my office to finish the session. I did not tell him the psychiatrist had been wrong, disgraceful, to treat him that way. I smoothed it over, only implying as much without actually holding the psychiatrist accountable in the name of professionalism lest James tell him, sometime later, what I had said.

While intrigued by James' outpouring I was still guarded. Was he expressing grandiose ideas, experiencing psychotic delusions, or was this the spiritual outpouring of a troubled youth on a spiritual quest? James ardently sought an answer in Buddhism and early in our work together told me that he had gone to a Buddhist temple close to my home to explore meditation. I fervently hoped he did not know that this was my neighborhood or that I lived in a ground floor apartment and slept with the window open. Yet, I could not discount that this gray-faced youth, so incapacitated by "mental illness," was prepared to spend five

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[15] J. Hillman, *The Soul's Code: In Search of Character and Calling* (Warner Books New York, 1997), p. 35.

[16] Chris Cook claims that "the relevance…of mysticism to psychiatry extends beyond issues of diagnosis and treatment" and that "[w]here this is denied, and where psychiatry colludes in pathologizing such experiences, the whole community is the poorer as a result". See: C.C.H. Cook, 'Psychiatry and Mysticism', p. 160.

hours alone on a return bus trip to engage in conversations about consciousness and meditation with Buddhist monks he had never met.

James had no formal religious background but knew that what he was pursuing involved an ultimate revelation of love. He called it by many names—cosmology, metaphysical passion, the essence of life, God, and preferred not to label it too closely. I wondered if his experience met the criteria for extrovertive mystical experience[17] or possibly exceptional experience.[18] His obsession drove him, gave his life direction and purpose.[19] Burdened as he was, James also seemed remarkably free, immune to the cultural and symptomatic evidence of his own pathology in his flight towards something greater than himself. It was as if he had walked through the wrong door looking for help with something else but having nowhere else to go, and finding something of possible benefit to forward his project, he stayed and asked for further direction.

James asked pointed and personal questions about my own spiritual practice, experience, reading and beliefs for clues to his next step and I felt self-conscious responding to his queries, afraid of influencing him and of revealing my own ragged spiritual history. It was a two-faced timidity, given my clinical carte blanche to interrogate him on the most intimate details of his life—his past, his thoughts and habits, and to influence him unequivocally in staying the course on a "treatment plan" over which he could have very little say. That plan, however, was to provide guidance on issues related to symptom management and future "functionality," not the possibility of a spiritual awakening. I evaded James' forthright questions, counselling him instead to look for spiritual mentors and communities of practice. I printed out a long list of Buddhist communities in the city and gave it to him. I urged him to move in the direction of higher education believing as I still do that he was gifted and would excel academically despite his problems with concentration and his own

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[17] For an analysis of "extrovertive" and "introvertive" mystical experience, see: W.T. Stace, 'Mysticism and Philosophy', pp. 49-66. For a clinical perspective of Stace's theory detailed in a measure for "mystical experience," see: R.W. Hood, Jr., 'The Construction and Preliminary Validation of a Measure of Reported Mystical Experience', pp. 31-32.

[18] More recent work on such experience is found in: N. Kohls and H. Walach, 'Exceptional Experiences and Spiritual Practice: A New Measurement Approach'.

[19] These authors examine the positive impact of mysticism that arguably fits into the much larger body of research on spirituality, religion and mental health. See: K.R. Byrd, D. Lear, and S. Schwenka, 'Mysticism as a Predictor of Subjective Well-Being'.

vocational moratorium. But, moving too closely to his spiritual search, immersing myself in his quest made me uneasy. Why?

It would mean stepping beyond the boundaries of my professional role. Although, I was well aware of the emerging literature on spirituality, religion and mental health and the benefits it was claiming,[20] the questions it was raising and the controversies it was igniting.[21] Yet, I doubted my ability or my right to engage with James honestly and deeply about spiritual matters. Beyond that, how could I even be sure I would not be feeding into his illness[22] or engaging with some darkness knit permanently into his psychological make-up that he might be using to manipulate me?[23] He was enigmatic, difficult to read despite his candour and had a very particular way of expressing himself verbally.

Within my work, I balked constantly at the pathologizing machine of the institution that defeated unusual or untypical ways of being or perceiving. Yet, this machine mesmerized me and justified my vigilance given the possibility of danger, which I could never entirely discount. This machine justified my collusion with medical protocols that not infrequently appalled me and endorsed a professional façade meant to reassure and support, but that hid my vulnerability and outrage. I was protected from the need to speak or act against the

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[20] Harold Koenig highlights the strong positive correlation between "religiosity and spirituality" and mental health regarding the many emotional benefits suggested by such research. See: H.G. Koenig, 'Research on Religion, Spirituality, and Mental Health: A Review', *Canadian Journal of Psychiatry,* 54 (2009). A contentious debate, initiated by Koenig, suggests it is appropriate and desirable for a psychiatrist to pray with his patients if requested to do so. H.G. Koenig, 'Religion and Mental Health: What Should Psychiatrists Do?', *Psychiatric Bulletin,* 32 (2008), p. 203.

[21] My reticence was informed by many factors, including the kinds of ethical questions raised in the prayer debate and a fear of transgressing professional boundaries. Nonetheless, the humanist focus of my counselling education had emphasized the almost sacred intimacy of the client-counsellor relationship and examined ideas about the transcendent. See: G. Egan, *The Skilled Helper: A Systematic Approach to Effective Helping* 4th edn. (Belmont, CA: Thomson Brooks/Cole Publishing 1990). See also: A.H. Maslow, 'Religions, Values, and Peak-Experiences'.

[22] The presence of spiritual and religious content in psychotic delusions is well established and of interest to researchers attempting to differentiate between legitimate religious or mystical experience and pathology. Jackson and Fulford suggest three current schools of thought representing both pro and anti-psychiatry biases identifying those who do not recognise any overlap between the pathological and the spiritual, those who pathologise any spiritual experience and those who see all pathology as being spiritually based. M. Jackson and K. Fulford, 'Spiritual Experience and Psychopathology'. See also: C.P. Heriot-Maitland, 'Mysticism and Madness: Different Aspects of the Same Human Experience?', *Mental Health, Religion & Culture,* 11 (2008).

[23] See: M. Zimmerman, L. Rothschild, and I. Chelminski, 'The Prevalence of DSM-IV Personality Disorders in Psychiatric Outpatients', *American Journal of Psychiatry,* 162 (2005).

system in which James was now caught, and guilty of safeguarding my professional position and hiding my private self.[24]

James' process intrigued me at first but eventually it thrilled me, given the profundity of his insight and my own interests in the clinical implications of mysticism – of actually "seeing" the help seeker in the special way James appeared to be apprehending his own world. It felt exploitative to mine his perspective, yet to ignore, downplay or pathologize his process denied him the most life-affirming theme in his story that I also counted on to help keep him alive. Caught within the machine of mental health care, James' plight confirmed what I had long believed was the brutalizing and assimilating folly of our institutional approach to emotional suffering. More distressingly, it denied James' wonderful *vision* and the implications of what I was then calling "mystical experience" as a larger possibility for our approach to psychological distress.

With our work now underway, James agreed to take the prescribed medication[25] and attended his appointments with me promptly if not eagerly, as if what was on offer might actually help him in his quest of spiritual discernment. "Yes, and the sooner the better," was his standard reply to my inquiry about his interest in coming back the following week to talk some more. I experienced that answer with a sting of shame because he was offering so much more than I could return. He was ablaze and I was warming my bloodless hands at his fire.

I asked him to report on his suicidal feelings each time we met, which to my chronic apprehension did not abate for several months. "Are you suicidal James? Is it better or worse than last week? Please tell me. Have you got a plan? Come on James, give. A place? A time? Don't look at me like that, this is serious. Do you know the risk of using LSD and being suicidal and mildly psychotic? Do you? Are you taking the antidepressants? Do you think they're helping? What about the anti-psychotics? No, stay on them, don't mess with

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[24] The need for greater mutuality and honesty on the part of clinicians regarding their own "roadblocks to change" is discussed in: S. Mead and M.E. Copeland, 'What Recovery Means to Us: Consumers' Perspectives', *Community Mental Health Journal*, 36 (2000), pp. 320-21. The issue of mutuality is not easily resolved within an unequal power structure despite Rogers' claim to the contrary. See: Reciprocity and mutuality (5.6.3). See also: C. Racine, 'Loving in the Context of Community Mental Health', p. 116.

[25] Patients with a good "therapeutic alliance" with their clinician are much more likely to remain medication compliant, which ironically may compromise a person's health and well-being. See: M. Olfson and others, 'Relationship between Antidepressant Medication Treatment and Suicide in Adolescents', *Archives of General Psychiatry,* 60 (2003), p. 219.

them. This is not funny. Yes, it does matter. On a scale of one to ten, tell me James, tell me". It was the same mantra I repeated for weeks. "If you think you're getting close you can tell your dad, or call your mom, or call me, or go to Emergency, or call Afterhours, or call 911 or just get in a cab and get to the hospital. Ok? Promise me. PROMISE me!"

I wanted to be there to catch him should he ever fall out of that tree but there was no guarantee. He would not die, I hoped. I worried about the medication hurting him, worsening his suicidal feelings,[26] numbing him, contributing to his suffering, but said nothing. How could I? These were a doctor's orders. My ambivalence to James' medication was also driven by my own self-protective fear. I really couldn't tell if I wanted him to live as much – or more – for my sake as for his. If the drugs kept him alive, even if everything else about them was wrong, they could be justified.

As our relationship developed, it became apparent that James had found a place where he could discuss his "metaphysical passion" and be himself. This situation rewarded but also haunted me because James felt so isolated. Though socially well connected to a group of childhood friends, he felt his consuming interest in "cosmology" contributed to his loneliness and his ability to connect meaningfully with others his age. He could not speak easily about his inner world to his contemporaries who lacked his perspective and who did not share his values. He played along wishing to belong, but saw through the game and had little heart for it. He was comfortable talking to adults and described himself as a freak, as someone who needed to hide to fit in, which seemed manipulative and troubled him.

While relieved and somewhat puzzled to witness James' imperviousness to clinical indoctrination I was discomfited by his lack of guile that made him look like an innocent treading trustingly through an institutional minefield about which he had no understanding. Protecting him from this environment was no simple matter. While attempting to straddle the diverging mandates of professional and personal ethics, I found

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[26] The question of SSRIs (Selective Serotonin Reuptake Inhibitors) contributing to an increase in completed suicides among youth remains contentious and inconclusive. One study found "there was no statistical difference in crude suicide rates among patients assigned to SSRIs, other antidepressants, or placebo". See: A. Khan and others, 'Suicide Rates in Clinical Trials of Ssris, Other Antidepressants, and Placebo: Analysis of Fda Reports', *American Journal of Psychiatry,* 160 (2003), p. 791. Another study looking exclusively at youth, funded by major pharmaceutical companies, highlights the difficulty of determining to what extent antidepressant medications can even reduce suicidality. See: M. Olfson and others 'Relationship between Antidepressant Medication Treatment and Suicide in Adolescents', p. 980.

small comfort in recognizing I could do neither well. It was confusing to feel so ethically compromised by stepping even slightly outside my professional role. I resisted the constant urge to tell him to trust no one, including me. But as our conversations evolved I became increasingly aware of the disquieting joy I felt in my growing recognition of James as a spiritual friend on a journey not dissimilar to my own.

The day James arrived in my office with religious tracts given to him by one of the monks at the Buddhist temple, my wariness of this young seeker suddenly seemed grotesque. He handed the literature over for me to look at and solicit my advice. James' fragility and terrifying proximity to suicide contrasted with the immensity of his wholeheartedness, his raw courage and determination to find answers he knew must be out there. His defenselessness was flawless; a deep mirror that finally, that day, captured and exposed my fraudulence as I confronted what appeared to be the superior moral integrity of this boy.

Clumsily, fearfully, I began to share what knowledge I had of spirituality and mental health, of Buddhism, of my own fragmented meditation practice and religious uncertainty, knowing I was leaving behind a familiar approach to therapy that left me sitting on the edge of my chair. It was a tipping point that stripped away the final vestiges of a professional identity I had questioned for years and would never reclaim. There was no sense of elation, freedom or even appropriateness in this choice that felt more like letting-go than a decision. I could not do it anymore. If this move was intended, even partially, to shield James from the risk of harm by the system, it also shifted the risk to me alone. I was still afraid for him and myself, only now I was the main threat.

From then on, the focus of our conversation was his pursuit of the wonder-full and my attempt to remove any impediments from his trajectory. I sought to help him plan his future and encouraged him to explore his experience and purpose during our sessions. I constantly urged him to think about higher education. I also urged him to join a meditation community rather than practice on his own, concerned as I was that solo practice could put him at further emotional risk,[27] but he disregarded my direction. Soon after, I decided that the

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[27] The literature examining the benefits of mindfulness meditation as an adjunct treatment for physical and psychological dis-ease is extensive and well established. See: J. Kabat-Zinn, 'Mindfulness-Based Interventions in Context: Past, Present, and Future', *Clinical Psychology: Science and Practice*, 10 (2003); J. Kabat-Zinn, *Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness* (New York: Dell, 1990). Two recent studies suggest evidence supporting the therapeutic use of mindfulness training with people dealing

benefits of introducing him to the Buddhist community to which I belonged outweighed the dangers of the professional boundary violation.[28] I spoke to him about attending a weekend retreat with me and ensured his father knew where he would be and we exchanged home phone numbers, another taboo. I also knew I would never chart the event, nor did I.

The night I drove James to his first Buddhist meditation retreat at the local university in the hopes of helping him find a spiritual community, another significant professional boundary was crossed. His pallor and the flatness of his affect worried me. He asked if he could put the car seat back so he could rest. He was exhausted for reasons I did not understand. He looked so unwell. I reflected on the legal implications of transporting a "patient" in a vehicle un-insured for such purposes and drove with not a little fear. We arrived at the meditation hall where I shepherded him through the registration process before we settled for the evening into the cavernous space of the University of British Columbia's Asian Centre. Meditators sitting on the floor or in chairs, some already with their eyes closed, surrounded us. James sat down beside me in lotus position with the ease of a skilled practitioner. When the meditation teacher walked by the following day I eagerly introduced James to him and explained that I had brought James to connect with the community, hoping this world-renowned teacher[29] would confirm the importance of James practicing with others. Meditators as young as James are valued and supported in this community. Instead of agreeing with me, this man smiled kindly at James and assured him that he had much to gain by meditating alone.

As we left the retreat, I asked James if he was experiencing hallucinations and he calmly described how the sidewalk seemed to undulate and break up before him as he walked on it.

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with psychosis. See: P. Chadwick and others, 'Mindfulness Groups for Distressing Voices and Paranoia: A Replication and Randomized Feasibility Trial', *Behavioural and Cognitive Psychotherapy*, 37 (2009); P. Chadwick, K.N. Taylor, and N. Abba, 'Mindfulness Groups for People with Psychosis', *Behavioural and Cognitive Psychotherapy*, 33 (2005).

[28] A.A. Lazarus, 'How Certain Boundaries and Ethics Diminish Therapeutic Effectiveness', *Ethics & behavior*, 4 (1994). A thoughtful argument on the difference between dual relationships and exploitation is found in: K. Tomm, 'The Ethics of Dual Relationships', *The California Therapist*, 5 (1993). A literature review on the subject of dual relationships examined the complexity and ambiguity of this issue and concluded that: "[w]hat one professional may deem as appropriate behaviour, another professional may view as a boundary violation". See: S.M. Moleski and M.S. Kiselica, 'Dual Relationships: A Continuum Ranging from the Destructive to the Therapeutic', *Journal of Counseling & Development*, 83 (2005), p. 8.

[29] Joseph Goldstein is one of the founders of an influential Buddhist teaching centre, the Insight Meditation Society that operates out of Barre, Massachusetts. See: <http://www.dharma.org/meditation-retreats/retreat-center> [accessed 30 July 2016].

It was not what I wanted to hear. Months later he explained how the meditation had helped him learn to observe and recognize his own delusional thinking which reduced his fear when such experiences occurred. He also believed the marijuana and LSD had been primarily responsible for altering his mind and for opening it to a source of understanding he now craved.

Throughout that weekend, I was vigilant and unsettled about my decision, about James' wellbeing and how far beyond the boundaries of my institution I had strayed. I felt awkward engaging with James outside the confines of my professional role that left me feeling strangely alienated from him. Who was this young man to me outside my counselling cell? What did I owe him? Why was I doing this? How could I see him, adequately or at all, beyond the organizing principle of our therapeutic relationship? What was the benefit to me? I was risking so much for what? I felt more like an anxious parent than an experienced therapist. Yet, I knew I wanted to protect him and help him. I saw the awe-full beauty of his quest, of his pursuit of the transcendent, of his own transparent nature, of his physical being and his goodness. In that seeing was such love and a wrenching sense of responsibility that I owed this young man, this boy, something that I could neither fully determine or pay.

Despite our rocky start, James made astonishing progress in the first several months of our work together. He stopped using cannabis and LSD. He stopped watching violent videos and began spending more time outside on his bicycle. He was amenable to participating for a while in a college preparation course. He began to change physically, the colour in his face returned, his skin took on a youthful lustre, his interest in killing himself eased and he found part-time work. Wanting to be sure he was experiencing no further thought disorder, I had him assessed by the staff psychologist who agreed that while James had a unique perspective and way of expressing himself verbally, there appeared to be no evidence of any psychotic process. During that time, James also maintained a meditation practice but preferred to meditate alone.

Remarkably, the significant gains James made in such a short time were never lost. There is no way of knowing how the many variables involved contributed to his rapid improvement. His recovery was even more astonishing given the stolid reality of the institutional

environment and the truth of Hillman's observation that, "[of] all of psychology's sins, the most mortal is its neglect of beauty".[30] Nonetheless, James' relentless search flourished and with it, the many decisions he made to turn his life around. Through his struggle, he emerged like a young Atlas carrying the weight of his addicted, disconnected, materialistic culture, his parents' broken marriage, his vocational uncertainty and a profound loneliness not easily understood or addressed within our community-riven culture. He stood in my doorway illuminating the destitution of my professional world, revealing the enormity of my privilege, including my relationship with him, and the paucity of what I had to offer within my professional role.

Ultimately, it seemed to me that my most important task was to help James recognize and reclaim his place in the human community. I wanted him to grasp that we—the world around him—needed him to join us for his own benefit, certainly, but even more pressingly for *ours*. In one of our final meetings logic spun on its head the day I carefully explained to James that the very system he had approached for help was the same one that created and maintained his sense of exile – both inside and outside institutional walls. He listened carefully, quietly, the day I played that card, placed the final revelation of institutional complicity in his hand. "Do you understand me, James? Do you understand what I'm saying?" He was so young. Yet, even with this confession, I could not sidestep my personal role in his alienation despite what had been my best intentions and many attempts to subvert and resist the institution. Paradoxically and painfully, my sense of guilt was further complicated by the very love that had emerged and driven my desire to keep him safe and help him understand and touch the transcendence he sought.

I had walked—or tried to walk—a tightrope between my fear of oppressing him professionally or exploiting him personally. The joy of witnessing the lovely arc of this young man's repeated attempts at flight towards something beyond—from which I profoundly benefitted— had called forth my love, the fierce desire to protect him, and the stinging recognition of my own loneliness. It was only much later that I would grieve, turning to a mentor to help me unpack this thing. I had done nothing wrong had I? Had I? I was not comforted by the reassuring words. I know what the path to hell is paved with and

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[30] J. Hillman, 'The Soul's Code: In Search of Character and Calling', p. 35.

that within my institutional and professional roles I would always be culpable of keeping the best for myself, no matter what I did. How could it be otherwise? From whatever angle I tried to "protect" James, I would always come out on top.

About a year after our initial meeting, I transferred to another community mental health centre to work part-time while I grieved the death of my mother and began preparations to pursue PhD studies at Durham. I asked a trusted colleague on my team to work with James in my absence. When I returned to my position months later, I resumed my connection with James for another few months. My colleague informed me that James had approached a Buddhist community and requested admission to train as a monk but had been refused by temple staff as he was still under the care of mental health and on medication.

James was transformed. He had matured and was more self-contained, and bore himself with immense dignity. He was even more articulate than the last time we had met and I could see how well he was. James was now 21 years old. His suicidality had resolved but remained, in his words, "ideologically interesting". The diagnosis of early psychosis never manifested into schizophrenia. When he was finally weaned off his medications and his file closed, the psychiatrist who had first treated James with such disdain seemed deeply impressed with James' quiet confidence during the final consultation. He later commented with amazement that James appeared to have the poise of a man twice his age. By then James was well enough to move out of his father's home and was living for the first time on his own. He was eager "to be of value to his employer," he said, despite the superficiality of his work environment in a restaurant and the indifference of his manager. He said he was "practicing confidence," working on his anger, trying to learn gratitude. He explained that he wanted to stay open and undefended when someone was mean to him. He was intentional in his efforts to cultivate himself and presented with the equanimity of a Buddhist monk, relaxed, easily moved to laughter and quick witted.

James also talked about his loneliness, how it embarrassed him, and his wish to understand it better. As for his future, he explained that "the essence of life" that he pursued so ardently was all he wanted to do with his life. But he had no idea how to translate this into practical action, or a career path, and he still struggled with what he perceived as the freakishness of this passion. "No James you're wrong," I countered. "This is a great gift, and you must

cultivate it, there are many things you can and must do with this. Many people have built their lives writing and teaching about this very thing. Go to school and study anything – math, philosophy, physics, music, languages. Any of those paths can get you there, but you must study". I told him that keeping this passion to himself was like hiding his light under a bushel. He had no real sense that his knowledge, his courage and his quest might be of benefit to someone else or that it had already been of tremendous benefit to me, although I had told him so more than once. He also knew that I had written a paper about him and presented it in Durham shortly before my final departure to the United Kingdom to begin PhD studies. After the conference and my return to Canada, we sat in my office and I read the paper aloud to him while he listened. It was not enough, but it was something and I was overjoyed to give it to him. I think he understood the homage.

Whether James might be described as a young mystic or simply a young man whose porous nature and experimentation with drugs facilitated his profound apprehensions of something beyond, his emergence within my Centre and my practice was epic. James' overwhelming desire to know and to love and his keen sense of being onto something of great import had immunized him against the influences that so easily entrap individuals connected with community mental health care away from their sense of agency and potential. Equally, his vision and courage in reaching for the transcendent had illuminated how far I had strayed from my most cherished values as someone who had wanted to be a healer.

When we met again for the first time after my year's absence from the Centre, shortly before his final discharge, I teasingly asked James if he was still passionately committed to finding the essence of life. He had looked at me with some impatience and said with utter conviction, "C'mon Catherine, we're all looking for that".

2.1 Conclusion

Through the alchemy of my relationship with James, I saw not for the first time but at last, that no amount of "professional" or "clinical" compassion or empathy could ethically balance the injustice at the core of my clinical work. Nor, could it begin to address the many spurious arguments in which the massive structure of community mental health care is so deeply entrenched.

The autoethnographic approach I have employed in this chapter and throughout the rest of this inquiry, speaks to the epiphanies evoked by wonder in clinical care and to the complexity and messiness of the many ethical issues it raises. Most of all, this narrative approach has helped illuminate my own active role in perpetuating the suffering and oppression of those seeking community mental health care. This is the suffering related to the disadvantaged lives of a large portion of the cohort "served" by community mental health, and amplified by the type of "care" offered there. This is also the suffering, which over the course of more than two decades I have witnessed, benefitted from, colluded in and endured as a professional and a student.

Chapter 3.
Three opponents of wonder:
Medicalization, asymmetry and dehumanization

[T]he doctor's ten-thousandth patient needs and deserves the same recognition of his common humanity and the same hushed acknowledgement of his tender fragility as does her first patient. These needs inhere in all patients equally, regardless of their personal qualities.[1]

3.1 Introduction

The importance of reverencing the vulnerable person who reaches out to community mental health care for help in understanding and healing the chaos and anguish of her life may not be overstated. But what does this reverence comprise? For reverence is not easily found or expressed in the clinical bustle of a large community mental health centre, given the relentless pressures and competing ethical demands exerted on the work-lives of clinicians. These pressures, as we shall see, are morally eroding, traumatizing, exhausting and put clinicians at considerable risk of harming the very people they are there to help.

In this chapter, three impediments—opponents—to ethical care will be examined both narratively and theoretically to analyse how they shape the assumptions and behaviours of clinicians. We wish to understand their contribution to the de-moralization of the clinician, to the proliferation, misunderstanding and mismanagement of "mental illness" and, most importantly, to the global dehumanization of the person labelled in this way.

We begin with an examination of medicalization and a provocative debate on "medical imperialism" forwarded by sociologist Philip Strong. In reflecting on the concerns of such imperialism, Strong took his own field to task for speaking out of both sides of its mouth, for criticizing medicine while enjoying the status that medicine conferred. This debate has implications for the critique I am attempting as a professional in the "allied health field" of counselling psychology, given its connection to medicine and the medical model within community mental health

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[1] H.M. Evans, 'Wonder and the Clinical Encounter', p. 128.

care. The examination of medicalization will be followed by an analysis of asymmetry and the unresolved problem of institutional hierarchy. This, of course, describes not only the imbalance of power between the clinician and the vulnerable help seeker, but also among professionals within the mental health team. Finally, we will consider the prevalence and meaning of dehumanization by examining the problems of infra-humanization, stigmatization and the "heart-sink" patient before concluding with a reflection on the dehumanized clinician.

To begin, however, I will provide a brief overview of the system of community mental health care and the influences that have helped move psychiatric care from the asylum to the community.

3.2 What is Community Mental Health Care?

In British Columbia, Canada, community mental health care is a provincial service employing a case management model within freestanding day clinics, or outpatient clinics attached to hospitals.[2] Case management, has been described as "an attempt to overcome deficiencies in community care…due to fragmented service systems and lack of continuity of care".[3] People attending community mental health services are often multiply disadvantaged and in need of many services, from life-skills coaching and dentistry to housing and employment, all of which extend far beyond the treatment of their psychological issues. Others are referred directly from the hospital psychiatric ward, and a primary function of community mental health centres is to keep people *out* of hospital. While there are various types and styles of case management, what they typically share in common is a multidisciplinary team approach.[4] According to one dated account, this approach appears to have changed very little in the past 45 years, although there has been a significant increase in para-

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[2] This discussion is confined to the systems and issues related to my own work environment. It would be fair to say that provincially funded community mental health facilities employing a case management model would share many commonalities represented and problematized in this inquiry.

[3] S.J. Ziguras and G.W. Stuart, 'A Meta-Analysis of the Effectiveness of Mental Health Case Management over 20 Years', p. 1410.

[4] S. Ziguras, G. Stuart, and A. Jackson, 'Assessing the Evidence on Case Management', *The British Journal of Psychiatry,* 181 (2002), p. 20.

medical staff.[5] In contemporary community mental health settings, psychiatrists, general practitioners, psychologists, clinical counsellors, social workers, occupational therapists, psychiatric nurses, mental health support staff, administrative staff and others, typically work as a "team" under one roof.

The "case manager" is the clinician who over-sees and co-ordinates the care of any given individual receiving service and is typically a psychologist, a clinical counsellor, a social worker or a psychiatric nurse, as was the case in my community mental health centre. The case manager is responsible for assessing the help seeker's psychosocial needs, for individual care planning, and for making referrals and linking the help seeker to appropriate services or supports. This includes monitoring the help seeker's progress with respect to the established care-plan, her mental state and her compliance with medication and its side effects. The case manager is also responsible for advocacy, for establishing and maintaining the therapeutic relationship and, depending on her education, for offering therapy.[6]

Although caseloads may vary from one community mental health centre to the next, case managers in my Centre carried caseloads of 30 to 40 files or more of varying acuity and complexity. Often, help seekers were already connected to multiple services within the community. Depending on her education and role within the team, a case manager might also provide one-on-one or group therapy, psychiatric follow-up and community outreach.

> Mental health centres provide many services including adult community support, adult short-term assessment and treatment, community residential programs, geriatric programs, crisis intervention, day and outpatient programs, addictions counselling, concurrent disorders services[7], group therapy, peer support and after-hours mental health support.[8]

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[5] B. Kenny and T. Whitehead, *Insight: A Guide to Psychiatry and Psychiatric Services* (London: Crom Helm, 1973), pp. 161-67.

[6] S. Ziguras, G. Stuart, and A. Jackson, 'Assessing the Evidence on Case Management', p. 17.

[7] Concurrent disorders are those that include an addiction. A diagnosis of major depression combined with the misuse of alcohol would constitute a concurrent disorder. These diagnoses are highly prevalent in community mental health and complicate the process of diagnosis and treatment.

[8] This description of service provision in community mental health care is from a web page of the Fraser Health Authority of British Columbia. See: <http://www.fraserhealth.ca/your-community/hope/> [accessed 30 July 2016].

Community mental health care employs a medical perspective focussed primarily, although not exclusively, on *underlying pathology*.[9] The pathologizing of mental distress, of course, gives primacy to the function of the doctor, the psychiatric "team" and psychiatric medicine itself. Every person accepted for care in my Centre was assessed by a psychiatrist or general practitioner, diagnosed, prescribed medication and followed-up.[10] *Only* doctors and nurses are involved in prescribing and managing medications, monitoring their effects, or giving injections. This is another reason why psychiatric nurses are near the apex of the team hierarchy, despite having considerably fewer years of education than their colleagues who had Masters' degrees in social work, counselling, and occupational therapy. The significant difference in education, training and professional orientation between medical staff and other team members also creates inter-team conflict and alienation but the primacy of medicine is unequivocal.

Strong's suggestion, that the rise of para-professionals has enabled doctors to "expand their empire while … severely restricting the production of new doctors" was confirmed by the chronic shortage of psychiatric hours available in my institution.[11] Severe doctor shortages in the community also meant it was difficult to find general practitioners to accept people labelled with mental illness as new patients or to find private psychiatrists for those refused service by our Centre.

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[9] Early and current critics have argued against psychiatry's focus on the "symptom," as do many counselling theories and other therapeutic approaches to emotional suffering. Of relevance are the socio-political dimensions of emotional distress examined, for example, by: I. Prilleltensky, 'The Role of Power in Wellness, Oppression, and Liberation: The Promise of Psychopolitical Validity', *Journal of Community Psychology,* 36 (2008). Similarly, feminist therapy seeks to educate and empower the help seeker by focussing on an analysis of power that views symptoms as evidence of *resistance* to the abuse of power, rather than pathology. Consequently, "posttraumatic symptoms are explicitly framed as coping strategies and evidence of clients' attempts to manage intolerable affects and knowledge arising from the trauma". See: L.S. Brown, 'Feminist Paradigms of Trauma Treatment', *Psychotherapy: Theory, research, practice, training,* 41 (2004), p. 465.

[10] Psychotropic prescription drugs are deeply tied to medicalization. Help seekers refusing medication were typically refused service at my Centre given the unstated but clear assumption that if an individual was not sufficiently "ill" to require medication then she, or he, did not require service. The work of prescribing is further complicated by: a) the high incidence of drug and alcohol addiction among the client population, b) the need to re-evaluate and re-calibrate medication initiated by other physicians less experienced with psychotropic drugs and, 3) the help seeker's addiction to anxiolytics or narcotics, which not infrequently begins during a hospital stay and requires clinical intervention.

[11] P.M. Strong, 'Sociological Imperialism and the Profession of Medicine a Critical Examination of the Thesis of Medical Imperialism', *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology,* 13 (1979), p. 210.

While it may be true that para-professionals now fulfil tasks that were formerly under the jurisdiction of the doctor, they remain "firmly under medical control".[12]

3.2.1   The shift from the asylum

The shift from the asylum to community-run clinics is significant and briefly discussed here to offer an historical context. The closure of mental institutions occurred with the emergence of the anti-psychiatry movement. Its chief proponents were vocal, prolific and political in their ambitions to reform mental health care. This movement was represented, among others, by critic Thomas Szasz, an indefatigable intellectual who denied the existence of mental illness over five decades.[13] Although Szasz is criticised for his provocative and flamboyant argumentation, Mark Cresswell underscores the staying power of a thinker who continues to influence contemporary critics of psychiatry.[14] R. D. Laing, another psychiatrist, famously argued that, "paranoid delusions were not signs of an illness but an understandable reaction to an inescapable and persecutory social order".[15] Both Szasz and Laing spoke out against psychiatry, the medicalization of social issues and the abuse of professional power, although from different perspectives[16].

A third psychiatrist and social reformer, Franco Basaglia, was enormously influential in changing the culture of the mental institution.[17] Basaglia's work led to the passing of the Italian National Reform Bill of 1978 that resulted in the dismantling of psychiatric hospitals and the rise of community mental health services in Italy. At the same time, hundreds of psychiatric institutions closed "throughout Europe, New Zealand, and Australia, including many in Ireland and Finland where the highest number of asylum beds were located".[18] Another major

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[12] Ibid.

[13] T. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper & Row, 1974). T. Szasz, 'The Myth of Mental Illness: 50 Years Later', *The Psychiatrist*, 35 (2011).

[14] M. Cresswell, 'Szasz and His Interlocutors: Reconsidering Thomas Szasz's "Myth of Mental Illness" Thesis', *Journal for the Theory of Social Behaviour*, 38 (2008).

[15] D. Rissmiller and J. Rissmiller, 'Open Forum: Evolution of the Antipsychiatry Movement into Mental Health Consumerism', *Psychiatric Services* 57 (2006), p. 864.

[16] D. Double, 'The Limits of Psychiatry', *BMJ: British Medical Journal,* 324 (2002), p. 900.

[17] D. Rissmiller and J. Rissmiller, 'Open Forum: Evolution of the Antipsychiatry Movement into Mental Health Consumerism', pp. 863-64.

[18] Ibid. p. 864.

critic, Michel Foucault,[19] was the only non-psychiatrist whose work still drives the arguments of the most recent wave of psychiatric critics in the Critical Psychiatry Network.[20] All four of these critics, "championed the notion that personal reality was independent from any hegemonic definition of normalcy imposed by organized psychiatry".[21]

Interestingly, psychiatry continues to be challenged by its own and, as Bracken and Thomas ironically note, by the implausibility of an "anti-paediatrics" or "anti-anaesthetics" movement. Meanwhile, the on-going influences of the antipsychiatry and critical psychiatry movements, as well as the movement towards post-psychiatry, continue to assert themselves.[22]

Professionals like psychiatrist Joanna Moncrieff, further endorse the validity of the claims against psychiatry. As Senior Lecturer at University College London and a leading figure in the critical psychiatry network, Moncrieff has spoken out and published widely on the "myth" of a chemical cure for psychiatric symptoms, warning of the limitations and dangers of psychotropic medications.[23] She is but one in an impressive line of psychiatrists who have challenged the institution over many decades. Moncrieff and those who have preceded her may not yet have eliminated a role for psychiatry, but they have certainly, and strenuously, called it into question. The considerable concerns raised and addressed by these reformers and activists, are sobering. They unanimously point to assumptions and practices that still place the vulnerable help seeker at the mercy of a medical machine and the unilateral authority of clinicians who uphold its regime.

3.3 Medicalization

> [A]cademic psychiatry has helped the industry to colonize more and more areas of modern life…Persuading people to understand their problems as

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[19] P. Bracken and P. Thomas, 'From Szasz to Foucault: On the Role of Critical Psychiatry', *Philosophy, Psychiatry, & Psychology*, 17 (2010), pp. 219-20, 23-27.
[20] D. Double, 'The Limits of Psychiatry', pp. 903-04.
[21] D. Rissmiller and J. Rissmiller, 'Open Forum: Evolution of the Antipsychiatry Movement into Mental Health Consumerism', pp. 863-64.
[22] P. Bracken and P. Thomas, 'Postpsychiatry: A New Direction for Mental Health', *BMJ: British Medical Journal*, 322 (2001), p. 724.
[23] See Moncrieff's lecture: The myth of the chemical cure: The politics of psychiatric drug treatment, at: <www.**youtube**.com/watch?v=IV1S5zw096U> [accessed 30 July 2016].

biological deficiencies obscures the social origin and context of distress and prevents people from seeking social or political solutions…Psychiatry with its medical credentials and associated respectability, and the financial power of the industry represents a formidable combination.[24]

Sociologist, Peter Conrad, who has written about medicalization and social control, describes medicalization as "a process by which non-medical problems become defined and treated as medical problems, usually in terms of illness or disorders".[25] He also notes that there is "strong evidence for expansion rather than contraction of medical jurisdiction".[26] Because of "complex social forces" and "market interests," medicalization now seems less influenced by medical imperialism and the control of physicians, than it was in the 1970s.[27] These forces and interests include aggressive strategies used by drug manufacturers to increase profits and influence the rise of individual consumerism. The latter are enhanced by the internet where people can now diagnose themselves, communicate with others on chat lines and instruct their doctors on what medications to prescribe. It is a construct that goes "far beyond psychiatry".[28]

> Marketing diseases, and selling drugs to treat those diseases, is now common in the "post-Prozac era" … GlaxoSmithKline has spent millions to raise the public visibility of SAD (seasonal affective disorder) and GAD (generalized anxiety disorder) through sophisticated marketing campaigns…The tag line was "Imagine being allergic to people"…Paxil internet sites offer consumers self-tests to assess if they have SAD or GAD (www.paxil.com). The campaign successfully defined these diagnostic categories as both common and abnormal, thus needing treatment.[29]

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[24] J. Moncrieff, 'Co-Opting Psychiatry: The Alliance between Academic Psychiatry and the Pharmaceutical Industry', *Epidemiologia e Psichiatria Sociale,* 16 (2007), pp. 192-93.

[25] P. Conrad, 'Medicalization and Social Control', *Annual review of Sociology,* 18 (1992), p. 209.

[26] P. Conrad, 'The Shifting Engines of Medicalization', *Journal of health and social behavior,* 46 (2005), p. 3. For other allusions to medical jurisdiction, see also: pp. 4, 12.

[27] For a thoughtful critique of the levels of medicalization that emerge and operate beyond the control of physicians, see: P. Conrad and J.W. Schneider, 'Looking at Levels of Medicalization: A Comment on Strong's Critique of the Thesis of Medical Imperialism', *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology,* 14 (1980).

[28] See: P. Conrad, 'The Shifting Engines of Medicalization', p. 3.

[29] Ibid. p. 6. Conrad also references the work of journalist, Brendan Koerner, who offers a biting account on the making and selling of mental illness. See: B.I. Koerner, 'Disorders Made to Order', *Mother Jones,* 27 (2002).

3.3.1   Spinning the illness of grief

One recent and contentious example is the medicalization is grief, which *almost*

found its way into the newest and fifth edition of the *Diagnostic and Statistical*

Manual of Mental Disorders (DSM V); the primary tool used in psychiatric diagnosis.[30]

Described as "complicated grief" or CG, the anticipation of this diagnosis provoked

much criticism.[31] Yet, clinical supporters claimed that CG's inclusion in the DSM V

would help many who are crippled by its debilitating symptoms. Not surprisingly,

the "hallmark" of CG is sadness and yearning. According to one source, the *only*

potential harm for this diagnosis would have been primarily related to labelling and

stigma," which these authors nonetheless felt was outweighed by the benefits, "as

long as the diagnosis was applied appropriately".[32] Given the ease with which

bereavement *could* be misdiagnosed, and treated as depression, we might

reasonably assume this diagnosis would be all too likely misapplied. Particularly,

since the level of medicalization within our cultural consciousness could reasonably

propel *anyone* dealing with the wrenching anguish of bereavement to seek clinical

help. A brief extract from an article that supported the recognition of CG as a

distinct mental illness illustrates how we pathologize yearning:

> Intense yearning or longing for the deceased is common in CG. There are
> strong feelings of wanting to be reunited with the lost loved one, associated
> with behaviours to feel close to the deceased, frequent intrusive or
> preoccupying thoughts of the deceased and efforts to avoid experiences that
> trigger reminders of the loss…[W]ell studied treatment for depression and
> medication studies suggest that improvement in depression can occur with
> only modest changes in CG symptoms. Overall, while symptoms can
> overlap, there is strong evidence that CG is distinct from major depression.[33]

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[30] There are two diagnostic manuals of psychiatry, the DSM and the ICD, the International
Classification of Diseases published by the World Health Organization. The DSM is published by the
American Psychiatric Association. Despite their similarities, the DSM is the most widely used in North
America and I have never seen or used the ICD in the course of my studies or my work as a clinician.
See: G. Andrews, T. Slade, and L. Peters, 'Classification in Psychiatry: ICD-10 Versus DSM-IV', *British
Journal of Psychiatry*, 174 (1999).

[31] See: L.J. Breen and M. O'Connor, 'The Fundamental Paradox in the Grief Literature: A Critical
Reflection', *OMEGA: Journal of death & dying*, 55 (2007).

[32] M.K. Shear and others, 'Complicated Grief and Related Bereavement Issues for DSM-V', *Depression
and anxiety*, 28 (2011), 107. See also: K. Lamb, R. Pies, and S. Zisook, 'The Bereavement Exclusion for the
Diagnosis of Major Depression: To Be, or Not to Be', *Psychiatry (Edgmont)*, 7 (2010), p. 20.

[33] M.K. Shear and others 'Complicated Grief and Related Bereavement Issues for DSM-V', p. 106.

Medicalization is nowhere more hauntingly illustrated than in the repackaging of the heart-wrenching human reality of bereavement and yearning as an "illness" that is justified as medically sound and ethically defensible. Such is the tide of medicalization that scholars and clinicians, past and present, have resisted while watching the spectrum of "normalcy," dwindle to a thread. Fortunately, for now, this diagnosis appears in the appendix of the DSM V, as a condition for further study described as "persistent complex bereavement disorder".[34]

3.3.2 *The thesis of medical imperialism*

Medicalization has been tied to the "thesis of medical imperialism" and prompted debate over two decades following a provocative essay by sociologist, Philip Strong, who lampooned his own field for its own imperialist motives.[35] Concerned with the implications of medical imperialism, Strong argued that this problem was actually *rivalled* by the imperialism of medical sociology itself. The following identifies a number of significant concerns claiming that the problem of medical imperialism:

(i)   has led to social problems being "professionalized" which in turn has increased the number of professions, professionals and bureaucracies who stand to benefit

(ii)   has promoted a monopoly in service provision that generally excludes the involvement, or the legitimacy of involvement, by other types of professionals or lay people

(iii)   has resulted in "services," and the criteria by which such services are judged, being almost entirely controlled by the professional rather than by the vulnerable help seeker

(iv)   has led to "empire building" and the redefinition of existing problems as well as the discovery of wholly new ones that medicalization would have us believe is the job of medicine to solve

(v)   has created a seemingly indefinite expansion of needs and problems based on human definition and a growing awareness that illness has *not*, in fact, been conquered by the creation of a national health service. On the contrary, the very agencies dealing with these

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[34] For a balanced analysis, see: R.A. Bryant, 'Prolonged Grief in Diagnostic and Statistical Manual of Mental Disorders, 5th Edition', *Current Opinion in Psychiatry,* 27 (2014).

[35] For a thoughtful critique of the levels of medicalization that emerge and operate beyond the control of physicians themselves, see: P. Conrad and J.W. Schneider, 'Looking at Levels of Medicalization: A Comment on Strong's Critique of the Thesis of Medical Imperialism'.

problems have played, and still play, a central role in their discovery and development

(vi)   has contributed to the possibility of the limitless expansion of any one profession, given the relative nature of need and the flexible nature of professions

(vii)   has informed the perception of aetiology as something to be understood in individualistic terms rather than something related to a social problem. Hence, "symptoms" are separated from the culture in which they emerge which consequently leads to the "depoliticisation" of social problems

(viii)   has resulted in such problems being primarily expressed in medical terms, with the emphasis being placed on science, and those professionals dealing with matters related to the sciences, including psychologists, psychiatrists, biologists, doctors. Even where such professionals do not directly manage or "treat" the help seeker, their doctrines inform the professions that do.

(ix)   has ultimately resulted in the construal and handling of contemporary social problems in predominantly "medical" terms

(x)   has contributed to the belief that effective prevention of disease must necessarily involve major social change rather than professional 'tinkering' at the individual level

(xi)   has developed the perception of the help seeker as someone who is ultimately "addicted" to and "dependent" on professionals, medical or otherwise.[36]

In his argument, Strong does not discount the "illegitimate medicalization of the social world," which Simon Williams agrees is a well-rehearsed issue. Instead, he uses the thesis of medical imperialism to excoriate sociology's covetousness of medicine's power and territory. Strong claims, for example, that sociology has only prospered through its critique of medicine while attempting to capture some of its status in the process. "Sociologists may be said to play a double game, seeking the support of the less powerful on occasion but in turn using this alliance to foster its

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[36] These points have been synthesised from Strong's work and summarized by Williams as well. See: P.M. Strong, 'Sociological Imperialism and the Profession of Medicine a Critical Examination of the Thesis of Medical Imperialism', pp. 199-200; S. Williams, 'Sociological Imperialism and the Profession of Medicine Revisited: Where Are We Now?', *Sociology of Health & Illness,* 23 (2001), p. 137.

other alliances with those in power".[37] Such an accusation might appear to hobble even the most legitimate sociological critique of medicine, psychiatry or any other area of human concern, leaving the most vulnerable at even greater risk of exploitation. Yet, Strong's claim has merit, even (or perhaps especially) for those para-professionals like myself, who find themselves embroiled to their benefit and ethical discomfiture in the cachet and trap of "the medical". His coup-de-grace makes clear that sociology might ultimately create even greater problems than the ones it seeks to challenge.

> The critics of the "medical model" tend to forget that its use, however barbarous on some occasions, has been liberating in others. In an alienated world, the sick role, far from having the entirely conservative implications which some ascribe to it may serve as an individual defence and refuge. A fully social model, because it reintroduces human agency into health and illness, can serve, in a context where the state has still to wither away, as a means for an even more systematic oppression than is offered by organic medicine.[38]

The acceptance of *any* barbarity in exchange for the "luxury" of being identified as "mentally ill" would seem to have little to recommend it. As Williams reminds us, however, Strong did not wholly discount the thesis of medical imperialism when he cautioned sociology against its own naivety and hubris. He acknowledged:

> medicine's own complex, multi-dimensional, multi-factorial knowledge base; its heterogeneous, if not faction riven, nature and internally contested boundaries, and … the positive (as well as negative) contribution which modern medicine makes".[39]

If the problem of medical imperialism is a complex mix with no "one" to hold responsible, the threat to the help seeker in community mental health care is no less real on that account. For, no matter where she is situated within the hierarchy, every clinician controls power over every vulnerable help seeker she encounters within this system. Strong's challenge to the thesis of medical imperialism speaks volumes

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[37] P.M. Strong, 'Sociological Imperialism and the Profession of Medicine a Critical Examination of the Thesis of Medical Imperialism', p. 203.

[38] Ibid. p. 212.

[39] S. Williams, 'Sociological Imperialism and the Profession of Medicine Revisited: Where Are We Now?', p. 152.

about the interests of medical sociology, and allied health professionals working under the protection of medical authority. This authority keeps clinicians compliant and morally disengaged in the face of questionable clinical practices, assumptions and behaviours in exchange for a cut of the action that medicine has to offer.

> It is power and authority over individuals under care with which mental health should be concerned. These are the tools used to legitimise assessments, diagnoses, prescriptions, and hospitalisations. These tools…allow clinicians to medicalize human emotion, facilitate the removal of children from family homes, and report at their discretion to the full roster of professionals including police, probation officers, social workers, and family doctors who are similarly endowed.[40]

3.4 Asymmetry

> The prototypical example is of a patient who arrives at a doctor's office and presents a complaint. The doctor, largely by way of questioning strategies that require delimited responses, works the complaint into biomedical categories that lack sensitivity to the patient's psychosocial concerns, life world, and folk understandings.[41]

Medical asymmetry refers to the inevitable imbalance of power between the clinician and the vulnerable help seeker in a hierarchy of care to which the help seeker must submit. This asymmetry describes the "knowledge and authority that allows doctors to promulgate a bio-medical model of disease and simultaneously undermine patients' own experience and understanding".[42] Such inequality, according to Douglas Maynard, is negotiated and "interactively achieved" with patient consent, by using "ordinary talk" to enlist the opinion of the patient, and over-ride her opinion, experience and knowledge. This is ostensibly to forward legitimate evidence based on tests, assessments and their objective findings. The "evidence" presented to the help seeker in specialist language is loaded with larger social and economic implications related to treatment options, privileges and services. Asymmetry is not only weighted in terms of power differentials but also in terms of the biomedical model *and* the opinion of the professional supporting it.[43]

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[40] C. Racine, 'Loving in the Context of Community Mental Health', p. 114.

[41] D.W. Maynard, 'Interaction and Asymmetry in Clinical Discourse', *American Journal of Sociology,* 97 (1991), p. 450.

[42] Ibid. p. 448.

[43] Ibid. p. 449.

3.4.1 The entrancement of medical authority

Maynard describes this transaction as the "Perspective Display Sequence" which involves the affiliative move of the clinician making an inquiry by appearing to solicit an opinion.[44] This is not simply to gain information but to gain an advantage, albeit collaboratively, that will enable the medical professional to *endorse* and *trump* the patient's experience. Maynard analysed this particular manoeuvre in verbal exchanges between a diagnosing physician and a cohort of parents and guardians whose infants and children were referred to a clinic for developmental delays.

The physician's strategy aims to confirm the patient's point of view while essentially exploiting it "to reinforce or affirm the position in the inviter's response".[45] This sequence is used where caution is needed, for example, in the delivery of "highly charged diagnoses". A developmental delay would surely qualify, given the repercussions of such a diagnosis on every aspect of that child's life for the rest of her life, and the life of her family. Interestingly, such verbal manipulation helps to sell an idea that is not only outside the help seeker's experience but that may actually *deny* it. The clinician's reformulation of the problem that diminishes or selectively ignores the content of the help seeker's experience, "permeates [the] doctor-patient interaction" and is a well-established phenomenon, although the reasons are less clear. Maynard suggests a number of possibilities including technology itself, by which he presumably means the technology of assessment and diagnosis.[46] However, asymmetry is underscored by the "surveillance" of computerized documentation, which must at least appear to uphold institutional norms and imperatives and, most importantly, its unassailability.

This is a complex picture when we consider how embedded the clinician is in a web of corporate accountability to "schools, school systems [and] government agencies". The "orientation to social structure" is exceptionally "clear and concrete" when the clinician is accountable to every member of the immediate and extended clinical

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[44] D.W. Maynard, 'Perspective-Display Sequences in Conversation', *Western Journal of Communication* 53 (1989), pp. 91-103.
[45] Ibid. pp. 100-01.
[46] D.W. Maynard, 'Interaction and Asymmetry in Clinical Discourse', p. 483.

team.[47] She is also accountable to the help seeker's employers, medical insurers, physician, lawyer, probation officer, financial worker, as well as the police, the Ministry of Children and Family Development, and the welfare office, among others. Within this "social safety net," the help seeker becomes, in no small way, the common property of every professional within and beyond the walls of community mental health.

There are checks and balances in this structure that are beneficial and detrimental to the clinician and the individual seeking help. However, the clinician within this corporate structure must learn to bend or skilfully manoeuvre around pressures exerted upon her if she values her employment and professional reputation.[48] Matters of individual ethical importance are sacrificed routinely in the interests of the hierarchy that maintains the integrity of the ruling structure and keeps workers in line.

3.4.2 *Tread lightly!*

I am in my office when the Centre manager and the line manager of my team both come in looking very serious and shut the door without asking permission. All clinical staff members are being subjected to this process—the auditing of their clinical files—and I am well prepared but suddenly feel invaded and wary. All clinical notes are computerized and mine have already been accessed and examined by these two. My notes tend to be extensive, neutral, observational and itemized with tasks to which I must attend on the client's behalf or that need to be fulfilled by the client.

The issue of confidentiality is discussed with each help seeker. At the beginning of "treatment," his or her signature is requested as "proof" of the clinician's due diligence, and the help seeker's agreement to the "ethical" and "confidential" contract into which she is entering with the institution. But this is an invention within a system where every word documented about a given individual is stored within a computerized file. These files can be accessed by employees from other hospitals and other community mental health centres operating within an enormous jurisdiction, although admittedly, with some restrictions. Interestingly, the penalty for going into the system to look at one's own personal medical file is immediate dismissal.

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[47] Ibid. pp. 478-80.

[48] K. Lamb, R. Pies, and S. Zisook, 'The Bereavement Exclusion for the Diagnosis of Major Depression: To Be, or Not to Be', p. 20.

Something is clearly wrong with my work. Without much preamble, the manager who is now sitting beside me in front of the computer monitor asks me to go a particular file to access a note he has me read as proof of my transgression. I have written something about a help seeker who, following recent surgery now breathes through a small hole, a stoma, in his neck. This man has had to re-learn to speak through this apparatus but also to blow his nose and cough through it, which is unsettling to witness and embarrassing for this man to do in the presence of others. He turns away when he coughs or removes phlegm from his throat with a Kleenex and apologises. Yet, he does so with some frequency as his condition causes him to suffer chronic lung infections. When he asks permission to put his Kleenex in my office waste paper basket, I typically pick it up and place it on the floor in front of him so he doesn't have to reach.

My apparent insurrection lies in a statement I have made about the distress he has expressed regarding his probation officer who prohibits him from putting his used Kleenex in the office wastepaper basket. This has occurred on several occasions and is a source of mortification and rage for my client. I have allowed myself one carefully worded sentence reporting my client's experience in neutral terms.

The Centre manager wants to know why I have written this. He is looking very intently at me, the arms of our chairs are touching, the file is open on the screen before us and my mind goes completely blank. An unpleasant tingling begins to spread up my back from the base of my spine. The line manager, whose micromanagement I am constantly attempting to deflect, is in a chair behind us and pipes up that I could get into trouble for writing this. I coolly ask her what kind of trouble that might be but I feel the fear they want me to feel. She has no answer. They want to know if I am aware of having written something that could reflect badly on the team's relationship with the probation office across the street from us, and imply that my own job could be at risk. I remonstrate but sound defensive. I have sinned against the hierarchy and it will not be tolerated for here deference to the system is law and one's solidarity with a vulnerable help seeker is more wisely expressed in private or not at all.

3.4.3   *Hermeneutic injustice*

Miranda Fricker's work on hermeneutic injustice demonstrates the significance of the dynamic that Maynard has examined. Hermeneutic injustice is "the injustice of having some significant area of one's social experience obscured from collective understanding owing to a structural prejudice in the collective hermeneutical

resource".[49] Fricker has observed that in the gap of unidentified experience there is no description because the injustice is hidden, "un-languaged," and therefore invisible to collective social awareness. Fricker illustrates this phenomenon in her analysis of a story found in Susan Brownmiller's work on the rise of the American women's liberation movement. This story documents the discovery of "sexual harassment" and the "aha" moment that revealed a truth that was finally and collectively recognized.[50] Its "discovery" may not have eliminated the problem, but sexual harassment is now legitimized as unjust and *illegal*. The strength of Fricker's work lies in her interest in *naming* this gap and in bringing it to collective awareness by singling out its essential, undeniable injustice. "For something to be an injustice it must be harmful but also wrongful, whether because discriminatory or otherwise unfair".[51]

If we return to the asymmetry in Maynard's example of the diagnosing clinician, we can see that such injustice or even wrongfulness is not so easily assigned. What is *wrong* after all, with a concerned and over-extended paediatrician doing his best to relay difficult news to frightened parents about the developmental delay of their child? Fricker's work, however, suggests that even if the physician was grieved to do so, the significance of the parents' powerlessness is of greater concern. For, *she* is the one who is suffering the injustice and for that reason, is more disadvantaged whereas for the doctor "there is an obvious sense in which it suits his purpose".[52] The clinician is not the one labouring to understand within this asymmetrical relationship. Nor will he have to live with the full implications of a diagnostic label, treatment plan and system of care that he is recommending. Thus, while both parties may be "cognitively handicapped by the hermeneutical lacuna," *only* the patient is seriously disadvantaged.

> The cognitive disablement prevents her from understanding an important patch of her experience; that is, a patch of experience which is strongly in her interests to understand, for without that understanding she is left deeply

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[49] M. Fricker, 'Powerlessness and Social Interpretation', *Episteme: A Journal of Social Epistemology*, 3 (2007), p. 100.

[50] S. Brownmiller, *In Our Time: Memoir of a Revolution* (London: Dial Press, 1999), pp. 279-94.

[51] M. Fricker, 'Powerlessness and Social Interpretation', p. 97.

[52] Ibid.

troubled, confused, and isolated, not to mention vulnerable to continued harassment. Her hermeneutical disadvantage renders her unable to make sense of her on-going mistreatment, and this in turn prevents her from protesting it, let alone securing effective measures to stop it.[53]

Fricker's work is coming under scrutiny by researchers examining its relevance to health care. Havi Carel and Ian Kidd employ Fricker's work on testimonial injustice to explore the difficulties of communication between doctors and patients.[54] The well-known complaint of people not being or feeling heard by their physicians is borne out by the evidence.

> "[T]he epistemic concerns of patients continue to be voiced through a vast body of pathographic literature, including online patient support groups, blogs, narratives, and listserves. These attest to patients' persistent experiences of being ignored, marginalized, or epistemically excluded by those professions who are charged with their care".[55]

Carel and Kidd focus their analysis on the experience of people with chronic "somatic illness," as opposed to mental illness, which I would suggest offers even greater opportunity for this type of injustice.

> Actual and potential testimonial injustice is endemic within mental health service delivery. For example, central to mental health legislation is the idea that some people lack the capacity to make decisions and it follows that what they might say, how they construe problems, their choices and preferences lack coherence, logic, or credibility. It is not surprising then that the testimony of all or most people who use mental health services might be considered suspect.[56]

The global implications of such injustice are immense. Indeed, Richard Lakeman's observation in the preceding quote confirms Fricker's description of hermeneutical injustice as "a kind of structural discrimination".[57] This would suggest that testimonial injustice is part of the very framework of institutional mental health care. Carel and Kidd express the same concern a little differently.

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[53] Ibid.

[54] H. Carel and I.J. Kidd, 'Epistemic Injustice in Healthcare: A Philosophical Analysis', *Medicine, Health Care and Philosophy,* 17 (2014).

[55] H. Carel and I.J. Kidd, 'Epistemic Injustice and Illness - Unpublished', (2013), p. 2.

[56] R. Lakeman, 'Epistemic Injustice and the Mental Health Service User', *International Journal of Mental Health nursing,* 19 (2010), p. 151.

[57] M. Fricker, 'Powerlessness and Social Interpretation', p. 103.

> Since the social and epistemic practices of giving information to others and interpreting our experiences is integral to our rationality, identity, agency, and dignity, it is evident that injustice which harm our testimonial and hermeneutical capacities will be sources of very deep harm.[58]

The problem of asymmetry between the professional and the vulnerable help seeker can hardly be overstated. If Maynard's work illustrates the profile and dynamic of asymmetry in action, Fricker's work identifies two kinds of injustice within it. In clinical care, hermeneutic injustice identifies the help seeker's lack of understanding within the asymmetrical clinical encounter but also within the system of care in which her life may become subsumed and harmed. Testimonial injustice occurs when a hearer discredits, diminishes, or disbelieves the testimony of another. Testimonial injustice provides additional evidence for the significance of hermeneutical injustice. It also describes the phenomenon underwritten in community mental health care that legitimizes the flagrant abuse of the help seeker's trust. This injustice is well documented in literature examining the final barrier to ethical care that we will discuss in the following section.

3.5 Dehumanization

> The ethical ideals of the medical profession are often and routinely unmet. One way this happens is when subtle forms of dehumanization enter hospital life. Specifically, care-givers may treat patients less like persons and more like objects or nonhuman animals—situations that physicians themselves often satirize.[59]

The "essence of dehumanization" is a process that denies the "distinctly human mind" of another person. This includes the denial of a person's experience or agency and her ability to feel the full spectrum of human emotion, including his or her capacity to choose and to act.[60] When we deny the experience of others, we tend to treat and to see them as machines. When we deny the agency of others, we are more likely to treat them like animals, "dogs, pigs, rats, parasites, or insects…. At other times they are likened to children, their lack of rationality, shame and

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[58] H. Carel and I.J. Kidd, 'Epistemic Injustice and Illness - Unpublished', p. 4.
[59] O.S. Haque and A. Waytz, 'Dehumanization in Medicine Causes, Solutions, and Functions', p. 176.
[60] Ibid. p. 177.

sophistication seen patronizingly as innocence".[61] The most sobering form of dehumanization occurs when another human being is described as "vermin" or filth.[62] While generally tied to the horrific violence of genocide like the Holocaust or the Rwandan massacre[63] the anathema of dirtiness and infection is not limited to such extremes.

3.5.1 Staff toilets only

Discussions about the disgust that a number of mostly female clinicians felt about having "our" toilets used by patients, routinely occurred during staff meetings and the majority of the staff was female. Reasons given were that the toilets were left in a mess; they smelled bad and were not being flushed after use. Apparently used paper towels were not being placed in the bin but left on the sink and there was the possibility of catching something off the toilet seat or of finding the toilet seat wet or soiled. Dirtiness was a major theme of concern. A boundary of great propriety was seen to be crossed when a patient was allowed by a staff member to use "our" toilets, and always reflected poorly on the clinician who provided such access.

Such dehumanization was generalized to the management of the patient toilet itself that was located in the waiting room area and which, for a number of years, had been available for the convenience of anyone waiting to be seen by a clinician. Later, the installation of a buzzer system required whoever needed to use the toilet to go to the reception window and ask to be let in. At which point the receptionist would press a loud buzzer announcing that the door to the toilet had been open for the individual to proceed. This alerted anyone else sitting in the waiting room that permission had been requested and granted. Part of the justification for these changes was that people off the street might be coming in to use drugs in the toilet, or were coming in off the street to use a toilet that was "reserved" only for registered patients.

The issues of cleanliness, propriety, and territoriality were once again on the agenda when the old padded chairs in the waiting room were replaced with hard metal benches that were nailed to the floor. These were apparently installed to discourage walk-ins off the street from sitting or sleeping in the waiting room if it was cold or raining outside. They were also easier to "clean" with a quick spray of disinfectant and a wipe down with a paper towel. Similarly, a phone that had been formerly available without request for people in the waiting room was suddenly removed. Requests to use the phone then had to be made to the receptionist who would pass the

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[61] N. Haslam, 'Dehumanization: An Integrative Review', *Personality and social psychology review,* 10 (2006), pp. 252-53.

[62] K.R. Monroe, 'Cracking the Code of Genocide: The Moral Psychology of Rescuers, Bystanders, and Nazis During the Holocaust', *Political Psychology*, 29 (2008), p. 700.

[63] N. Haslam, 'Dehumanization: An Integrative Review', p. 253.

phone out through the reception window from where the call would be conducted within a few feet of the witnessing receptionist.

All of these strategies designed for safety, hygiene and fairness were at the exclusive expense of those least able to maintain and manage their own lives—or to afford the luxury of a cell phone or even a bank account—including the homeless.

Nick Haslam's review of the literature reveals the presence of dehumanization in a surprising number of fields from medicine to modern art, reminding the reader that dehumanization is ubiquitous.[64] Curiously, it is not a question of whether we dehumanize but only *how* and *how much.*

3.6 Types of dehumanization

Medical dehumanization expresses itself in various ways. *Dissimilarity*, for example, arises simply by virtue of a clinician's perception of herself as different from the help seeker, based on the fact of his illness, his label, and the imbalance of power between them. Dissimilarity is tied to power and *objectification* where "the experience of power leads people to treat people as a means to an end rather than as ends in themselves".[65] Other research demonstrates the ranked nature of objectification predicted by the *amount* of power held by an individual. Objectification is "an instrument of subjugation whereby the needs, interests, and experiences of those with less power are subordinated to those of the powerful".[66] These authors note that philosopher Martha Nussbaum underscores the importance of "instrumentality" where "the target is a tool for one's own purpose".[67] One series of experiments, for example, showed that "high-power perceivers were more attracted to targets' usefulness, defined in terms of the perceiver's goals, than were perceivers in low-power and baseline conditions".[68] Those with the highest power tended to objectify subordinates and peers while people with lower power only objectified their subordinates.

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[64] Ibid. p. 254.
[65] O.S. Haque and A. Waytz, 'Dehumanization in Medicine Causes, Solutions, and Functions', p. 178.
[66] D.H. Gruenfeld and others, 'Power and the Objectification of Social Targets', *Journal of personality and social psychology*, 95 (2008), p. 111.
[67] Ibid. p. 112.
[68] Ibid. p. 123.

There are many clinical practices contributing to objectification including *de-individuation,* where a person's identity is lost in the anonymity of the patient group. In contrast, m*echanization* appears to contribute to clinicians' withdrawal of empathy and to their moral disengagement.[69] Such observations are relevant to community mental health settings where, despite the purported collaboration of multi-disciplinary team members, there is a clear demarcation of professional ranks—likely unstated—and well-established chains of command. Within such a structure, *everyone* is at risk of being objectified by superiors or peers with the exception of the vulnerable help seeker who, in being the *most* subordinate of all, is objectified *by definition.*[70] Nonetheless, a clinician's ability to recognize that she is dehumanizing a help seeker may well elude her, even while she is being dehumanized herself.

3.6.1   Infra-humanization

Infra-humanization is an emerging phenomenon in the literature on dehumanization that has special relevance for clinicians because it is so difficult to detect.[71] Its theory is concerned with the formation of in-groups and out-groups and the process by which in-group members assign themselves a greater share of "human essence".[72] Infra-humanization does not reduce anyone to an animal or a machine but to something a little *less* human than "in-group" members. This human essence relates to what are defined as primary and secondary emotions. The primary emotions are those recognized as being shared by *both* in-group and out-group members as well as even animals. It is the *secondary* emotions that we apparently view as the most uniquely human which we, therefore, tend to assign only to members of our in-group. For example, a number of studies have shown that a group tends to be infra-humanized if they are considered to lack "intelligence, language, and uniquely human emotions".[73]

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[69] O.S. Haque and A. Waytz, 'Dehumanization in Medicine Causes, Solutions, and Functions', pp. 177-79.

[70] My italics. The authors state: "[W]e assume that subordinates are objectified almost by definition". See: D.H. Gruenfeld and others, 'Power and the Objectification of Social Targets', p. 114.

[71] J.P. Leyens and others, 'Emotional Prejudice, Essentialism, and Nationalism: The 2002 Tajfel Lecture', *European Journal of Social Psychology,* 33 (2003), p. 703.

[72] S. Demoulin and others, 'The Role of in-Group Identification in Infra-Humanization', *International Journal of Psychology,* 44 (2009), p. 4.

[73] Ibid. p. 6.

Interestingly, infra-humanization operates regardless of group status, meaning that out-group members of higher *or* lower ranking groups may be similarly infra-humanized. This can occur in the context of a community mental health team where, for example, clinicians infra-humanize managers, nurses infra-humanize counsellors, administrative staff infra-humanize the clinicians and the entire team infra-humanizes the patients. Infra-humanization combines "in-group favouritism and out-group derogation," which cannot be understood as favouritism alone because infra-humanization is contingent on the difference between groups being *meaningful*.[74]

One group of researchers has suggested that our need for significant others, and the importance of these relationships to us, necessitate the creation of out-group members.[75] Indeed, "the more a group is perceived as essential and the more that people identify with their in-group, the higher the level of infra-humanization".[76]

> Infra-humanization, like moral exclusion, delegitimization, and lesser-perceived humanity, probably constitute a strong defence mechanism for those who want to live in a quiet environment. It explains how one can watch apartheid, wars, and genocide on TV without being too much disturbed, or having to be sent to a psychiatric hospital".[77]

Infra-humanization may help explain how clinicians can be involved with institutional practices and systems they recognize as morally wrong, and devastating for the vulnerable help seeker, without being sufficiently distressed to protest or protect. There is sufficient research to predict the occurrence of infra-humanization but the mechanism is still not well understood.[78] Most interestingly, this form of dehumanization "occurs in the absence of intergroup conflict and therefore extends the scope of dehumanization well beyond the context of cruelty and ethnic hatred," which further contributes to its invisibility.[79]

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[74] J.P. Leyens and others 'Emotional Prejudice, Essentialism, and Nationalism: The 2002 Tajfel Lecture', pp. 703-05.

[75] Ibid. p. 704.

[76] S. Demoulin and others 'The Role of in-Group Identification in Infra-Humanization', p. 10.

[77] J.P. Leyens and others 'Emotional Prejudice, Essentialism, and Nationalism: The 2002 Tajfel Lecture', p. 712.

[78] S. Demoulin and others 'The Role of in-Group Identification in Infra-Humanization', p. 6.

[79] N. Haslam, 'Dehumanization: An Integrative Review', p. 255.

3.6.2   Stigmatization

Another pernicious form of dehumanization is stigmatization. One group of researchers investigated five separate factors influencing the public's interaction with those who have "mental health problems". These included: 1) behaviour, 2) the reasons or causes of the behaviour, 3) perceived dangerousness of the person to others, 4) the pathologizing label and 5) the person's socio-demographics. All of these factors appear to contribute to the avoidance and fear of the mentally ill. There is generally greater acceptance of problems related to "structural causes (e.g., stress or genetic/biological causes)," and less acceptance of problems associated with alcohol or drug misuse.[80] The ranked nature of each of these variables suggests the complexity of out-group construction.

The greatest concern is the prevalence and impact of stigmatization given the levels of aversion expressed towards people with mental health problems. We do not like the "mentally ill" coming into our homes or marrying into our families. We do not value having them as colleagues at work or as friends, neighbours or residents in nearby group homes.[81] Other research on stigma, stereotyping and employment has shown that public stigma tends to be *lower* if someone with mental illness reports having worked in the past three months to a year, but is otherwise higher.[82] Such stigma is further complicated by the difficulty involved in finding and keeping employment when one is labelled with a mental illness. Not surprisingly, such attributions appear to lead to social avoidance and segregation in the work place. It is *self-stigma*, however, which internalizes the devastating and isolating effects of public stigma. This may well be the form of stigma that results, poignantly, in so many help seekers being identified as having "low self-esteem".

As far back as the 1950s, research indicated that a mentally ill person would likely be perceived "with fear and dislike". The strength of public aversion has, however, been tempered in recent years with a "sophistication" of understanding and social

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[80] J.K. Martin, B.A. Pescosolido, and S.A. Tuch, 'Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness', *Journal of Health and Social Behavior*, 41 (2000), p. 208.
[81] Ibid. p. 219.
[82] P.W. Corrigan, K.J. Powell, and N. Rüsch, 'How Does Stigma Affect Work in People with Serious Mental Illnesses?', *Psychiatric rehabilitation journal*, 35 (2012), pp. 381-83.

tolerance brought about by campaigns to educate the public about mental health. These are "based on scientific research portraying mental illness as a "disease" rather than a "moral flaw".[83] This strategy also supports medicalization by legitimizing symptoms as "pathology" while denying or ignoring the larger social context of the distress, and stigma persists despite ongoing campaigns to address it. Help seekers, in sum, are almost inevitably dehumanized and stigmatized within the institution and beyond its walls. All of which contributes to the scourge of self-stigmatization and damage to every aspect of a person's private, social and work life. Yet, the case of the "heart-sink" patient illustrates that stigmatization can be even more grievously perpetuated.

3.6.3   *The heart-sink patient*

The heart-sink patient corresponds to a demographic that apparently causes a clinician's heart to sink, and their numbers are legion in the halls of community mental health care.[84] Help seekers labelled with a Borderline Personality disorder are especially vulnerable to this form of stigma.[85] They are seen as using and abusing valuable resources and time that too often fail to provide significant change in the help seeker's life.[86] The homeless also belong to the heart-sink cohort because their needs are so extensive and complex. Homeless people are hard to reach, difficult to coax off the street and to treat effectively or consistently. Their diagnostic profile is made more complicated by alcohol and drug abuse and homelessness itself.

A brief digression on the label of BPD illustrates just how destructive this type of stigma can be. People with this diagnosis can challenge the system given their tendency to self-harm, the chronicity of their crises, their serial hospitalizations and their typically lengthy connections to mental health facilities. Community mental

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[83] J.K. Martin, B.A. Pescosolido, and S.A. Tuch, 'Of Fear and Loathing: The Role of 'Disturbing Behavior,' Labels, and Causal Attributions in Shaping Public Attitudes toward People with Mental Illness', p. 209.

[84] C.C. Butler and M. Evans, 'The 'Heartsink' Patient Revisited', *British Journal of General Practice,* 49 (1999).

[85] See: D. Markham, 'Attitudes Towards Patients with a Diagnosis of Borderline Personality Disorder': Social Rejection and Dangerousness'.

[86] R.E. Drake, F.C. Osher, and M.A. Wallach, 'Homelessness and Dual Diagnosis', *American psychologist,* 46 (1991).

health care is poorly equipped, for many reasons, to provide the necessary care to this cohort. Yet, it is almost impossible to deny treatment to an individual dealing with this level of acuity during a period of crisis, on legal grounds alone.

The sobering implications of "heart-sink" stigmatization captured in one study showed that a group of 50 mental health nurses were "the least optimistic about patients with a BPD label and…more negative about their experience of working with this group".[87] This diagnosis alone is so damning that it appears to contribute to the blame clinicians assign people with this diagnosis. Blame is highly correlated to the perceived control that people feel others have over their own behaviours. Not surprisingly, the contempt, fear and distrust experienced by clinicians who work with this cohort contribute to impoverished levels of care.

In terms of general medicine, Christopher Butler and Martyn Evans note that:

> Several authors have associated psychopathology, depression, psychosomatic illness, lower social class, being female, having thick clinical records, being older, having more acute and chronic medical problems, and making greater use of health care services with 'difficult' patients.".[88]

Heart-sink patients can be referred to by clinicians as "black holes," "difficult," "hateful" and "health care abuser".[89] Where I worked they were also described as "cutters," "resistant," "combative," "revolving doors," "frequent flyers," "privileged" and "non-compliant". The sense of emotional disengagement that GPs have reported when dealing with heart-sink patients denies the legitimacy of the help seeker's request as well as her humanity.

> Patients' complaints were not legitimate demands on medical care, reflecting the absence of "real" illness; it was impossible to help them, or it was pointless to try, because they refused what GPs thought was necessary or they were unwilling to change. Denigratory language was common and a few GPs were explicit in their dislike.[90]

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[87] D. Markham, 'Attitudes Towards Patients with a Diagnosis of Borderline Personality Disorder': Social Rejection and Dangerousness', p. 595.

[88] C.C. Butler and M. Evans, 'The 'Heartsink' Patient Revisited', p. 230.

[89] Ibid. p. 231.

[90] L. Gask, C. Dowrick, and R. Morriss, 'Why Do General Practitioners Decline Training to Improve Management of Medically Unexplained Symptoms?', *Journal of General Internal Medicine*, 22 (2007), p. 567.

Such aversion arguably relates to a bias for bio-medical care and physicians' tendency to undervalue the psychological or professional intolerance for uncertainty, and the failure of physicians to manage this population skilfully.[91] Yet, in community mental health care, one might reasonably expect such aversion to be tamed—subdued. That is, by nature of the work, the great focus placed on the therapeutic relationship, and the clinician's psychological education, training and skill. Yet, such is not the case.

3.6.4   *The blue file*

I don't remember her name, only that she finally stopped calling. She was a Borderline, a woman not even forty with an adult daughter who lived in town, so she had someone. She'd had repeated suicide attempts, she'd used up the system, she had a two inch file, nothing helped, nothing worked, she expected too much and had been seen at the Centre too many times, so I was told. She was just another revolving door with a string of para-suicidal attempts behind her and another go-round would change nothing. I'd never met her, didn't even know what she looked like, but she called and called and badgered me to get her in. I was doing intake at the time—assessment and triage—and had already presented her case and been refused by the team. She didn't meet the mandate, whatever that was, but she was overdrawn.

By the time she stopped calling I felt fairly skillful at blowing her off and took small pride at having put out that little fire. What could I do? Her file would only be refused again. It was still on my desk sometime later—a month or more at least—when I heard that she'd succeeded in killing herself. I can't remember how I heard or how she did it. Pills probably, and alcohol, she abused alcohol. I vaguely remember someone asking me if I was alright, I must have looked upset. I wasn't alright. I was not alright. I think I asked if I could go to the funeral but was discouraged from doing so. Someone suggested that my presence there could be interpreted as an act of culpability. But wouldn't it have been? I didn't go. Anyway, I carried that file in my arms, along with my other work, to and from the room where staff collected their armload of files from a cubicle in the morning and put them back at night. I carried that woman's file for six months before I could finally put it away.

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[91] Ibid. pp. 568-69.

3.6.5   *The dehumanized clinician*

The impact of dehumanizing a vulnerable help seeker or of colluding in such dehumanization can leave a clinician devastated by her work.[92] It is widely recognized that indirect exposure to trauma involves an inherent risk of significant emotional, cognitive and behavioural changes in the clinician. This is a phenomenon described in such terms as vicarious traumatization (VT), secondary traumatic stress (STS) and compassion fatigue (CF), and is an occupational hazard of clinical work. It also constitutes a form of psychological trauma confirmed by a growing body of empirical research.[93]

Vicarious trauma can be a daily fact of the clinician's life in the routine processes of assessing and working with trauma survivors. This work also involves eliciting and witnessing the fine details of an individual's trauma story and encouraging the repeated talking through of the story as part of the therapeutic process. One researcher suggests that through chronic exposure, clinicians "may show non-recognition of the client's experience, fragmented attention, limited empathy, intellectualization, or dehumanization".[94]

Very high levels of secondary traumatic stress (STS), and secondary traumatic stress disorder (STSD), affect from 17% to 64% of clinicians working with trauma. Interestingly STSD, much like PTSD (post-traumatic stress disorder), is experienced by those—including clinicians—who are affected indirectly by the trauma experienced by the victim.[95] Although many clinicians do not experience compassion fatigue, these statistics are relevant to clinicians in community mental health practice given the high incidence of trauma in the complex cases that

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[92] A significant portion of my caseload was weighted with individuals dealing with issues related to sexual, physical and emotional trauma, self-harming and suicide.

[93] B.E. Bride, M. Radey, and C.R. Figley, 'Measuring Compassion Fatigue', *Clinical Social Work Journal*, 35 (2007), p. 155.

[94] R.T. Ringenbach, 'A Comparison between Counselors Who Practice Meditation and Those Who Do Not on Compassion Fatigue, Compassion Satisfaction, Burnout and Self-Compassion', (University of Akron, 2009), p. 31.

[95] C.R. Figley, 'Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care', *Journal of Clinical Psychology*, 58 (2002), p. 1435.

clinicians routinely handle.[96] The impact of trauma on clinicians working with such cohorts may reach clinical levels of severity.[97]

3.6.6   *The insulin coma*

> *I am walking late at night around the fragrant garden of the apartment complex where I live in a seaside town outside Vancouver. I am crying while I walk, raging and thinking of the man whose story I heard today that had stolen my peace and I can't sleep. He was dying of cancer and quietly distressed about what would happen to his sister when he was gone. She had been put into an insulin coma as a young woman decades previously. It was a barbaric, ill-informed psychiatric procedure that left her brain injured and incapacitated the whole of her adult life. This man, and now her only family member, had never married and had cared for her his whole life, at his own expense. His dignity was immense. There was no bitterness, only concern and sadness. He had no history of mental illness, was never unemployed and had no wish to hurt himself or anyone. It had simply made sense to him to contact an agency that was connected to the source of his problem, although he himself did not really know what he is asking for when we met.*

> *The needs of this man's sister fall far outside the mandate of our Centre. But, he himself will be seen by a psychiatrist or doctor at our Centre and provided with counselling if only as a humanitarian gesture, given his story. From our standpoint, his acceptance for care is a privilege when the majority of all service requests are denied, especially since he has no history of mental illness, medication or previous hospitalization. But having made it through the front gate with my help, he will be diagnosed and medicated with an anti-depressant for his anguish and maybe something else for sleep. It is a supreme irony that I will be relieved to know that at least he will be seen by someone and will not be completely alone, even if his care requires a psychiatric diagnosis and medication to legitimize it.*

Dehumanization in community mental health presents as something of a closed loop. The clinical environment is oriented to a medicalizing, mechanistic approach to care that pathologises social ills and inequalities which, intentionally or not, co-opts and disenfranchises the most vulnerable for its own purposes. Clinicians are also dehumanized through their on-going exposure to a profoundly distressed and socially isolated cohort whose life circumstances they have little or no means of ameliorating. The trauma stories of violence, abuse and injustice recounted by the

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[96] B.E. Bride, M. Radey, and C.R. Figley, 'Measuring Compassion Fatigue', p. 156.
[97] C.R. Figley, 'Compassion Fatigue: Psychotherapists' Chronic Lack of Self Care', pp. 1436-38.

vulnerable help seeker can, and do, vicariously traumatize the clinician who is then at even greater risk of re-victimizing the vulnerable help seeker.

3.7 Conclusion

The implications of medicalization, asymmetry, and dehumanization are devastating and all encompassing. One might wonder what justification remains for labelling *anyone* with a mental illness beyond maintaining the machine it feeds. Yet, the depth and complexity of emotional suffering related to poverty, race, gender, violence and trauma, in all its forms, together with the immense financial burden of such suffering worldwide, may not be denied. Nor is the decline of community mental health care anywhere on the immediate horizon, given the ever-increasing call for the provision of more and better mental health care. At the same time, the need to humanize the vulnerable help seeker has never been greater.

Chapter 4.
Autoethnography: An invitation behind the mask

Some ethnographers, now, desire their work to be both "scientific" and "literary". I am one who does so desire. We recognize the historical split between scientific and literary writing that emerged in the 17th century as unstable and mutable".[1]

4.1 Introduction

This chapter examines an increasingly popular form of social research called *evocative autoethnography* and considers its relevance to our inquiry. Autoethnography is also called "auto-anthropology, autobiographical ethnography or sociology, or even personal self-narrative research and writing, and combines ethnography and autobiography". Simply stated this type of research is aimed at describing and analysing "(graphy)" the personal "(auto)" to illuminate the cultural "(ethno)".[2] A second type of autoethnography described as "analytic" differs significantly from evocative autoethnography in form and orientation and will be discussed shortly. However, "autoethnography" is generally associated with its *evocative* form, as it will be in this chapter.

Autoethnography's emergence in the past twenty-five years represents the fork in the road between old and new schools of ethnographers. Its performative approach focuses on the expression of emotion and a narrative style driven by the self-reflexive voice of the researcher/practitioner. It is characterized by a "postmodern scepticism" about the "generalization of knowledge claims"[3] illustrated by a "minimalist" application of theory and criteria—for some autoethnographers more than others.[4] Above all, autoethnography embraces a transparently moral and political agenda of particular relevance to this inquiry that takes aim at the *anti-social* and *anti-socializing* nature of the reductive worldview it opposes.

Autoethnography is taking hold in the social sciences through the leadership of an influential group of mostly American scholars who are still refining and developing its form.

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[1] L. Richardson, 'Evaluating Ethnography', *Qualitative Inquiry*, 6 (2000), p. 253.

[2] C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', *Historical Social Research/Historische Sozialforschung*, 6 (2011), p. 273.

[3] L. Anderson, 'Analytic Autoethnography', *Journal of Contemporary Ethnography*, 35 (2006), p. 373.

[4] A term used by Norman Denzin. See: N.K. Denzin, 'Moments, Mixed Methods, and Paradigm Dialogs', *Qualitative Inquiry*, 16 (2010), p. 424.

They include, among others, Carolyn Ellis, Arthur Bochner, Norman Denzin and Laurel Richardson.[5] It is also gaining momentum in fields related to science education,[6] medicine,[7] nursing and community mental health,[8] psychology[9] and counselling psychology.[10]

In this inquiry, autoethnography plays a significant—but not quite central—role as we have already seen in *James' Story* and elsewhere in the vignettes used throughout this inquiry. The vignette is a compelling narrative form which, like poetry, "makes another world accessible to the reader" by presenting "a lived experience" that is "emotionally and morally charged" because it is "*felt*". Also like poetry, the vignette presents one single "candid photo" or "episode" of "epiphany" through which "[p]eople organize their sense of self."[11] Michael Humphreys describes the vignette as an approach that is explicitly reflexive.[12]

Although the vignette's epiphanic power lies in its reflexive potential, this epiphany can be stillborn as we see in one example of autoethnography written in a medical setting, where it is reduced to an acronym –"AEG ".[13] Here, the over-processed AEG lies dead on the page having been so contextualized, explained and graphically framed in black to separate it from the "real research," that there is nothing left to see *or* feel. So intent are the authors on showing the reader the division between the "subjective" and the "objective," that the narrative translates as the kind of "decorative flourish" Ruth Behar disparages. In failing to transgress or transform the reader's perspective or—in Behar's words—to add anything to the argument, the narrative cannot qualify as autoethnography.[14] Yet, if mastery of execution is vital to its purpose, the question of excellence is less easily determined.

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[5] L. Anderson, 'Analytic Autoethnography', p. 374.

[6] P.C. Taylor, E.L. Taylor, and B.C. Luitel, 'Multi-Paradigmatic Transformative Research as/for Teacher Education: An Integral Perspective', in *Second International Handbook of Science Education,* ed. by K.G. Tobin, Fraser, B.J. & McRobbie, C. (Dordrecht, The Netherlands: Springer, 2012), pp. 373-87.

[7] J. Gallé and L. Lingard, 'A Medical Student's Perspective of Participation in an Interprofessional Education Placement: An Autoethnography', *Journal of interprofessional care,* 24 (2010).

[8] K. Foster, M. McAllister, and L. O'Brien, 'Extending the Boundaries: Autoethnography as an Emergent Method in Mental Health Nursing Research', *International journal of mental health nursing,* 15 (2006).

[9] N. Devlin, 'A Critical Examination and Analysis of the Processes by Which Educational Psychologists Constructed Themselves as Ethical Professionals: To Be What I Am Not', (Newcastle University, 2013).

[10] P. McIlveen, 'Autoethnography as a Method for Reflexive Research and Practice in Vocational Psychology', *Australian Journal of Career Development,* 17 (2008).

[11] L. Richardson, 'Nine Poems Marriage and the Family', *Journal of Contemporary Ethnography,* 23 (1994), p. 8-9.

[12] M. Humphreys, 'Getting Personal: Reflexivity and Autoethnographic Vignettes'.

[13] J. Gallé and L. Lingard, 'A Medical Student's Perspective of Participation in an Interprofessional Education Placement: An Autoethnography'.

[14] R. Behar, 'The Vulnerable Observer: Anthropology That Breaks Your Heart ', p. 14.

I have used autoethnography fluidly and intuitively in this inquiry to "perform" and problematize the moral issues rarely explored in clinical literature, and to illuminate the theory I am examining. As Norman Denzin observes, these "performance narratives do more than celebrate the lives and struggles of persons who have lived through violence and abuse". They refer us back "to the structures that shape and produce the violence in question".[15] These are the structures that autoethnography has allowed me to infiltrate, illuminate and challenge as a clinician who struggled with and perpetuated this violence within her profession.

This chapter consists of four main sections. The first of these is *Ladies' shoes* and as the only narrative in this chapter, invites the reader behind the mask of this clinician into an affective process that describes an ethical morass. The story, indeed all autoethnography, invites the reader to appraise its narrative worth. To help with this task, we will briefly consider a number of fundamental "criteria" proposed by autoethnographer, Arthur Bochner.

The second section situates autoethnography historically by analysing its recent emergence through the "paradigm wars" of the past 50 or more years. These wars essentially describe the fight for qualitative parity with quantitative research. As we shall see, the ongoing dominance of "scientific legitimacy" is entrenched in a positivist, *quantifying*, worldview despite the emergence of a good number of ideologies that refute its current authority. Our analysis will include examples of these ideologies to illustrate the ever-shifting backdrop of these wars and the ongoing struggle of qualitative researchers—and now autoethnographers—to resist the policing restrictions and interests of positivism.

The third section examines four of the primary characteristics—or criteria—of autoethnography, including *thick description, membership, self-reflexivity and narrative* that we will examine along with the broader implications of their use. Finally, our chapter concludes with a brief synthesis and analysis of the most typical critiques levelled at autoethnography. These inevitably point back to the primacy of a "generalized" worldview and the unrelenting hold of "scientific" research still dominating the world stage. Our critique also considers the problem of power in research and the legitimate concerns of those who oppose autoethnography as well as its adherents.

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[15] N.K. Denzin, 'Performing [Auto] Ethnography Politically', *The Review of Education, Pedagogy & Cultural Studies*, 25 (2003), p. 273.

4.2 Anatomy of an autoethnography

[W]e need other forms of criticism, which are rigorous but not disinterested; forms of criticism which are not immune to catharsis; forms of criticism which can respond vulnerably, in ways we must begin to try to imagine.[16]

4.2.1 Ladies' Shoes

It was my first few weeks on intake in community mental health. I had finally cinched a government job with the kind of salary and benefits package I'd waited too long to achieve. I wasn't used to dealing with doctors and psychiatrists and nurses every day, it was foreign and everything moved fast. I only had a three-month contract and no back-up. I'd left a full-time job I could no longer afford to keep, hoping that this might lead to something permanent. I could not fail. I'd lose the apartment if I couldn't keep up the mortgage payments, my beautiful apartment with the little garden, south facing, and all mine.

Besides the steep learning curve, the medical vibe of the place gave me an adrenaline rush with the onslaught of emergencies that came through the in-take phone lines or showed up at our door. The GP who called me that day was intense and wanted to know if he could get backing from a psychiatrist to force one of his patients to have dialysis who was suddenly refusing it. He needed a signature to certify his patient because this man needed dialysis right now. This man was one of "our" patients living uneventfully in a community housing situation with others who couldn't manage on their own and who were taken care of by the state. They weren't incarcerated or dangerous or locked up in a mental hospital. There was no psychiatric emergency, the resident had simply decided he'd had enough dialysis and made it clear—no thanks.

But I got the hit, the drive of this doctor who would not be refused by his patient. I could hear the quaver of fear in his voice, could hear him breathing on the other end of the phone, the insistence, the urgency, and I could see it all made sense. Or did it? What was he afraid of, what was the panic after all? The GP knew this was not a standard practice, nor a clear-cut psychiatric matter, this was a physical illness and a personal choice. I had no idea how to proceed or what to say but I didn't want him to know that and went to find out. It seemed like an important task and a murky situation. One of the staff psychiatrists I approached rolled his eyes wearily when he got the gist of the story and told me to leave it with him. A signature was found before the end of the day and the resident's wishes were over-ridden. For his own good. It felt like a small victory for me, the newbie who'd helped finesse it all.

I spoke a few days later to a staff member of this man's residence. Had she called me to tell me or had I made a follow-up call to find out how things were going? I can't remember. But I remember how it all happened in slow motion and unfolded like a film clip while we talked. Her words came slowly and deliberately, her voice was soft and tinged with sadness while she described this middle aged man as a character who'd always endeared himself to others with

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[16] R. Behar, 'The Vulnerable Observer: Anthropology That Breaks Your Heart ', p. 175.

his sweet ways and gentleness, his offbeat style and a penchant for wearing ladies' shoes. He'd been known, seen, valued, possibly loved, if only by this staff member and then he was—gone. He'd reached some kind of endpoint, maybe he'd known he was about to die or simply wanted to, and had decided to claim this last act as his own, or tried.

Neither of us said what was really on our minds, but that our hushed conversation belied. We, or someone, had brutally imposed his will—or hers—on another human being with the same rights as anyone but with no way to claim them in his vulnerable position. His sanctity and desecration were so surprising after all, emerging like this in his death.

I didn't want to think about the details but they arose while she kept talking in that slow, soft voice while I drifted away to wonder if they'd strapped him into a chair for this last, or almost last, dialysis. Maybe they'd restrained him in his bed or medicated him into submission beforehand. Or, had he finally acquiesced after a brow-beating from his doctor and the house staff, knowing there was no choice and doing it just to please them and get it over with? He died, anyway, a few days later.

How could it be? The rush, the excitement, the mission I'd been on just days before of talking to that doctor, of discussing it with the psychiatrist. It had all worked out, only it hadn't. There I was, sitting in a small, dimly lit, windowless consultation room bowed over the desk, holding the receiver tightly to my ear and looking blankly at the wood grain of the veneer on the desk while her voice trailed on. I was stunned, nauseous with the sense that I had this man's blood on my hands. But why? I hadn't done anything wrong. I'd only listened, I'd only asked, I'd only tried to help. I was only doing my job. Wasn't I only doing my job?

4.2.2 Appraising autoethnography

Ladies' shoe performs some of the major themes of our inquiry and invites the reader to appraise its narrative worth,[17] but how is to be judged? Arthur Bochner provocatively suggests we should not use *any* criteria to judge an autoethnography as good or bad. He also suggests six general "qualities" that help him "feel with" a story, given the fundamental role of feeling and emotional integrity to autoethnography's effectiveness and success.[18] It is also true that in other literature related to autoethnography, these are "qualities" defined as criteria.[19]

According to Bochner, the first of these qualities is *thick description* that calls for a richness of narrative detail. Ideally, this should evoke an interest in daily routines and the authenticity

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[17] Inviting the reader into the text to engage in such an evaluative process is not antithetical to the autoethnographic process but part of it, as this author illustrates. See: M. Humphreys, 'Getting Personal: Reflexivity and Autoethnographic Vignettes', pp. 850-51.

[18] A. Bochner, 'Criteria against Ourselves', *Qualitative Inquiry*, 6 (2000), p. 270.

[19] In the work of Guba or Lather, however, Bochner's ostensibly non-evaluative "qualities" are defined with some considerable precision, including the quality of "thick description".

of emotion discovered in negotiating unexpected and difficult circumstances. The second quality is a *narrative line* that is complicated and made interesting by a non-linear movement in the narrative that shifts the reader between the past and present, but also between the writer and her cultural context. The third quality emerges when the sincerity of *the writer's vulnerability* accurately reflects and responds, in Bochner's words, to "life's limitations". These relate to "the cultural scripts that resist transformation…contradictory feelings, ambivalence, and layers of subjectivity".[20]

Of greatest interest to the subject of wonder and the ethical is the fourth quality, which leads to *transformation* that is provoked by an *epiphany* to move the writer from who she was, to who she has become.[21] The fifth, re-confirms the centrality of the writer's *ethical accountability* and its evocation which *emerges* through the narrative. We find this articulated in *Ladies' Shoes* during the phone call and the revelatory moment of horror and moral clarity, that exposes me to my responsibility for this utterly innocent man in whose betrayal I have undeniably participated. How effectively the narrative communicates this moral imperative—and only the *reader* can say—relates to the sixth quality, which is *the story's ability to move us*. Without this quality, this *momentum*, the possibilities or meanings emerging from the story may not succeed in shifting our perspective, our thinking and behaviour.[22]

These six qualities are at the heart of autoethnography's unapologetic moral project and its resistance to the ongoing imposition of a positivist—generalizing—worldview. I have little interest in attempting to discredit science's *inestimable* contributions to the world here. Nonetheless, my decision to use autoethnography to interrogate the moral ramifications of my clinical role has found me at the centre of an academic and ethical maelstrom.[23]

4.3 Dodging bullets in the paradigm wars

> I have learned that heresy is greatly maligned and, when put to good use, can begin
> a robust dance of agency in one's personal/political/professional life. So…I began
> writing and performing autoethnography concentrating on the body as the site from

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[20] A. Bochner, 'Criteria against Ourselves', pp. 270-71.

[21] Ibid. p. 270.

[22] Ibid. p. 271. Ellis describes similar characteristics. See: C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', pp. 275-77.

[23] For a good overview, see: N.K. Denzin, 'Moments, Mixed Methods, and Paradigm Dialogs'.

which the story is generated.[24]

The priority of social justice in qualitative research aims to address and *redress* the problem of dehumanization and the erosion of personal liberty.[25] This is central to the project of evocative autoethnography that has incubated through the "paradigm wars" of the past fifty years.[26] These are the wars between the interests of scientific based research—quantitative research—and qualitative research that have played out between these two opposing camps and among opponents within each one, in a constantly shifting ideological landscape. Denzin has theorized that no fewer than seven paradigmatic shifts have taken place from the beginning of the twentieth century to this present or "seventh moment". While these shifts may cut across disparate historical periods and ideologies, they appear as Denzin claims, to be operating simultaneously. Far from being frozen or contained within their historical contexts, these differing and opposing ideologies are constantly interacting, competing and informing each other in *this* present moment.[27]

Qualitative ground has been won and lost throughout these wars although at the end of the 1990s Denzin observes that the "the key assumptions of the interpretive movement were demolished". This occurred when the "incompatibility and incommensurability" debates emerged once again to derogate and destroy the legitimacy of qualitative research as "nonscience". Yet, qualitative research does not and *cannot* employ the same criteria used to prove the validity and reliability of quantitative research.[28]

Even within the qualitative camp, the criteria debate is fraught. Some argue for the need for rationalist criteria to improve the quality and standing of qualitative research. Others claim that the research community's insistence on rationalist criteria undermines the legitimacy

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[24] T. Spry, 'Performing Autoethnography: An Embodied Methodological Praxis', *Qualitative inquiry,* 7 (2001), p. 709.

[25] Denzin is impassioned about the need for a socially conscious approach to research given what he describes as the clear erosion of individual rights and the mobilization of a police state in America in the aftermath of 12/11. See: N.K. Denzin, 'Performing [Auto] Ethnography Politically', p. 258.

[26] N.K. Denzin, 'Moments, Mixed Methods, and Paradigm Dialogs', pp. 420-22.

[27] In 1994 Denzin noted 5 historical periods, and in 2001, 7 historical periods. See:
N.K. Denzin, 'Romancing the Text: The Qualitative Researcher-Writer-as-Bricoleur', in *Qualitative Methodologies in Music Education Research Conference,* ed. by Bulletin of the Council for Research in Music Education' (University of Illinois Press, 1994), pp. 15-30 (p. 16); N.K. Denzin, 'The Reflexive Interview and a Performative Social Science', *Qualitative research,* 1 (2001), pp. 24-25.

[28] N.K. Denzin, 'Moments, Mixed Methods, and Paradigm Dialogs', p. 423.

and clout of qualitative research.[29] Still others attribute the problem of legitimacy to a setback for qualitative research caused by the growing conservatism in research practice in the past ten years.[30]

Further complicating this picture are those scholars describing quantitative and qualitative approaches as *methods* rather than paradigms, when methodology is actually secondary to the question of *paradigm*. For, certainly, the worldview of the researcher is as informed methodologically as it is ontologically and epistemologically.[31] Indeed, the interests of this study strongly support such a view given the remarkable shift in research focus to the moral and political that is now heralding a "third paradigm".

> A paradigm may be viewed as a set of basic beliefs (or metaphysics) that deal with ultimates or first principles. It represents *a worldview* that defines, for its holder, the nature of the "world," the individual's place in it, and the range of possible relationships to that world and its parts, as, for example, cosmologies and theologies do.[32]

A brief analysis of the shifting ideologies forming the backdrop of the "paradigm wars" will help contextualize the historical emergence of this new paradigm. Four of these ideologies, sketched-in below, define positivism, post-positivism, constructivism and postmodernism.[33]

4.3.1   Positivism

Quantitative research generally reflects the values and beliefs of positivism, which claims the existence of an "apprehendable reality". This is supposedly "driven by immutable laws and mechanisms…in the form of time and context-free generalizations, some of which take the form of cause-effect laws".[34] "The term positivism denotes the "received view" that has dominated the formal discourse in the physical and social sciences for some 400 years."[35] This approach describes a reductive, rationalistic, deterministic or atomistic perspective seen only by the observer. The perspective assumes that whatever—or *whoever*—is being

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[29] L. Krefting, 'Rigor in Qualitative Research: The Assessment of Trustworthiness', *The American journal of occupational therapy,* 45 (1991), p. 214.

[30] S.J. Tracy, 'Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative Research', *Qualitative inquiry,* 16 (2010), p. 838.

[31] E.G. Guba and Y.S. Lincoln, 'Competing Paradigms in Qualitative Research', in *Handbook of Qualitative Research,* ed. by N. K. Denzin (Thousand Oak, CA: Sage, 1994), pp. 105-17.

[32] Ibid. p. 107.

[33] See Table 6.2 for an overview of the differences between positivism, post-positivism and constructivism see: ibid. p. 112.

[34] Ibid. p. 109.

[35] Ibid. p. 108.

observed is also completely independent of the researcher or, more accurately for our interests, *dissociated* from her.

The precision developed through this kind of research is inarguably necessary when the goal is prediction and control, and may explain why mathematics has been called the *queen* of science.[36] Yet, the ongoing dominance of positivism means that the "hard sciences" like chemistry and physics still command far greater respect and legitimacy. Whereas, those fields of research that do not quantify their findings, are derogated as "soft" sciences and deemed less valuable and less scientifically legitimate for that reason.

4.3.2 Post-positivism

By comparison, post-positivism embraces the notion of an ultimate reality we can only assume but never wholly grasp. Since we can never perfectly apprehend reality, the best we can do is approximate the truth by subjecting our research claims to critical examination. This process is "always subject to falsification" and accomplished by measuring or comparing the research to what is known—or agreed—and by submitting it to the scrutiny of the research community.[37] Its methods are practiced through qualitative approaches that recognize the importance of social context and meaning making on the part of its subjects. Norman Denzin describes this approach as multi-method, interpretive and naturalistic. Its methods include the use of case study, personal experience, introspection, life story, interview, observational, historical, interactional, and visual texts that describe routine and problematic moments and meanings in individuals' lives.[38]

4.3.3. Constructivism

Constructivism moves beyond the notion of an ultimate truth to idea*s* about the fluidity of knowledge. In this instance, truth is not established but rather, informed and refined.[39] The findings are "literally created" as the research emerges through the process occurring between and among investigators and respondents. "The naturalistic paradigm asserts … that the inquirer and the respondent (note the shift in terminology from "object") are

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[36] Ibid. p. 105.
[37] Ibid. p. 110.
[38] N.K. Denzin, 'Romancing the Text: The Qualitative Researcher-Writer-as-Bricoleur', p. 16.
[214] E.G. Guba and Y.S. Lincoln, 'Competing Paradigms in Qualitative Research', pp. 110-11.

interrelated with each influencing the other".[40] The outcome is consensual, co-created and evolving as autoethnography partially demonstrates. This kind of research started showing up on the desks of thesis committees, peer-review committees and journal editors as a new and emerging form of research demanding recognition.[41] Finally, the academy had to respond to the demand for an emerging form of research that recognized new values and took aim at traditional research approaches.

4.3.4   *Postmodernism*

Finally, postmodernism shows the connection between truth and the "vocabularies and paradigms" used to describe it. Within this research, new relationships are established between "authors, audiences and texts" to *resist* the methods of those who formerly used and discarded the cultures they investigated. Postmodernism recognizes the significance of the story for its complexity and ability to communicate morally and ethically. It represents a move *away* from the notion of value-free to value-laden research that favours literature over the hard sciences.[42] The self-reflexive voice that emerges as the centrepiece of this approach reflects the many possible ways of "knowing and inquiring,"[43] enabling the researcher to become a "boundary-crosser" of a whole constellation of identities. These are constantly shifting and identify not only the speaker but also *the one for whom she speaks*.[44]

4.4 The third paradigm

These four ideologies trace the movement towards an emerging *third* paradigm that is beyond the current capacity or interests of quantitative, qualitative, or even "mixed methods" research, which combines the two.

> The field is on the edge of a new paradigm dialogue, a third formation existing beyond SBR[45] and mixed methods. This is the space primarily filled by non-mixed methods interpretive researchers, the empowerment discourses: critical constructionists, feminists, critical pedagogy and performance studies; oral historians … and interpretive interactionists. These are scholars in a different space. They

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[40] E.G. Guba, 'Criteria for Assessing the Trustworthiness of Naturalistic Inquiries', *Educational communication and technology,* 29 (1981), p. 77.

[41] Ibid. pp. 75-76.

[42] C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', p. 274.

[43] S. Wall, 'An Autoethnography on Learning About Autoethnography', *International Journal of Qualitative Methods,* 5 (2008), pp. 147-48.

[44] D.E. Reed-Danahay, *Auto/Ethnography* (Berg New York, 1997), p. 3.

[45] SBR is the acronym for science based research.

seldom use terms like *validity* and *reliability*. For some, a minimalist approach to theory is endorsed. A disruptive politics of representation is the focus, as are the methods that disturb the smooth surfaces of SBR. Scholars are crafting works that move persons and communities to action ..."[46]

Paradoxically, autoethnography's strength lies not in the policing of boundaries or the imposition of theory and truth claims. It lies in the emotional intimacy and vulnerability of a well-crafted story and the emerging epiphany that may help "move" the reader and his or her communities to political action.[47] There are no tidy boundaries in autoethnography between the "ethnographic, the artistic, the epistemological, the aesthetic, and the political".[48]

Despite the emergence of these new cultural perspectives and the ever-growing role of subjectivity, positivism is still the orthodox approach for empirical research.[49] Research failing to reflect these positivist standards is consequently less well regarded, or rewarded, in terms of research dollars, authority, visibility, or "scientific" legitimacy.[50] American qualitative scholar, Yvonna Lincoln, suggests the stakes are actually *much* higher than this.

> There is a "politics" of evidence. Beyond the questions of legitimacy, hegemony and reward structures at universities, there are larger questions, which subsume mere issues of legitimacy. Three of those questions are whether or not science has a moral aspect; who determines what counts as evidence and who is persuaded by it; and what is the nature of the "language game" which is being played out in the politics of evidence?[51]

The policing function of the dominant discourse constantly overshadows autoethnography to threaten its legitimacy and development. Bochner has attempted to extricate autoethnography from this political tug-of-war by suggesting that these two ways of seeing are not so much opposing as simply incommensurable. He suggests that the arguments claimed by either side are ultimately "contingent on human choices".[52] Autoethnography

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[46] N.K. Denzin, 'Moments, Mixed Methods, and Paradigm Dialogs', p. 424.

[47] Ibid. p. 423. For more on this new paradigm, see also: N.K. Denzin, 'Aesthetics and the Practices of Qualitative Inquiry', *Qualitative Inquiry*, 6 (2000).

[48] N.K. Denzin, 'Aesthetics and the Practices of Qualitative Inquiry', p. 261.

[49] P. Lather, 'Issues of Validity in Openly Ideological Research: Between a Rock and a Soft Place', *Interchange*, 17 (1986), p. 63.

[50] For new criteria suggested for qualitative research, see: S.J. Tracy, 'Qualitative Quality: Eight "Big-Tent" Criteria ', pp. 839-40.

[51] Y.S. Lincoln, 'On the Nature of Qualitative Evidence', in *Annual meeting of the Association for the Study of Higher Eduction*, (Nov. 21-24, 2002), pp. 1-23 (p. 16).

[52] A. Bochner, 'Criteria against Ourselves', p. 266.

does focus on the ethical and the epiphanic as opposed to a "pre-existing or static set of standards". As Bochner confirms, however, the latter is what distracts us from the work of clarifying the "important differences that separate us," and ultimately hobbles the progress of truly ethical research.[53]

Denzin also suggests that "moral and epistemological discourses" need not be in conflict and are not antithetical to each other but can cohabit "side by side". Evidence of which may be found in emerging fields of study on "[r]ace, ethnicity, sexuality, class, the research rights of indigenous peoples, whiteness, and queer studies". These are now informing discourse that, Denzin observes, would never have occurred in the 70s and 80s.[54] Nonetheless, the paradigm wars rages on.

4.5 From ethnography to autoethnography and thick description

In this section, we examine the rise of autoethnography from its ethnographic roots and consider the central role played by "thick description". Ethnography is a theoretical field of practice aimed at deepening understanding of a given culture or group from an insider or an outsider's perspective. The researcher is engaged first-hand in observing, participating and closely documenting the people within a given culture or environment.[55] As a participant observer, the ethnographer uses "thick description" to develop her written accounts and to look for repeating patterns within that culture. These emerge in recurring themes found, for example, in songs, stories, belief systems, rituals or events.[56]

"Thick description" is a term coined by leading American anthropologist, Clifford Geertz that emerged in the development of ethnography.[57] It was an approach used to deepen knowledge and cultivate depth, perspective and understanding within *single* cases, as opposed to "codify[ing] abstract regularities" to generalize *across* cases.[58] Thick description, Geertz claimed, was inseparable from cultural theory given the limitations of its inner logic. Any emerging ethnographic theory, he believed, must necessarily reflect back to this

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[53] Ibid. p. 269.

[54] N.K. Denzin, 'Moments, Mixed Methods, and Paradigm Dialogs', p. 424.

[55] C. Ellis, *The Ethnographic I: A Methodological Novel About Autoethnography* (Walnut Creek, CA: AltaMira Press, 2004), p. 26.

[56] C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', p. 277.

[57] See: C. Geertz, 'Thick Description: Toward an Interpretive Theory of Culture', in *Turning Points in Qualitative Research: Tying Knots in a Handkerchief,* ed. by Y. S. Lincoln and N. K. Denzin (Walnut Creek, CA: AltaMira Press, 2003), pp. 143-68.

[58] Ibid. p. 165.

description and grow "out of the delicacy of its distinctions, not the sweep of its abstractions".[59] The strength of thick description lies in its *resistance* to generalization and its ability to glean not only difference but also the refinement and subtlety of such difference.

Ethnography becomes *autoethnography* when this rich, detailed, evocative language focusses on the *author* within *her own* cultural context. Rather than the researcher remaining in the background, as she does in ethnography, the autoethnographer is the writer and protagonist. Her inner process, experience and response are central to the story and to an understanding of the social world that she inhabits.[60] In this inquiry, as we have already seen, thick description eludes a generalizing, reductive perspective to evoke the *irreducibility*—the perfection, the inviolability—of the help seeker, while also asserting what is irrevocably *relational* between the clinician and the help seeker. The "method and text"[61] of thick description justifies a minimalist approach to the use and development of theory in autoethnography. For, as Bochner reminds us, "there is nothing more theoretical than a good story".[62]

4.5.1 *Evocative versus analytic autoethnography*

The issue of theory building emerges as the central debate between analytic and evocative autoethnographers, although this is something of a sidebar as autoethnography is generally identified with its evocative form. Nonetheless, the issue of generalizability is the main dividing line between these two types and the argument is heated.

Denzin abandoned his own analytic roots for what he believes to be higher moral ground, despite the greater academic risks involved. He also strenuously objects to the appropriation of evocative autoethnography's creative techniques by analytic autoethnographers who, he claims, continue to oppose "poststructural,[63] antifoundational arguments" of the past quarter

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[59] Ibid. pp. 164-65.
[60] L. Anderson, 'Analytic Autoethnography', p. 384.
[61] D.E. Reed-Danahay, 'Auto/Ethnography', p. 8.
[62] A. Bochner, 'It's About Time: Narrative and the Divided Self', *Qualitative Inquiry,* 3 (1997), p. 435.
[63] Poststructuralism is defined as the abandonment of the aims of "transcendence," characterized by a focus on "individual or particular/local resistance to the effects of power," including power legitimized as transcendental. See: M. Morris, 'The Critique of Transcendence: Poststructuralism and the Political', *Political Theory,* 32 (2004). pp. 121-122. Lather suggests that, poststructuralism and the autoethnographic are attempts to move from "yesterday's institutions" by focussing on the "difficulties involved in representing the social rather than repressing them in pursuit of an unrealized ideal". See: P. Lather, 'Fertile Obsession: Validity after Poststructuralism', *The Sociological Quarterly,* 34 (1993), pp. 673, 76, 77.

century.[64] Denzin derides his analytic colleagues for failing to "write messy vulnerable texts that make you cry," and for "keep[ing] politics out of their research".[65]

> Ethnography is a not an innocent practice…Through our writing and our talk, we enact the worlds we study…The pedagogical is always moral and political; by enacting a way of seeing and being, it challenges, contests, or endorses the official, hegemonic ways of seeing and representing the other.[66]

In contrast analytic autoethnographer, Leon Anderson, calls for an approach to autoethnography that embraces theory building and claims the need for broader generalization.[67] Despite these differences, analytic and evocative types still share three of five major characteristics which Anderson himself claims are central to autoethnography and which include, membership, self-reflexivity and narrative.[68]

4.5.2   Membership

American anthropologist, Davie Hayano, was the first to theorize the importance of the *social* connection between the researcher and the subject that is so fundamental to the interests of autoethnography. [69] This approach to research came to his attention in 1966 during a seminar at the London School of Economics when the story was recounted of a "shouting match" that had occurred some years before between a black and a white African, Jomo Kenyatta and L.S.B. Leakey. Their ferocious argument hinged on Kenyatta's study of his own people that brought into question the "validity of anthropological data" that did not also include a careful assessment of the "characteristics, interests, and origin of the person who did the field work".[70] Hayano went on to theorize this issue.

Hayano claimed that the "membership" of the researcher to the subject(s) actually defined autoethnography and he theorized three possible types. In each case, membership minimally required that, "researchers possess the qualities of often permanent self-identification with a group and full internal membership, as recognized both by themselves

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[64] N.K. Denzin, 'Analytic Autoethnography, or Déjà Vu All over Again', *Journal of Contemporary Ethnography,* 35 (2006), p. 421.
[65] Ibid. p. 421.
[66] See: ibid. p. 422.
[67] L. Anderson, 'Analytic Autoethnography', p. 388.
[68] Anderson proposes five main characteristics for analytic autoethnography including, membership, reflexivity, narrative visibility of the researcher, dialogue with other informants and theoretical analysis. See: ibid. p. 378.
[69] C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', p. 278.
[70] D.M. Hayano, 'Auto-Ethnography: Paradigms, Problems, and Prospects', *Human organization,* 38 (1979), pp. 99-100.

and the people of whom they are a part".[71] This represented a major step forward in addressing the problem of research conducted within a hierarchical system that had previously placed the "subject" *below* the researcher.[72]

Such distinctions have blurred as the field advances, giving way to more contemporary ideas about affiliation and "co-participant" equality. [73] Carolyn Ellis, for example, recognizes even friendship as an ethical platform for moral research because it eliminates the researcher's need to "pretend". Ellis regretfully recounts how, earlier in her career, she and other colleagues had feigned friendship with research participants to obtain the information they required.[74] In community mental health care, we find similar emotional manipulations replicated within the "therapeutic relationship" where the help seeker's trust is conscripted in the service of clinical exigencies.[75]

Encouragingly, the vocabulary describing the "subject" within ethnography has evolved over time, moving her ever closer to the researcher as an "informant" a "participant," a "co-participant" and now even a "friend". The narrowing gap has changed the researcher's role from the "privileged possessor of expert knowledge" to a collaborator and community member allied with her subject.[76] This increasing intimacy has also opened the dialogue to ever more complex questions about relational possibilities that are moving autoethnography towards a form of moral practice and social activism. This approach has enormous salience for the clinical relationship in community mental health care and is an area of research that is virtually unexplored in psychological literature.[77]

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[71] Ibid. p. 100.

[72] Referring to a term coined by Reinharz, S. (1979), Lather observes this ""rape model" of research: career advancement of social scientists built on alienating and exploitative methods". See: P. Lather, 'Issues of Validity ', p. 75.

[73] D.E. Reed-Danahay, 'Auto/Ethnography', pp. 8-9.

[74] C. Ellis, 'The Ethnographic I: A Methodological Novel About Autoethnography', p. 148.

[75] The work to which I repeatedly return for its fine synthesis on the mechanism of clinical manipulation is: M.T. Taussig, 'Reification and the Consciousness of the Patient'.

[76] P. Lather, 'Issues of Validity ', p. 73.

[77] Sayers' work examines the theories various legendary psychoanalysts, from William James to Julia Kristeva, to examine their theoretical and personal perspectives on love and relationality in therapy. See: J. Sayers, *Divine Therapy: Love, Mysticism, and Psychoanalysis* (New York: Oxford University Press, 2003). Beyond this resource, I have only found a handful of articles specifically related to love in the context of psychiatric or psychological care such as: Y. Cohen, 'Loving the Patient as the Basis for Treatment', *American Journal of Psychoanalysis,* 66 (2006).

4.5.3 *Reflexivity*

Reflexivity is central to autoethnography and becoming more widely accepted, Denzin insists, as part of a "global, reflexive, critical ethnography".[78] Reflexivity is an introspective process that mines the feeling, memory, cognition, impulse and physiological response of the researcher. These allow her to map new knowledge about a given experience or encounter.[79] The reflexive voice of the researcher becomes the research itself in its reflection on her experience, process and role.[80]

There are also various forms—theoretical approaches—of reflexivity. Of greatest interest to our inquiry is "confessional reflexivity" because it so closely allied to my own narrative interests and style.[81] Carolyn Ellis describes confessional ethnography as the story *about* the research that early ethnographers typically kept separate from their public work. This term now refers to an approach focussed on the interaction between the researcher and the participant within the evocative writing process. Ellis prefers the term "ethnographic memoir" despite the problematic associations with memoir that undermine autoethnography's legitimacy. Still, the term "confessional" is equally problematic given its connotations of shame, weakness and guilt used to derogate and dismiss autoethnography, and is an issue that Ellis, Behar and Bochner have addressed in their work.[82] Nonetheless, it is the interior process of self and other interrogation, which transforms the researcher's "beliefs, actions, and sense of self".[83]

In earlier conceptualizations of this term, reflexivity referred to one of several different practices aimed at increasing the "trustworthiness" of naturalistic research.[84] These included daily journaling, "peer debriefings" or "member checks" that helped solicit participants' response to the research. They also included the use of "triangulation," aimed at testing

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[78] N.K. Denzin, 'Performing [Auto] Ethnography Politically', p. 268.

[79] C. Ellis, 'Sociological Introspection and Emotional Experience', *Symbolic interaction*, 14 (1991), pp. 23-25.

[80] S. Wall, 'An Autoethnography on Learning About Autoethnography', pp. 147-48.

[81] For details on all three theoretical approaches to reflexivity, see: N.K. Denzin, 'Performing [Auto] Ethnography Politically', pp. 268-70.

[82] See: C. Ellis, 'The Ethnographic I: A Methodological Novel About Autoethnography', pp. 49-50.

[83] L. Anderson, 'Analytic Autoethnography', pp. 382-83.

[84] Guba translated quantitative criteria into criteria applicable for the qualitative approaches of naturalistic research and changed the concept of rigour as the primary measure of quantitative excellence to *trustworthiness*, as its qualitative equivalent. See: E.G. Guba, 'Criteria for Assessing the Trustworthiness of Naturalistic Inquiries', pp. 85, 87.

one's reflexivity against various data sources, investigators, theories, and methods.[85] This early formulation of reflexivity was entrenched in ideas of scientific neutrality and objectivity that have given way to the transparently political and subversive aims of autoethnographers that are openly "committed to a more just social order".[86]

In working to make a place for itself in the academy, autoethnography will need to establish clear criteria to claim its validity, no matter how persuasively those autoethnographers—described as theoretically minimalist—may argue to the contrary. Patti Lather's work on validity in autoethnography has shown that the issue of criteria is very much part of the dialogue. The work of developing, theorizing and translating quantitative criteria into their qualitative equivalent, and more specifically their *autoethnographic* equivalent, is ongoing and challenging. An example, found in the notion of "rigour" as a measure of quantitative merit, translates into the qualitative equivalent of "trustworthiness".[87] This skilful translation also reflects the necessary integrity of the writer's process to the verisimilitude of her narrative, *if* she is to move the reader. It seems reasonable, therefore, to suggest that such trustworthiness does reflect the "rigour" of the story's ethical veracity. These are also early days in the development of criteria that, Patti Lather cautions, will have to be fully articulated to genuinely support "morally engaged" *research*.[88]

The role of reflexivity has changed significantly over time. No longer primarily or simply used to establish the legitimacy of naturalistic research as a respectably neutral player in empirical research, the self-reflexive voice is emerging in autoethnography as a radical political tool. In our current inquiry, the trustworthiness of this voice lies in its capacity to interrogate and illuminate the ethical violations of clinical praxis while extending a moral appeal to the clinician that is exceptionally compelling.

4.5.4   Narrative
Narrative presence is fundamental to autoethnography and typically expressed in the form

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[85] For autoethnographic perspective of triangulation, see also: P. Lather, 'Issues of Validity ', pp. 69, 72, 74, 77, 78.
[86] Ibid. pp. 66-67.
[87] J.M. Morse and others, 'Verification Strategies for Establishing Reliability and Validity in Qualitative Research', *International journal of qualitative methods,* 1 (2008), p. 15.
[88] See Patti Lather's excellent work in this area. P. Lather, 'Issues of Validity '; P. Lather, 'Fertile Obsession: Validity after Poststructuralism'.

of a short story written in the first person with the researcher as subject.[89] This narrative can also be expressed through other creative mediums, including photography, dance, stage plays, and video music, even film. The choice is contingent on the research question and the researcher's creative skill, which determine the process and outcome of the work.[90] A written narrative could be virtually anything from a poem to a comic book. In evocative autoethnography, however, the narrative *becomes* the theoretical and, as we have mentioned, may remain as a stand-alone piece stripped of any additional theory or analysis as illustrated in the three following examples.

In *The Academic Tourist*, for example, Robert Pelias' ironic examination of his life as a career academic offers a witty but poignant expose of the pretensions of academia. As the mortified writer, Pelias mines these pretensions to uncover the hubris of the academy and the humanity of an academician trying to keep up appearances.[91] In *Girl in a Cast*, American anthropologist, Ruth Behar, tracks an anguishing period in her childhood to a spiritual awakening in adulthood that helps her reclaim her vulnerable and authentic voice in mainstream anthropology.[92] In, *It's about time: Narrative and the divided self*, Arthur Bochner connects the sudden news of his father's death to his recognition of the inadequacy of the academy in which he is also deeply entrenched.[93] The transformative moment occurs when Bochner sees – *as if for the first time*—what he already profoundly knows but learns anew. "I was stunned to learn how tame the academic world is in comparison to the wilderness of lived experience".[94]

These are all gripping, emotional, seamless, stand-alone pieces that qualify as autoethnography. They are revelatory, artistically crafted, convincing, evocative, and speak for themselves without the need for theory or analysis. They also demand an ethical response from the writer as well as the reader. For, in each of the three narratives, a paradox emerges that discloses and confirms a problem—an *enigma*—as well as a possible resolution pointing towards the ethical and the *relational*. The latter is also elusive, complex and

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[89] C. Ellis, 'The Ethnographic I: A Methodological Novel About Autoethnography', p. 30.
[90] Ibid. p. 193.
[91] R.J. Pelias, 'The Academic Tourist: An Autoethnography', *Qualitative Inquiry*, 9 (2003).
[92] R. Behar, 'The Vulnerable Observer: Anthropology That Breaks Your Heart ', pp. 104-35.
[93] A. Bochner, 'It's About Time: Narrative and the Divided Self'.
[94] Ibid. p. 421. For an emotive narrative of Bochner's involvement with his mother's death and its intersection with 9/11, see also: A. Bochner, 'Love Survives', *Qualitative Inquiry*, 8 (2002).

somehow thwarted by the impregnable defense of the status quo in which the writer is situated.

As we can see, narrative presence provides the researcher with the means to attempt a very different kind of research discovered in narrative's capacity to make visible the unjust and policing mechanisms of power. This transparency resides in the inclusive style of the narrative that also makes the meaning of the story accessible to a broad range of readers beyond the boundaries of the academy and its obscure lexicons. Certainly, the creation of narrative presence that calls for *evocation* would seem to require the writer's abstention from professional or academic jargon that might exclude many readers.[95] Finally, narrative presence enables the researcher to explore protected worlds of highly personal experience rarely accessed in traditional research that subvert boundaries and hierarchical separations between and among us. Within them, the writer can sensitize the reader to the politics of her experience and the larger truth about people different—or perhaps *not* so different—from herself.[96]

4.5.5 Conclusion

Autoethnography illustrates the salience of membership, self-reflexivity and narrative to its moral and political project. In our current enquiry, these characteristics have enabled me to interrogate and reveal the harrowing injustice beneath the seamless veneer of clinical praxis and authority, as we find explored in *Ladies' Shoes*.[97] Here the stunning singularity of the vulnerable help seeker—whose face we never even see—infiltrates the writer's generalized worldview to assert its shattering truth. The transformative moment magnifies and confirms the clinician's—*my*—undisputable intimacy with the stranger and the devastating responsibility she has failed to honour.

Yet, even the most successful autoethnographer remains open to the ongoing threat of eviscerating personal critique that can be emotionally wounding and academically damaging. Carolyn Ellis recounts the emotional risk she took with her students, in sharing an exceptionally personal story of loss that she had written with her husband. She had only intended to open up a wider dialogue about a sensitive issue and about the significant risks

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[95] C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', p. 277.

[96] Ibid. p. 274.

[97] See: Ladies' Shoes (4.2.1).

of undertaking this type of research, but the feedback from some of her students was devastating.[98]

> I am trembling by the time I finish. I want to dismiss these responses but … I push myself to face them. I know people react in these ways, but that knowledge doesn't dull the pain of seeing the condemnation in print, a pain that is part of the cost of doing autoethnography deeply and honestly. [99]

Ruth Behar suggests that the vulnerable writer also has more to lose because "boring self-revelation" is ultimately "humiliating".[100] Yet, the exposure of the writer's inner world to such scrutiny also speaks to the integrity of an intensely moral research process that makes the autoethnographer something of a cultural whistle blower and more likely to be reviled for that reason.

4.6 Criticism and limitations of autoethnography

> Qualitative researchers are called journalists, or soft scientists. Their work is termed unscientific, or only exploratory, or entirely personal and full of bias. It is called criticism and not theory, or it is interpreted politically, as a disguised version of Marxism or humanism.[101]

Autoethnography is subject to criticism from inside and outside of its borders as it should be. Its most predictable "defect," however, seems to lie in its heresy of defying the laws of logical positivism. Patti Lather has suggested this is a specious argument given the "increasingly definitive critique of the inadequacies of positivist assumptions in the face of the complexities of human experience".[102] This is the critique based in feminist research, neo-Marxist critical ethnography and Freirian "empowering" research," whose greater foci lie in "transformative agendas" and "research as praxis".[103] This has opened a space for the recent flourishing of autoethnography, although the opposition is still attempting to tarnish its "scientific legitimacy" while ignoring the gravitas of its moral project.

The dominion of scientific neutrality and objectivity—so cherished by the positivist

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[98] C. Ellis, 'The Ethnographic I: A Methodological Novel About Autoethnography', pp. 75-81.

[99] Ibid. p. 81.

[100] R. Behar, 'The Vulnerable Observer: Anthropology That Breaks Your Heart ', p. 13.

[101] N.K. Denzin, 'Romancing the Text: The Qualitative Researcher-Writer-as-Bricoleur', p. 19.

[102] P. Lather, 'Issues of Validity', p. 63.

[103] Lather notes that feminist research seeks to overcome invisibility and distortion; Marxist research aims to show how schooling establishes social and economic inequality. Frierian research blurs "the distinctions between research, learning, and action". See: ibid. pp. 68-75.

worldview—seems inviolable when invoked to delegitimize autoethnography, but these are also myths, Lather has observed. Indeed, these are the very elements that "mystify the inherently ideological nature of research in the human sciences and legitimate privilege based on class, race, and gender".[104] In contrast, autoethnography's project seeks to *demystify* which is why its methods are transgressive and performative. Not surprisingly it is fiercely opposed by those upholding the very structures that autoethnography seeks to subvert. The backlash predictably hinges on a singularly one-dimensional argument that is uniformly consistent with a reductive worldview. This view asserts that autoethnography is *not* reliable, valid, rigorous, sufficiently theorized, generalizable, scientific or legitimate *enough*, because it does not embrace the positivist project. From a positivist viewpoint, this is quite true but as Bochner and his colleagues have asserted, and as post-modernity has shown it *is* a myth that criteria are "beyond culture…ourselves and our own conventions".[105] Nonetheless, the consequences of challenging this myth are substantial.

4.6.1 The perils of writing autoethnography

The concerns of any researcher undertaking autoethnographic research can be withering and Niall Devlin suggests eight different "traps" for the unwary. In identifying these, Devlin confirms his own awareness of the kinds of opposition he can anticipate as an autoethnographer, and a readiness to ensure that no offence is given. I would suggest, however, that this list is already underwritten with contempt for the autoethnographer that is hard to miss on closer investigation.

Thus, autoethnography is to avoid being:

1. Normative (attempting to establish a new set of universal rules)

2. Sanctimonious/Pharisaic (adopting an inappropriate tone)

3. Instrumental (assuming that experiences can be unproblematically codified, categorized and made thematic)

4. Narcissistic/vainglorious (reflectivity that just said "look at me")

5. Monologic (developing knowledge only through self-reflection instead of dialogic interaction with theory and others)

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[104] Ibid. p. 64.
[105] A. Bochner, 'Criteria against Ourselves', p. 267.

6. Enabling closure (presuming that there is only one truth and enabling only one reading of the situation)

7. Warranting insider accounts (privileging the knowledge produced just because it has been developed by a practitioner)

8. Slipping into reflectivity as personal therapy.[106]

This list really addresses only two concerns. The first, and arguably the most benign, is the need to avoid *generalization* which, interestingly, is the whole point of evocative autoethnography. Certainly, this "trap" would appear to pose little—if any—risk. For, in writing autoethnography, the researcher is establishing her intention—indeed her *desire*—to assiduously *avoid, sidestep and subvert* the very problems generalization create, the argument for analytic autoethnography notwithstanding.[107] Nonetheless, Devlin's list stipulates that the researcher is to *resist* undertaking autoethnography that might appear to be normative, thematised, codified or closed as enumerated by items 1, 3 and 6 respectively.

The second concern is the self-reflexive voice which apparently is at risk of extraordinary and un-conscious self-indulgence. Hence, the researcher is to avoid the traps of being sanctimonious, narcissistic, monologic, of privileging her knowledge, or worse, of slipping into personal therapy, according to items 2, 4, 5, 7 and 8. These concerns raise the immediate question of why any researcher would *ever* willingly risk such accusations. For, these could effectively decimate a scholar's academic reputation and her research, rendering it worthless if not contemptible by *any* standards. Of greater interest is whether this self-reflexive voice— and the damning and disturbing moral issues it reveals—can ever avoid being pilloried by these accusations from the opposition.

With respect to Devlin's list, it would seem that the indictment of generalization would more likely come from other autoethnographers who, like Denzin, have intentionally distanced themselves from the theoretical pursuits of analytic autoethnography. In contrast is the reflexive voice that is so vulnerable to such blistering censure by its positivist critics *simply because it is used*. I would have to agree that it is entirely possible for autoethnography

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[106] N. Devlin, 'A Critical Examination and Analysis of the Processes by Which Educational Psychologists Constructed Themselves as Ethical Professionals: To Be What I Am Not', p. 24.
[107] See: Evocative versus analytic autoethnography (4.5.1).

to be poorly written, narcissistic, psychologically naïve and boring to read. It is equally possible for positivist research to be shoddy, bloodless, obtuse, dehumanizing and irrelevant. More importantly, the sheer dominance of positivist research protects it from the criticism to which autoethnography remains vulnerable. Indeed, the contempt and power of the positivist critique is the very one that *confirms* autoethnography's raison d'être.

4.6.2 *Power and responsibility: The problem of integrity*

It is also true that autoethnography's self-reflexive voice can never be completely beyond suspicion or reproach no matter how responsibly or vulnerably it is used. For, the voice tracking the researcher's moment-to-moment process as well as the power dynamics in which she is embedded also benefits *the researcher*. While autoethnography invites me to resist the mechanisms of power on behalf of the vulnerable help seeker, it also compromises my efforts to do so, given my membership with the authorizing institution. This is what shapes and legitimizes my speech and writing as a scholar—even my clinical notes—that I hesitate to imperil with autoethnographic candour.[108] I am well aware that my self-conscious confession and discomfort, within a form that makes any evidence admissible, leaves me all too visible and consequently vulnerable professionally *and* ethically.[109]

Despite the moral distress, and the sometimes harrowing sense of culpability I have experienced as a clinician, my institutional authority is valuable to me. As William Tierney observes, however, this authority continually jeopardizes the integrity of my autoethnography. Postmodernity may sufficiently disturb my perspective to help me resist slipping into the comfortable roles of "power and domination". Yet, claiming membership, kinship or friendship with those I wish to authorize and dignify as an autoethnographer is *not* enough. Tierney notes that this is especially true for the researcher who does not *like* working with those with whom she is engaged in research, and with whom she will never become "comrades" or "find solidarity".[110] Even if she *does* like them, however, her research will still be at risk. For, this solidarity can "reinstill in our relations … who is right and who is wrong," even though the researcher is the one who always holds the balance of "power,

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[108] Tierney describes the difficulty in balancing the "inner logic" of the story with the audience's need to understand and the publisher's willingness to print. See: W.G. Tierney, 'Life History's History: Subjects Foretold', *Qualitative Inquiry*, 4 (1998), p. 53.

[109] L. Richardson, 'Evaluating Ethnography', pp. 253-54.

[110] W.G. Tierney, 'Life History's History: Subjects Foretold', p. 56.

voice, and authority".[111]

By refusing to essentialize the help seeker, or to fall prey to the illusion that there is any real refuge from the problem of power, the danger posed by my authority is still only partially resolved. This is especially true, Tierney suggests, when I wish to rescue someone as I surely have in the context of my work.[112] Moreover, like Ruth Behar, I too have been unsettled to find myself "resisting the "I" of the ethnographer as a privileged eye, a voyeuristic eye, an all-powerful eye".[113] There *is* no escape, Tierney confirms, because "[t]he relationship in which we involve ourselves is inherently infused with power. Our challenge is to recognize it and decide how we will function within it".[114] Yet, there is good reason to confront these challenges, and to be heartened by the integrity of an approach that places the problem of power at the forefront while demanding the ethical vigilance of the researcher.[115]

4.7 Conclusion

> It is not *just* about "method or technique". Rather, qualitative research is about making the world visible in ways that implement the goals of social justice and radical progressive democracy.[116]

The ethical concerns at the centre of this inquiry make evocative autoethnography's demand for "radical social change" both urgent and hopeful.[117] Its proponents are courageously if not recklessly demonstrating how scholars can and must disclose their inner lives in their research. These scholars are committed to the ongoing evolution of autoethnography as a form of research which recognizes that "[t]he critical imagination is radically democratic, pedagogical, and interventionist".[118] Its mandate rejects the idea of research for its own sake. That is, research aimed at gaining ever more fine-grained or sophisticated perspectives or theories of problems or phenomena, while ignoring the suffering of people at the centre. "Its ethics challenge the ethics of the marketplace, it seeks utopian transformations committed to

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[111] Ibid. pp. 56-57.
[112] Ibid. p. 56.
[113] R. Behar, 'The Vulnerable Observer: Anthropology That Breaks Your Heart ', p. 17.
[114] W.G. Tierney, 'Life History's History: Subjects Foretold', p. 64.
[115] See: J. Taylor, 'The Intimate Insider: Negotiating the Ethics of Friendship When Doing Insider Research', *Qualitative Research*, 11 (2011).
[116] N.K. Denzin and M.D. Giardina, 'Introduction', in *Qualitative Inquiry and Human Rights*, ed. by N. K. Denzin and M. D. Giardina (Walnut Creek, CA: Left Coast Press, 2010), (p. 14).
[117] N.K. Denzin, 'Performing [Auto] Ethnography Politically', p. 259.
[118] Ibid. p. 261.

radical democratic ideals".[119] All of which help expose and subvert the many accepted norms, beliefs and values of academic research.

Autoethnography corrects the still restricted view of what constitutes real or significant research, and has enabled me to perform what *should* profoundly concern anyone seeking the help of community mental health care or working in this field.[120] The term "performance ethnography" denotes what Denzin sees as the imminent future of autoethnography. That is, as a form of discourse and a way of being in the world that is fundamentally moral and political. Performance, he believes, will eventually blur the line between autoethnography and ethnography altogether when the self-reflexive researcher becomes the "guiding presence" in the text. At which point the critical social sciences will become "a force to be reckoned with in political and cultural arenas".[121] Perhaps they will.

Nonetheless, Tierney's point that the self-reflective voice is never beyond the problem of the power it seeks to subvert, cannot be overstated. Even within this inquiry there are good enough reasons for caution and restraint in challenging the professional and institutional boundaries of community mental health care. Yet, the dark side of "professional boundaries" and the epistemic injustice they hide are rarely made clear, which is where autoethnography can shine its light and must be allowed to do so.

The last word goes to Patti Lather who soberly observes that: "Only those with advanced education have a shot at piercing through the theory and the jargon and arriving at a greater understanding of social forces".[122] With this shot in view, autoethnography offers researchers in the field of community mental health care the opportunity and the tools to break down the barriers of this theory and jargon and the moral obligation to try.

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[119] Ibid.
[120] C. Ellis, T.E. Adams, and A.P. Bochner, 'Autoethnography: An Overview', pp. 274-75.
[121] N.K. Denzin, 'Performing [Auto] Ethnography Politically', p. 259.
[122] P. Lather, 'Issues of Validity', pp. 75-76.

Chapter 5.
Wonder: A the turn towards the divine

Once we are smitten we are never healed. To be human means to be an open wound.[1]

5.1 Introduction

It was a chance encounter twenty years ago during the course of my Master's studies that led, one afternoon, to the shattering of conventional awareness and an opening to a sense of presence, perfection and awe. I have pursued this evanescence through a Master's dissertation and PhD thesis, looking for a way to bring its epiphany to bear on the harsh realities of community mental health care.

We begin with the story of *The Nitobe Garden* in which I attempted so many years ago to capture this remarkable event. The Nitobe Memorial Garden is a formal Japanese garden on the campus of the University of British Columbia in Vancouver, where a colleague from class and I had escaped one afternoon to take turns practicing "empathy skills" as we had been instructed. We sat in the open air protected from a soft summer's rain under the roof of a rustic wooden shelter surrounded by the manicured garden and a pond populated with orange Koi. When it was my turn to take the counselling role, my colleague began to speak quietly and thoughtfully about his life while I leaned in to listen more carefully, but as his story unfolded, I found myself overtaken by rapture.[2]

5.1.2   *The Nitobe Garden*

> *You're talking, I see your lips move and hear the sound, but my mind is running. For what? For shelter, for validation, for a reason, for joy. I feel my mind turning over like a car with a dead battery, stalled, while an unseen driver intently turns the key, turns the key, turns the key. I am struggling to remember the name of your sister, your brother, the details of what happened. I want to hang on to the details, I'm supposed to have them in mind, but I can't. There is only You, only You and this dawning ecstasy.*

> *…Gazing down at my arms I see my skin spiked with gooseflesh, I feel the hairs standing at attention, tuned to this impossible moment. The moment endures past*

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[1] J.A. Miller, *In the Throe of Wonder: Intimations of the Sacred in a Post-Modern World* (Albany, New York: State University of New York Press, 1992), p. 117.
[2] See: The origins of this study (1.2).

my fear, I dare breathe, I can trust it, can't I? This feeling is everywhere around us, but mostly here, the source is here, in this rain shelter, where he speaks while I listen. Where the rain falls in a mist around us, smudging the edges and filling all the in-betweens with something that loves me, all of me, and that I love in return with an inundating gratitude that longs to express itself in great wracking sobs.

Does he know what's happening? How can he not? He offers no clue but the words keep coming and the story opens like a rose, petal by petal. I yearn towards its centre as a flower leans towards the light. With each word, each poetic pause, each gesture, he becomes more naked, more precious, the wounds and scars more clearly defined and dear. I wonder if he will undress down to his bones. The parade unreels like a film behind my eyes. I see the people he describes, meet his family members, walk through their home, stroll around his town. I endure the indignities, the penury, the loss, the unbearable loss. What can I offer him for his pain? What? Empathy? Guidance? For what? For his gift? For the joy? The sight? For his sacred story? What can I offer? Nothing. Nothing.

My body riots behind a seamless composure. I clench my teeth to keep them from chattering. A fist expands in my throat and aches with a need to cry. Finally tears break through the barrier and sit on my eyes blinding and burning me. I tip my head back to keep them from spilling down my face, but there are too many waiting for release. I brush them away with the back of my hand pretending my eyes are tired and want to be rubbed. "Are you cold?" he asks me. I don't know, am I? "No I'm fine, please go on," someone with my voice responds.

What has seeped into my pores now thunders through me like a mountain cascade. I adore him, his unbearable perfection; the angel wings hidden from view but surely there, the golden cadence of his voice, the fine milky skin on his forehead, his heroic fear. I have to celebrate, I have to share this. I look at him and know there is even more, much more. I am you, I am you, I AM YOU! Yes, yes, I see it. I am trembling with joy, I have always loved, always been, always will be, never alone, impossible, impossible, loved always and loving this way, without knowing, but knowing, always knowing.

"Do you feel it?" My voice is hushed. My eyes probe his beautiful face for hidden evidence of an experience he is for some inexplicable reason withholding from me. A pause ensues; his eyes meet mine and then scan the rain shelter for clues to my question. He looks puzzled and returns his gaze to my face. "Feel what?" he asks, soberly. Neither of us pursues the question, and seconds later he is back at the loom weaving his words. I look out at the trees beyond our enclosure and worship the

spaces between the leaves, knowing what glue it is that binds these beings together, and how it is they sing.[3]

In seeing my *self* in the transfigured face of my colleague, there was no confusion about my identity or his. Nor could this this astounding recognition be interpreted as a metaphor. It was a visceral cataclysm that confirmed the pricelessness of this life—*my* life—and an immensity of love for which I now owed this stranger everything.

The Nitobe Garden articulates the question implicit in this inquiry. What *does* it mean when a clinician recognizes the vulnerable help seeker as *herself*, when the person she is educated and paid to help becomes extraordinary, transfigured, dear as kin, *dearer*?[4] This question has problematized the moral complexities of *James' story* in chapter 2 and the systemic reduction of the vulnerable help seeker discussed in chapter 3. It has also supported my argument for autoethnography and fuelled the moral plea for clinicians to come out from behind their professional masks to disclose their wonder-full and disturbing stories. The next three chapters will attempt an answer to this question by undertaking three respective tasks of, 1) naming and describing, 2) theorizing and, 3) applying—or trying to apply—this enigma to the interests of our study.

5.1.3   *The focus of this chapter*

This chapter traces a shift of emphasis on wonder as a phenomenon or experience towards a more nuanced perspective of its moral and *relational* implications. We begin with an historical perspective that touches on wonder's origins and etymology to frame a preliminary understanding of this notion and demonstrate its congruence to praxis. As we shall see, various elements emerging from our etymological analysis, embedded in the therapeutic process itself, make wonder possibly less of a novelty in the clinical encounter than one might imagine.

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[3] This story was originally titled *The third thing*. The narrative also captures the essence of Emmanuel Levinas' ethical vision whose work was to remain unknown to me until midway through this project. See: C. Racine, 'Mystical Experience of a Counsellor', *Women and Therapy,* 20 (1997), 62-64.

[4] Philosopher, Professor Martyn Evans uses the term *transfiguration* in his work on wonder. See: H.M. Evans, 'Transfigurings: Beauty, Wonder and the Noumenal', in *Transfigurings: The world, wonder and beauty* (Published, 2012), pp. 1-8.

We will also turn to contemporary scholarship to mine several definitions and orientations describing the current play of wonder in the literature, and to examine their relevance to the question evoked in *The Nitobe Garden*. Finally, Professor Martyn Evans' work on wonder and the clinical encounter will move us towards an orientation more specifically allied to our practical and ethical interests.[5] In diverging from Evans' perspective, my critique and analysis will build towards an argument for an accommodation of awe and horror in our interpretation of wonder. This will also claim the *unilateral* responsibility of the clinician for the help seeker that refutes any suggestion of mutuality or reciprocity within the therapeutic relationship so-called.

5.1.4   *Wonder and Levinas, a strategic marriage*

The central argument for wonder is as informed by the question raised by *The Nitobe Garden,* as by the work of Emmanuel Levinas discussed in the following chapter. Levinas' work has profoundly influenced this inquiry and motivated my interest in contributing to the budding conversation on the role of Levinasian ethics in clinical praxis. Nonetheless, the deceptively simple and compelling notion of "wonder" offers an imaginative and accessible working term for the clinician that is useful for our purposes. "Wonder" is also possibly still free enough from academic colonization to enable its unequivocal moral invitation to transgress the reductive sphere of such concern to our inquiry.

A modest renaissance of interest in wonder is currently creating a niche for itself in the medical humanities. This emerging field employs narrative to help transform clinicians' understanding of dis-ease and reconfigure our approaches to healing. The medical humanities also invite a more philosophical consideration and critique of the "underlying unquestioned assumptions within medical policy and practice".[6] One such question is "whether medicine is essentially a technical science or an existential practice with a centrally ethical task,"[7] and the interests of this inquiry

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[5] This article motivated my decision to shift the focus of this study from mysticism to wonder. See: H.M. Evans, 'Wonder and the Clinical Encounter'.

[6] J. Macnaughton, 'Medical Humanities' Challenge to Medicine', *Journal of Evaluation in Clinical Practice,* 17 (2011), p. 927.

[7] H.M. Evans, 'Travelling Companions: Ethics and Humanities in Medicine', *Bioethica Forum,* 4 (2011), pp. 129-30.

clearly chime with the latter. This evolving conversation, together with Martyn Evans' work on wonder, has opened a space for the examination of wonder's moral potential in the unlikely context of community mental health care.

If the overuse or misuse of "wonder" in the vernacular has diminished wonder's value over time, its ubiquity has certain virtues. Chief among them is that wonder offers a benign, non-polarizing point of departure for ethical discourse that is arguably more conducive to the secular environment of community mental health care than Levinas' obscure terms of reference might yet allow. In sum, I would not wish to see the notion of *wonder* subsumed or eliminated by Levinas' ethical vision so much as integrated, developed and strengthened by it.

5.2 A brief genealogy of wonder

> What is the source of "wonder"? Is it something in the wonderful, or in the wonderer, in the person who experiences wonder? Or should it be located at the level of context or relationship, something that emerges in certain situations? Does it just arise, do we have to wait on it, or can it be learned or elicited? Does it really speak of something beyond? Do we have to try and indicate the level of that beyond? Does it require religious or theological language, or can it be psychologised or biologised, or would these be reductions?[8]

Several philosophers now writing about wonder, including Sam Keen, Dennis Quinn, Mary-Jane Rubenstein and others, lament wonder's demise and misinterpretation. They claim that the immense impact of this loss is now a matter of pressing social concern. Keen suggests that wonder's dissolution implies the erosion of our connection with nature and our sense of place within the cosmos. The outcome of which has robbed us of our identity, our sense of continuity and purpose, as well as our affiliation to the sacred world we inhabit, including the universe beyond.

In domesticating our world, Keen claims that we "insulate it against the intrusion of strangeness".[9] He interprets the central significance of wonder as a gift of meaning[10]

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[8] These questions were kindly suggested by Professor Gerard Loughlin in an earlier draft of this chapter.
[9] S. Keen, *Apology for Wonder* (New York: Harper & Row, 1969), p. 28.

that is not simply eclipsed—or *reduced*—by an increase of knowledge.[11] Similarly, Dennis Quinn blames wonder's demise on the scientific revolution that has reduced wonder to the empirical and the quantifiable, making the notion of "quality" almost obsolete.[12] Wonder, Quinn suggests, is now mistaken as "doubt, aesthetic delight, curiosity, the pleasure of discovery, vague religious sentiment, delight in novelty, indiscriminate approval, and sheer gush".[13] Rubenstein also decries the tragedy of wonder's loss and the consequences of this cultural and linguistic destitution that cheats us of those aspects of our nature that fully define our humanity.

> [W]onder's capacity to arouse and inflict terror, worship and grief is utterly decimated—or more precisely, fervently repressed—by the modern brand of wonder that connotes white bread, lunchbox superheroes and fifties sitcoms…wonder is only wonder when it remains open".[14]

Wonder emerged as the origin of Greek philosophy before following the rise of religion and reaching its apogee in the twelfth and the thirteenth centuries. It was subsequently claimed by the emerging project of science during the Renaissance, and then by the interests of the Enlightenment, until its subsequent demise thereafter.

Keen observes that the Greeks "discovered"[15] the centrality of wonder to philosophy when "Plato had Socrates proclaim that it was the source and foundation of philosophy".[16] Quinn recounts the story of Socrates and Theatetus, the boy whose own encounter with wonder led Socrates to observe that this experience was the beginning of philosophy. For, "[h]e who said that Iris was the child of Thaumas made a good genealogy".[17] This genealogy began with Iris, goddess of the rainbow and daughter of Thaumas, the sea god of wonders, and Electra his wife. Iris' beauty, "divine nature" and mysterious celestial appearance, were to have aroused the

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[10] Ibid. p. 27.

[11] Ibid. p. 26.

[12] D. Quinn, *Iris Exiled: A Synoptic History of Wonder* (Lanham, MD: University Press of America, 2002), pp. 239-49.

[13] Ibid. p. xii.

[14] M.J. Rubenstein, *Strange Wonder: The Closure of Metaphysics and the Opening of Awe* (New York: Columbia University Press, 2008), p. 10.

[15] S. Keen, 'Apology for Wonder', p. 62.

[16] Ibid. p. 72.

[17] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. ix.

"passion that initiates and sustains the love of wisdom".[18] Thaumatology, American literary critic Philip Fisher suggests, was the science of wonders and miracles until the Renaissance. At which time the fork in the road divided science from theology when the miraculous became superfluous to the modern notion of science.[19] Yet, it was believed that through Iris, the love of wisdom was initiated and sustained.[20]

Mary-Jane Rubenstein's re-interpretation of this story suggests that wonder was misappropriated to exclude the darker side of what she claims to be its profoundly ambivalent nature. Rubenstein suggests that Socrates' version of the story left out Thaumas' other two daughters in wonder's lineage. Like Iris, her sisters Aello and Oypetes were winged creatures—"inter-cosmic messengers"—who had the frightening task of carrying humans to the underworld. Unlike Iris, the image of these Harpies deteriorated over time into terrifying clawed creatures leaving Iris and her divine beauty as wonder's only representative. [21]

In silencing "the ravenous and noisome" as fundamental aspects of wonder, Rubenstein believes Socrates sanitized wonder's meaning by "declawing it" and inaccurately claiming wonder's place as the origin of philosophy. Yet, it was also the Socratic tradition, Rubenstein insists, that sought to keep wonder *open* before this focus was replaced by Aristotle's "remedy for wonder in the knowledge of cause and effect". This moved wonder's function from one of infinite potential for opening and expansion to one, "that eliminates itself through the knowledge of causes" in the *pursuit* of answers to the mystery posed by wonder.[22] In these two perspectives, we discover the long-standing tension central to our inquiry between the open and closed. By which we also mean the a-theoretical and theoretical, the anarchical and hierarchical, the affective and the rational and, as we shall discuss in the next chapter on Emmanuel Levinas, the *moral* and the *reductive*.

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[18] Ibid.

[19] P. Fisher, *Wonder, the Rainbow, and the Aesthetics of Rare Experiences* (Cambridge, MA: Harvard University Press, 1998), p. 11.

[20] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. ix.

[21] M.J. Rubenstein, 'Strange Wonder: The Closure of Metaphysics and the Opening of Awe', p. 11.

[22] Ibid. p. 12.

5.3 Etymology

In attempting to resuscitate wonder, these and other authors have turned to its etymology for evidence of lost meaning. The following analysis suggests a number of meanings to guide our investigation that also resonate with the central themes emerging through *The Nitobe Garden*, and the therapeutic process itself.

5.3.1 *Passive participation, witnessing and astonishment*

In relating wonder's meaning to Thaumas and thaumatology, for example, we discover in the Greek root *thau* a connection to something in which we also participate, albeit *passively*. Thus, *thaomai* "may mean to wonder or to gaze upon with wonder," while *thauma* from *thea* alludes to theatre, the place we go to be exposed to and overwhelmed by wonder. "*Thau*" also relates to the notion of theory as the focus of philosophical contemplation. In contrast, Greek words like "*thambos*" and "*tethepa*" have a stronger resonance with terror in emphasizing "a condition of helplessness, bewilderment, confusion, amazement, or stupor".[23] These words apparently "derive from the idea of being struck," while the Latin "*attonius*," for astonish, means "thunderstruck".[24]

5.3.2 *Pleasure and delight*

Beginning with its German connections, *wunder* may also suggest joy or delight and the pleasure often associated with wonder.[25] Lorraine Daston and Katharine Park suggest a connection between wonder and smiling in the French *"merveille,"* the Italian *"meraviglia,"* and the English *"marvel,"* dating back to twelfth century.[26] This might suggest the source of wonder and the delight it conjures as emanating from the object of wonderment itself. These authors also find a strong commonality in "the vocabulary of wonder" from the twelfth to the thirteenth century onwards that did not differentiate the sacred from the profane, "the miraculous and the marvellous"[27] that would, centuries later, be differentiated as "religion" and

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[23] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', pp. 6-7. See also: S. Keen, 'Apology for Wonder', p. 28.

[24] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', pp. 6-7.

[25] Ibid. p. 2.

[26] L. Daston and K. Park, *Wonders and the Order of Nature, 1150-1750* (New York: Zone Books, 1998), p. 16.

[27] Ibid.

"science". With respect to delight, there is also the old English *wendan*, associated with ideas of wending or turning, that Quinn suggests may describe the process of searching this way and that for an answer posed by the wonderful.[28] Such peregrinations might reflect the profound and compelling pleasure—the *yearning*—that drives our pursuit of wonder's enigma.

5.3.3   Esteem, love, approval

Interestingly, wonder has lost its historical connection to "esteem-love-approval".[29] Until the nineteenth century, wonder and admire were used synonymously whereas esteem is now more clearly expressed in words like "wonderful," or "wonderfully". With this ungluing of wonder from the more binding and refined aspects of human relationship, wonder may have been effectively removed from the elevating or reverential implications of esteem, thereby diminishing its relational significance to little more than a novelty. Yet, the historical connection between admire and wonder is still found in the German *wunder*, although ambiguously. "*Verwundern*," for example, refers to astonishment and "*bewundern*" to esteem, which might appear to connect the object of wonder with the response it elicits or even the wonder *within* it.[30]

5.3.4   Light, reflection, mirror

"*Admirare*," is the Latin root for *marvel* and *admire* as well as *miracle* and "probably derives from *mir* which refers to seeing," and may include the notion of sensing or seeing with the mind's eye. Mirror and mirage also share the same root.[31] Again, this connects wonder to seeing but also *reflecting;* something akin to a mirage or a dream captured by "soft" eyes, rather than a hard analytic gaze. In medieval mysticism, the allusion of the "inflamed/enflaming" mirror alluded to the soul's need for purification for her to "become the perfect reflective surface for the divine".[32] Daston and Park suggest that a departure from the root *mir* to *mira* relates

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[28] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. 2.

[29] Ibid. pp. 3-4.

[30] Ibid.

[31] Ibid.

[32] This mirror was a central motif in the work of one especially controversial medieval woman, Marguerite Porete. See: M. Porete, *The Mirror of Simple Souls* (IN: University of Notre Dame Press, 1999). See: A.M. Hollywood, 'Beauvoir, Irigaray, and the Mystical', p. 169.

to the Latin words *mirabilia* or *miracul*a that refer to *objects* of wonder themselves. "Admiration" was also used synonymously with *paradox* which Quinn defines as "contrary to or beyond *doxa* – opinion…as opposed to real knowledge".[33] For, in paradox we find what is real and worthy of such admiration and esteem.

Evelyn Underhill references a number of writers from medieval mystics to poets like Blake and Whitman who bore consistent witness to a light that evokes an intense emotional response associated with some profound meaning.[34] The theme of light is also significant in *The Nitobe Garden* where, "*I …worship the spaces between the leaves, knowing what glue it is that binds these beings together".* Evans has evoked a similar quality of light in his enigmatic encounter with an ash tree, where he finds himself "fixated" by the tree's "elaborate structure" and the "precise and almost granular penetration of the air around it".[35] This light or space has a physicality or mass that is somehow magnified yet diffuse, "thick" and imbued with its own sentience.

5.3.5 Ambivalence

Another historical connection relevant to our discussion is found in the old English *wundor*, related to the German *wunder* as well as *wunde,* which can mean, "cut, gash" or even *wound*. Rubenstein suggests that such contrasting interpretations imply wonder's ambivalent nature that connects us simultaneously to "marvel and dread, (or) amazement and terror". Rubenstein notes, for example, several biblical allusions to the word "*fear*" which illustrate the quality of awe, dread and reverence that wonder also evokes. In describing wonder as a "kind of wound of the everyday" which must remain open or become something else, Rubenstein highlights the importance of *openness* and *ambivalence* to our definition.[36] Her observation could hardly be more relevant to our inquiry because this wound is confronted by the mental health clinician in her every encounter with the vulnerable help seeker. The two aspects of openness and ambivalence arguably transform the clinician's self-perception and understanding of her "clinical" task by radically

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[33] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', pp. 8-9.

[34] E. Underhill, 'Mysticism: A Study in the Nature and Development of Man's Spiritual Consciousness', pp. 249-56.

[35] H.M. Evans, 'Transfigurings: Beauty, Wonder and the Noumenal', p. 1.

[36] M.J. Rubenstein, 'Strange Wonder: The Closure of Metaphysics and the Opening of Awe', pp. 9-10.

revising her relationship to the help seeker, as *The Nitobe Garden* illustrates. In discovering the wonder-full aperture in the seamless armour of the status quo, issues of closure, resolution, solution, interpretation or even understanding are surpassed by the more immediate, astounding and problematic issue of *recognizing* the help seeker as oneself.

This brief etymology suggests a surprising congruence with the evocation of *The Nitobe Garden* and the therapeutic process, which according to these descriptions might appear capable of *calling forth* wonder. Mental health clinicians are actually exquisitely poised for this kind of illumination given the nature of their "listening" and witnessing practice, and the historical[37] and still current connection of mental health care to the clergy and spiritual practice.[38] There should be little doubt that in her day-to-day routines, the community mental health clinician has unlimited access to a rare intimacy afforded by the raw suffering of others in the *theatre* of the consultation room. There, the clinician may be chronically exposed to amazement and terror, and confronted by an ambivalence that will alternately attract and repel her.

5.4   *Praxis and wonder*

In this next section, we briefly examine the characteristics of light, love, openness and ambivalence to illustrate how they translate in praxis. I draw in part on the work of psychologist Carl Rogers for this analysis, whose counselling theory was central to my own education and practice.

5.4.1   *Light*

The notion of light is central to the act of "reflection" in the process of "talk-therapy".[39] It is the therapist's task to "reflect" or "mirror" back observations, intuitions, feelings, and aspects of the help seeker's narrative to promote insight, illumination and epiphany – to *enlighten*. The art of reflection—empathic

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[37] A number of key players advocated for the mentally ill from the late 1700s to the mid-1800s whose crusade was motivated by their own religious faith. See: H.G. Koenig, M.E. McCullough, and D.B. Larson, 'Handbook of Religion and Health', pp. 24-29.

[38] For remarkable statistics on the involvement of clergy with the mentally ill in America, see: A.J. Weaver and others, 'What Do Psychologists Know About Working with the Clergy? An Analysis of Eight APA Journals: 1991–1994', *Professional Psychology: Research and Practice,* 28 (1997).

[39] For a perspective on the loss of "talk" in contemporary psychiatry, see: G. Harris, 'Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy', *New York Times,* (Mar. 5, 2011).

reflection—was raised to a very sophisticated level by Carl Rogers. His immense legacy now drives a clinical interest in empathy and person-centred—*patient-centred*—care that has become an industry standard. Rogers apprehended a quality of connection and depth with those who came to him for help that prompted him to speak of "other realities" to which he believed psychology needed to pay closer attention.[40] He also acknowledged the threat that this reality posed his profession and his colleagues who were, and still are, blinkered and silenced by the dictates of the hard sciences. Daringly, he theorized that the accuracy of non-directive "reflection" was foundational to therapeutic change and claimed that its impact was as transformational for the clinician as for the help seeker.[41] Herein we find a troubling issue we will shortly consider regarding Rogers' notion of mutuality and reciprocity.[42]

5.4.2   Love

The transformative implications of "unconditional positive regard" or "empathy," so central to Rogers' theory of psychological change, resonate profoundly with the notions of esteem, love and approval.[43] Yet, Rogers was careful to assert that these "conditions" should never seek to possess, control or satisfy the needs of the *clinician* because they represented a "caring for the client as a *separate* person."[44]

The issue of love is almost anathema within praxis despite the undisputed centrality of the "therapeutic relationship" and "trust" to the help seeker's process of change. Esteem, love and approval all inform our ideas of affiliation, kinship, friendship,[45] community, inter-dependence, intimacy, tenderness and reverence, especially where positive regard for the other *elevates* the person in question.[46] Yet, the spectre

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[40] C.R. Rogers, 'Some New Challenges', *American Psychologist*, 28 (1973), 385-86.

[41] C.R. Rogers, 'The Nondirective Method as a Technique for Social Research', *American Journal of Sociology*, 50 (1945), p. 279.

[42] See: Reciprocity and mutuality (5.6.3).

[43] See: C.R. Rogers, 'The Necessary and Sufficient Conditions of Therapeutic Personality Change', *Journal of consulting psychology*, 21 (1957), p. 96.

[44] Rogers' italics. See: ibid. p. 98.

[45] This study showed that women make less distinction between friendship and kinship, which raises questions about wonder and gender in clinical care and the implications of the sense of kinship arising in the wonder-full encounter. J.M. Ackerman, D.T. Kenrick, and M. Schaller, 'Is Friendship Akin to Kinship?', *Evolution and Human Behavior*, 28 (2007).

[46] See: D. Keltner and J. Haidt, 'Approaching Awe, a Moral, Spiritual, and Aesthetic Emotion', *Cognition & Emotion*, 17 (2003).

of boundary violation inevitably pre-empts any serious examination of love in praxis.[47] This would seem to preclude love's inclusion in any interpretation of wonder relevant to our interests.[48] However, Quinn reminds us that the traditional view of wonder recognizes the centrality of love, which must be present for the negative emotions even to arise. "In fact this love abides and persists in all emotions as their first principle".[49] Quinn claims Socrates left no doubt that love is inherent in the friendship formed through the shared quest for truth. This is one that is "fired by wonder" and the recognition that ultimately, "the object of wonder is not knowledge at all but love".[50]

Interestingly, the sense of *being in love* or overwhelmed by love, as I was in *The Nitobe Garden,* resists any qualification that might reduce my meaning to something benign—safe—or in Rubenstein's terms, "declawed".[51] This cataclysm does *not* correspond to an "appropriate" or institutional[52] "type" of love authentic enough to claim the name, or "cool" enough to ensure no violation is implied. We will return to this theme in the chapters ahead.[53] For now, I will resist imposing any disclaimers on love in praxis other than to assert that love either recognizes and reveres the help seeker, and yearns to protect her sanctity and vulnerability, or is *not* love.[54]

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[47] The authors express regret for the loss of love as a cornerstone of nursing practice relevant to this discussion. They offer reasons for its erosion and suggest the need for love to be cultivated as a practice which, as Rogers' suggests, seeks to give but not take from the patient. Yet, their analysis fails to identify the reductive paradigm in which they are also educated, indoctrinated and collude. See: T. Stickley and D. Freshwater, 'The Art of Loving and the Therapeutic Relationship', *Nursing Inquiry,* 9 (2002).

[48] During my counselling education students were admonished, to *never* to touch their clients. The concern was that the help seeker could interpret such a gesture as a sexual invitation *or* violation that could cost the clinician a malpractice suit, her reputation and career.

[49] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. 16.

[50] Ibid. p. 87.

[51] Psychotherapist Janet Sayers provocatively suggests the centrality of love to the aims of psychotherapy that "entails the oneness…at the heart of the mystical and the religious…and also the heart of falling in love, making love and being in love. J. Sayers, 'Divine Therapy: Love, Mysticism, and Psychoanalysis', p. 1.

[52] Evans alludes to "institutional love". H.M. Evans, 'Wonderful Treatment', in *Medical Humanities Companion,* ed. by P. Louhiala, I. Heath, and J. Saunders (London: Radcliffe Publishing, 2013), pp. 17-32 (p. 24).

[53] Ibid. pp. 30-31.

[54] The prohibitions of loving are explored in: C. Racine, 'Loving in the Context of Community Mental Health', pp. 113-14.

5.4.3   *Openness*

The openness to which Rubenstein alludes invites the clinician to *lean into* the ineffability rather than attempting to solve or resolve its enigma. This is the openness suggested by Evans' definition of wonder as "an attitude of special, intense, preparatory, and transfiguring attentiveness to what may be revealed as extraordinary."[55] Rogers also suggested that "openness to experience" was as fundamental as any other aspect of research.[56] Here, then, we are referring to a quality of being disarmed; an inclination towards the unexpected or unknowable and a willingness to be affected—*changed*. This can be difficult to achieve or maintain in practice although psychologist Tobin Hart claims that "deeply empathic therapists," sensitive to the feeling states of others, appear able to "regulate" their degree of openness.[57] Without discounting the possibility of an individual proclivity or porosity for such openness, such skill is also cultivated with practice.[58]

"Openness" is also prescribed for "skilled helpers" of all stripes in Gerard Egan's seminal text on counselling, which illustrates a model for how one is to physically attend the help seeker according to the acronym, "SOLER".[59] This dated model is current in the literature and represents what appears to be the ongoing effort of researchers to help clinicians maintain an edge on institutional reduction and indoctrination. It is poignant to imagine that future clinical professionals need to be "taught" how to cultivate the open stance of the most rudimentary human response to vulnerability and pain[60] or conversely, how to perform it. Yet, such openness also necessitates great courage in willingly softening one's psychological and intellectual

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[55] H.M. Evans, 'Wonder and the Clinical Encounter', p. 128.

[56] C.R. Rogers, 'Some New Challenges', p. 380.

[57] T. Hart, 'Carl Rogers as Mystic', *The person-centered journal,* 6 (1999), p. 85.

[58] Lynn Underwood examines the practice of love among monks living in a monastery, to compare the role of intention to the practitioner's "success". Failure to love is always the practitioner's limitation and not the responsibility of even the most difficult person he is attempting to love. Ownership of such failure is crucial to praxis where a clinician may easily project her own sense of failure or inadequacy onto the help seeker. See: L.G. Underwood, 'Interviews with Trappist Monks as a Contribution to Research Methodology in the Investigation of Compassionate Love', *Journal for the theory of social behaviour,* 35 (2005).

[59] This was the introductory text used during my Master's education in counselling psychology. See: G. Egan, 'The Skilled Helper: A Systematic Approach to Effective Helping'.

[60] SOLER: **S**quarely, **O**pen, **L**ean towards the other, **E**ye contact, **R**elax. For a recent re-evaluation of this model, see: T. Stickley, 'From Soler to Surety for Effective Non-Verbal Communication', *Nurse education in practice,* 11 (2011).

defences to be with, contain and *feel* extremes of emotion—from the sublime to the horrifying. Certainly, openness resonates with spiritual practice or contemplation and has a well-established role in therapy.[61]

5.4.4 Ambivalence

In terms of praxis, ambivalence refers to the clinician's emotional process and her response to the help seeker that might elsewhere be construed as counter-transference. Of interest is the clinician's ambivalence to the paradoxical and the emotional extremes at either end of the spectrum of wonder. Keen, for example, suggests that we are ambivalent to wonder because it is traumatic.[62] Levinas also described the "wonder-full" cataclysm as a trauma. Certainly, the themes of light, love, and openness we have discussed here are potentially and profoundly uplifting, yet they are also disturbing, mesmerizing and overwhelming. In confronting the combination of horror and awe, grief and worship, and the interplay of darkness and light within her work, the clinician is continually negotiating her emotional but also her *moral* ambivalence. This relates not only to the paradox at the centre of wonder and the extremes it communicates but, more importantly, to the paradox posed by the help seeker herself. We will revisit the issue of ambivalence later in this chapter along with the role of awe and horror in our definition of wonder.

The characteristics examined in this section resonate with therapeutic praxis and my own subjective experience, although they are not necessarily representative of every wonder-full encounter. As I have shown, wonder's etymology offers a diversity of meanings. These, at least partially, reaffirm the value of our emerging interest in wonder, and claim a place for it within the enterprise of community mental health care. The clinician's ability to see the help seeker and reflect something *beyond*, to remain open and undefended in the face of her anguish and vulnerability, and to love and esteem her in opposition to every clinical sanction against such intimacy, informs not only a wonder-full perspective but a *just* one as well. Yet this intimacy

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[61] For a thoughtful examination of Buddhist practice in the clinical relationship see: A.L. Back and others, 'Compassionate Silence in the Patient–Clinician Encounter: A Contemplative Approach', *Journal of palliative medicine*, 12 (2009).

[62] S. Keen, 'Apology for Wonder', p. 28.

is contingent on the clinician's ability to negotiate her own ruminating ambivalence to the help seeker's plea, and rendered inscrutable and dangerous by the institution.

5.5 What is Wonder?

In clarifying what it means to see another as oneself, we are also asking *how* the clinician can adequately respond to the help seeker, although this may not be easily decoded. Sitting with my colleague in the Nitobe Garden that day, I was shocked to find that there was no adequate *"therapeutic response"* and nothing to offer in the *"realm of possible options"*.

> *All paled in comparison to the staggering beauty and integrity I perceived in him…
> which enveloped us both. Anything I could do as a counsellor would simply
> diminish and impose on or corrupt the perfection…I remember scanning my mind in
> disbelief, finding there was nothing to be done, and coming to what seemed like more
> adequate, if unprofessional alternatives…I found myself wondering if I should
> offer…my sweater, or extend my hand to hold his, or get up from my seat to embrace
> him…. Seeing this spark of divinity before me, embraced in the sacred shelter of this
> relationship and knowing the depth of its meaning in my own life, I have a terrible
> decision to make: what can I do? What must I do for this person?[63]*

The following section examines various explanations of wonder by considering the mechanism—that we might describe as a *hinge*—to account for the shift that swings open one's perspective so radically and suddenly before closing it again. The impact of the help seeker's *appeal* is of greatest interest here, for this insinuates itself *wonder-fully* and problematically into the clinician's *most interior* life. The orientations to wonder examined ahead also appear to provide less than an adequate response to our moral question. They are included, however, because they reflect the philosophical foundations of the problem we are attempting to address and for that reason are relevant to our discussion.

5.5.1 A cognitive account

In their attempt to explain what it is that strikes a sense of wonder within us, Dennis Quinn, Sam Keen and Robert Fuller all refer briefly to Piaget's theory of *accommodation* and *assimilation* for a partial answer.[64]

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[63] C. Racine, 'Mystical Experience of a Counsellor', pp. 65-66.
[64] J.H. Flavell, 'Piaget's Legacy', *Psychological Science,* 7 (1996), p. 200.

Piaget was a Swiss developmental psychologist who focussed on the cognitive development of children. He theorized "accommodation" as a process of cognitive disturbance that occurs when a child is confronted by an unknown experience. This is subsequently "assimilated" through a cognitive adjustment that reconfigures the child's conceptual map to the new situation. The process is curiosity driven and enables the child to explore and understand the material world in a trajectory moving constantly from accommodation to assimilation.

Piaget's detractors criticized his formulation for its "theological and mythic thought" that represented a form of pre-logical thinking at odds with developmental psychology and its interest in cognitive process.[65] His formulation might appear to resonate with a more "open" interpretation of something preceding thought and the theoretical. But this aspect of Piaget's theory arguably has less to do with the apprehension of wonder and more with the drive to denature, neutralize and theorize it. The endpoint is cognitive mastery of the child's world, making wonder a thrilling anti-chamber to *knowing* but possibly little else. Assimilation also reflects but one aspect of a comprehensive and controversial theoretical framework used to describe *childhood* stages of cognitive development. Altogether, this theory fails to address our moral question and might even appear to deny it with a perspective confined to that which is yet to be encountered and conquered, if only cognitively.

5.5.2   *An account of the consciousness of ignorance*
Quinn suggests that a more traditional view represents wonder as the seat of wisdom. In these terms, wonder is capable of moving us from the unknown to knowledge and inheres especially in philosophy, poetry, the arts and "the passion that arises from the consciousness of ignorance".[66] Quinn repeatedly claims that wonder works through our *awareness* of ignorance and must shock us sufficiently with its mystery to jeopardize our intellectual life and challenge what we thought

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[65] R. Fuller, 'Wonder and the Religious Sensibility: A Study in Religion and Emotion', *The Journal of Religion*, 86 (2006), 375-76.
[66] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. 5.

we knew. Quinn claims this view prevailed from the time of Plato to Descartes and is not to be confused with curiosity or the irrationality of "radical romantics".

This view of wonder upholds the "love of truth," love being the first "presupposed" of all emotions that "abides and persists" in all others which is also necessary for negative emotions to be detected. Such love, Quinn claims, is antithetical to the sceptic unable to wonder or the pragmatist incapable of rising above the practical.[67] Nonetheless, Quinn's interpretation of wonder is continually re-directed towards inquiry and thinking. We may be "purged" of ignorance by writing poetry or doing philosophy, which can bring the highest pleasure.[68] We may even transcend "mortal art" by storytelling, which the Greeks believed was a "God-like" pursuit.[69] Yet, even these sacred practices, Quinn insists, are in the service of "knowing" and knowledge, the greatest peril being ignorance or not-knowing.

5.5.3   An aesthetic account

In contrast is Philip Fisher who claims a "connection between intellectual curiosity ("I wonder if…"), and the pleasure of amazement".[70] Fisher denies any association of religion or spirituality to wonder, claiming that efforts to connect the two only hide religious feelings in an "aesthetic disguise".[71] Fisher's view of wonder works through the encounter of aesthetic novelty and the hit of the first encounter accessed *only* through the faculty of sight and certain forms of art. These include architecture, painting, sculpture and some engineering projects, as opposed to "the arts of time—narration, dance, music" which, he insists, leave us immune to wonder.[72] Even conventions of syntax and grammar, Fisher claims, can trigger memory and build expectation that pre-empt wonder's possibility. He takes no account of the enigmatic canon of metaphysical or mystic writers and poets whose linguistic wizardry might contest his view. Fisher does concede, however, that on rare occasions temporal art may give way to the possibility of wonder.[73]

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[67] Ibid. p. 16.
[68] Ibid. p. 45.
[69] Ibid. p. 42.
[70] P. Fisher, 'Wonder, the Rainbow, and the Aesthetics of Rare Experiences', pp. 10-11.
[71] Ibid. p. 2.
[72] Ibid. p. 21.
[73] Ibid. p. 21.

His is a perspective informed by a relentless drive for "the visual, the sudden, and the unexpected," which is limited to the notion of "first sight" and the privilege of youth that declines with age.[74] Rubenstein might suggest that in chasing down the new and unfamiliar for the satisfaction of another *now-I-get-it* moment, Fisher's perspective denies the possibility of wonder moving in another direction. Denies, that is, the movement from the ordinary to the strange or to the *extraordinary*, which might challenge Fisher's keen appetite for a constant stream of novelty. Fisher insists that the "fate of the ordinary" is to remain in the shadow of whatever is rare and sudden in experience, "like the rainbow".[75] Even so, it is difficult to imagine that a rainbow could hold more potential for our wonderment than an epiphanic encounter with another.

5.5.4 An account of curiosity

Curiosity, according to Quinn, suggests a deficiency in wonder. Emerging from the Latin *cura,* curiosity holds an earlier association with ideas of "care, solicitude, or concern," still found in words like *pastoral care* and *curate.*[76] Related to the idea of carefulness or skilfulness, curiosity's meaning has also degenerated to inquisitiveness and the vice related to the intemperance of wanting to know too much or to an excess of studiousness. Together with its association to the vice of lust, curiosity does not fare well in the wonder discourse.

Quinn also equates curiosity with scientific colonization and suggests it emerged from contemporary mechanistic science and the false assumption that everything can be known. The idea of curiosity as a drive to be sated or problem to be solved fails to correspond to our search for a more "open" interpretation of wonder that might resist capture by the theoretical. Yet, curiosity can help the clinician hesitate and remain—however briefly—in the destabilizing open-ness of the unknown. Even Quinn grudgingly accords curiosity "a certain commendable habit of mind in scientific inquiry".[77] He insists, however, that curiosity's desire to plumb unsolvable

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[74] Ibid. p. 21.
[75] Ibid. p. 37.
[76] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. 26.
[77] Ibid. p. 27.

mysteries far exceeds its interest or capacity.[78] Interestingly, curiosity plays a role in mindfulness and compassion practice.[79] One recent study also suggests the importance of curiosity's role in helping psychotherapists achieve greater "attunement" with the help seeker.[80]

5.5.5 A scientific account

Richard Dawkins shares Fisher's aversion to religion but claims that wonder is accessible only through science. His scorn for mystery or any "benevolent overseer of our lives"[81] might appear to weaken his claim that "the purveyors of superstition, the paranormal and astrology" are eroding science.[82] For these purveyors presumably include the considerable population of all religious believers and spiritual seekers, scholars and scientists among them. Yet *only* the scientist, Dawkins claims, responds adequately to wonder. Underscoring his contempt for the Church and the mystic "happy to revel in a mystery," Dawkins claims that only the *productive* scientist can acknowledges the profundity by getting to work to find the answer.[83]

Dawkin's accounts of the natural world are mesmerizing in showing how squid change colour, how insects hear, how DNA might reconstitute human beings on other planets.[84] Yet, his rhetoric is as dogmatic as any religious fundamentalist he might wish to challenge. In attempting to "un-weave the rainbow," Dawkins argues that by understanding phenomena more deeply their mystery can be more wonderfully known and this may be true.[85] Yet his view of wonder would deny *any* inherent value in the mystery itself or its connection to the moral question, which is a rather significant oversight. Dawkins may be justified in claiming that poets are

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[78] Ibid. p. 26.

[79] In the teaching of mindfulness practice, Daniel Siegle has developed the acronym "COAL," that stands for curiosity, openness, acceptance and love. See: D.J. Siegel, 'Mindfulness Training and Neural Integration: Differentiation of Distinct Streams of Awareness and the Cultivation of Well-Being', *Social cognitive and affective neuroscience*, 2 (2007), p. 259.

[80] N.G. Bruce and others, 'Psychotherapist Mindfulness and the Psychotherapy Process', *Psychotherapy: Theory, Research, Practice, Training*, 47 (2010), 83-84.

[81] R. Dawkins, *Unweaving the Rainbow: Science, Delusion and the Appetite for Wonder* (Boston: Houghton Mifflin, 2000), pp. 6-7.

[82] Ibid. p. 118.

[83] Ibid. p. 17.

[84] Ibid. pp. 7-8, 75, 90, 104-05.

[85] For Dawkins' scientific explanation of the rainbow, see: ibid. pp. 42-48.

led by, "the very same spirit that moves great scientists."[86] Still, his perspective

belies a conqueror's acquisitive taste for knowledge and consigns wonder to

insignificance unless it can be refuted, unlocked or *proven* through science into

tangible existence—like a prize.

5.5.6   A biologised account

In contrast is American philosopher of religion Robert Fuller, whose biological slant

identifies wonder as an emotion central to our religious sensibilities.[87] Fuller

condemns the one-dimensional view of evolutionary biology and psychology that

has given greater priority to issues of survival related to fight, flight and aggression.

We have erred, he suggests, in focussing away from the affiliative emotions that

contribute to our sense of belonging, bondedness and bliss. Consequently we have

failed to recognize how joy, amazement, interest and an absence of utility

correspond to wonder and give rise to "more abstract and higher conceptions of the

world" and their pursuit.[88] It is these emotions, Fuller claims, that have contributed

to the highest forms of human and moral development. He is less clear on how this

development has arisen and refers, in part, back to Piaget's model to support his

argument.[89] Despite his transparently religious bias, Fuller's argument seems to

relate more to human survival than he might wish. In suggesting that the emotion

of wonder is an adaptive aspect of brain function, however, he "biologises" the very

thing he is attempting to divinize. Nonetheless, he claims that our adaptive capacity

to wonder is "seeking the intentionality of the whole that lies behind the observable

parts".[90]

Fuller deserves some credit for attempting to claim scientific authority for a divine

principle by examining wonder as an emotion to prove its existence. Yet, he has not

effectively bridged the divide between the languages of reductive science and

philosophical inquiry. Wonder is constituted as a bland although high-minded

"emotion" directed by some ultimate principle that Fuller earnestly wishes to show

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[86] Ibid. p. 27.
[87] R. Fuller, 'Wonder and the Religious Sensibility: A Study in Religion and Emotion', p. 365.
[88] R. Fuller, *Wonder: From Emotion to Spirituality* (Chapel Hill, NC: University of North Carolina Press, 2006), p. 101.
[89] R. Fuller, 'Wonder and the Religious Sensibility: A Study in Religion and Emotion', p. 379.
[90] Ibid. p. 370.

is mediated through the sensitive radar of brain chemistry. Yet, this "emotion" eludes the deeper implications of the unifying principle that really underlies Fuller's work, leaving it too mechanical or limited to neurology to really matter.

As we have seen in this section, scholars who are writing about wonder view this notion as having profound and urgent significance psychologically and developmentally, culturally, scientifically, aesthetically and religiously. Yet, the orientations examined here fall short of addressing the enigmatic moral appeal for which we are seeking an adequate answer. They focus instead on knowledge and resolution, solution and assimilation and a drive that is largely appetitive, acquisitive or implies mastery. Interestingly, the possible significance of wonder as a wild card that remains untamed, unknowable and *open* is not found in these formulations. This leaves the pressing ethical and relational implications of the emotionally super-charged event in *The Nitobe Garden* curiously absent in these formulations of wonder.

5.6 Wonder, the clinician and Martyn Evans

> [T]he proper attitude of the clinician is to combine intelligence with a proper form of reverence: an attitude neither of terrified awe at responsibility, nor of immobile marvelling at the incomprehensible, but of dynamic, transfiguring wonder in the face of shared embodiment. When the doctor addresses the patient's wonderful fragility she also, thereby, reengages with her own.[91]

Professor Martyn Evans' thoughtfully argued formulation of wonder speaks relevantly to the clinician and supports and informs the interests of our inquiry. His analysis provides solid groundwork on which to build, especially with respect to his invitation to the research community to go further, as noted earlier.[92]

> No one has attempted any sustained analytic discussion on the clinical relevance of wonder, nor exploration of the ethical or aesthetic aspect of wonder in relation to medical practice from the perspective of either the clinician or the patient.[93]

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[91] H.M. Evans, 'Wonder and the Clinical Encounter', pp. 134-35.
[92] See: The possibilities of wonder (1.3.4).
[93] H.M. Evans, 'Wonder and the Clinical Encounter', p. 124.

Evans' engagement with the medical humanities encouragingly prioritizes the importance of wonder as a *value* in medical practice.[94] He calls for the replacement of the mechanized notion of medical training with *education* that emphasizes the clinician's need for greater ethical sensitivity.[95] Evans also appeals for an easing of the strict boundaries among competing areas of academic specialization towards the development of a shared interdisciplinary language that might better address the needs of the patient.[96] His focus on the ethical, his absolute concern for the welfare of the patient and his terms of reference reflect arguments I have pursued elsewhere in research on "mystical experience".[97]

Evans' formulation of wonder as something both "epiphanic" and "transfiguring" confirms Grace Jantzen's observation that our culture—and its vernacular—are deeply embedded in its Christian roots, despite what some theologians might describe as its secular veneer.[98] Evans concedes, for example, that wonder's ineffable significance cannot be discounted for, "not only is metaphysics not discreditable, it is not even avoidable in thinking about our experience of the world."[99] He construes wonder as an orientation or attitude rather than an emotion—but not quite a *relationship*—sympathetic to ideas of spiritual or meditative practice now playing an increasingly important role in clinical literature. He also notes that wonder has greater durability than curiosity because it "survives explanation" and remains enigmatically refreshing for that reason.[100] In saying as much, Evans also confirms his recognition of wonder's *openness* as something beyond reason or resolution.[101]

Evans' use of narrative additionally supports the argument for self-disclosure and emotional transparency in research on wonder and ethics, and his vignettes evoke

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[94] See: H.M. Evans, 'Medical Humanities: Stranger at the Gate, or Long-Lost Friend?', *Medicine, Health Care and Philosophy*, 10 (2007), 369-70.

[95] H.M. Evans, 'Reflections on the Humanities in Medical Education', p. 511.

[96] The differences between multi-disciplinarity and inter-disciplinarity are set-out in: H.M. Evans and J. Macnaughton, 'Should Medical Humanities Be a Multidisciplinary or an Interdisciplinary Study?', *Medical Humanities*, 30 (2004).

[97] Evans defines ethics as the "specific name" of any number of values associated with medicine from the spiritual to the political. See: H.M. Evans, 'Medical Humanities: Stranger at the Gate, or Long-Lost Friend?', p. 366.

[98] G. Jantzen, 'Becoming Divine: Towards a Feminist Philosophy of Religion ', p. 14.

[99] H.M. Evans, 'Transfigurings: Beauty, Wonder and the Noumenal', p. 6.

[100] H.M. Evans, 'Wonder and the Patient', *Journal of Medical Humanities*, 36 (2015), 49.

[101] H.M. Evans, 'Transfigurings: Beauty, Wonder and the Noumenal', p. 2.

the mystery he is attempting to analyse. In one account, Evans describes his enraptured response to a musical performance through which his life became "more nearly complete as a result of hearing and understanding…than it would have been otherwise".[102] Elsewhere, he describes seeing a premature infant struggling for life in a hospital where he states, the child "emanated wonder in the invitation to see him as one of us".[103] Evans' personal evocations point to an extra-ordinary and life-affirming apprehension tied to an ultimacy that is beautiful, mysterious and tacitly relational but which also requires metaphor and affective language to translate. Hence, wonder is:

> [A] special kind of transfiguring encounter…a very particular attitude of special attentiveness…prompted by circumstances that may be entirely ordinary yet…yield an object in which the ordinary is transfigured by and suffused with something extraordinary as well. The attitude of wonder is thus one of altered, compellingly intensified attention to something that we immediately acknowledge as somehow important—something that might be unexpected…and towards which we will likely want to turn our faculty of understanding; something whose initial appearance to us engages our imagination before our understanding; something…larger and more significant than ourselves; something in the face of which we momentarily set aside our own concerns (and even our self-conscious awareness, in the most powerful instances)…Wonder is not the same as awe: its object need be neither sublime nor terrifying. It is closer to marveling, yet it is not confined to static gazing but has its own dynamic leading-on to the desire to understand. It has pale echoes in curiosity, but its objects persist in our imagination, even beyond the point where we have at one level explained them.[104]

Evans wants to ignite a sense of *reverence* to enable the clinician to *see* the help seeker as if for the first time, to be morally refreshed and better able to resist the *de-moralizing* drudgery of the clinical environment and routine. Less clearly articulated are the implications of the wonder-full encounter for community mental health care, but neither are they excluded. Yet, I am inclined to argue for a formulation of wonder less affectively limited than the one Evans proposes. I hesitate to confine the

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[102] Ibid. pp. 6-7.
[103] H.M. Evans, 'Wonderful Treatment', p. 25.
[104] Ibid. p. 27.

clinician's wonder-full apprehension such that it fails to take into clear account the horrendous ethical problems looming in the background that wonder is supposed to mitigate. I would also contend that community mental health care differs sufficiently from all other kinds of health practice to warrant an adjustment to Evans' definition. My argument relates specifically to the complex dangers of the therapeutic relationship and its much greater focus within community mental health care, and to the issue of patients' legal rights in community mental health care.

These concerns are less relevant for the patient seeking medical care and at complete liberty to decline any treatment, even if this decision contributes to the patient's deterioration or death. If it is a question of mental health, however, such liberty can be swiftly and brutally curtailed, making the issue of systemic violence suddenly much more relevant. Consequently, I must argue for a definition of wonder that includes the *awe-full* and recognizes the presence of the sublime.

Evans is entirely persuasive in reckoning that "[w]hen the doctor addresses the patient's wonderful fragility she also, thereby, reengages with her own".[105] Yet this *wonder*-full reengagement—whether tender or unsettling, astonishing or horrifying—is neither neutral nor benign in calling the clinician to account. To apprehend another as one's *self* is to be confronted by the awe-full moral question beyond all "therapeutic" considerations. *What can I do, what must I do for this person?*

5.6.1 *My flower*

> *My friend Mariana is howling, incoherent at the other end of a Skype call from Canada while I am here in Durham writing my thesis. Her daughter, Julia, has been committed to the psychiatric ward of the local hospital for what appears to be a psychotic breakdown. We look at each other in horror through the computer screen and cry while Mariana chokes out the complicated details of the past 24 hours.*

> *We had said goodbye only weeks before after holidaying together in England, the three of us. When we met, I could see Julia was not quite herself. Her laughter was more subdued and the relaxed intimacy between us, developed from her adolescence over twenty years, had been replaced with a remoteness that eluded my efforts to*

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[105] See the epigraph to this section.

connect with her. The complexity of her life and the heartache she had recently sustained helped me account for her unaccustomed gravity.

The week Mariana calls is a nightmare. I don't really know what's happening and I can't get to Julia on the other side of the world. It's maddeningly all second hand and coming from Mariana who can't stop crying. But also from one of Julia's devoted friends and two nurses I speak to during that week as well from Julia herself, the little ghost girl who talks to me all too briefly every day from the public phone on her ward.

Julia tries from the first day of her incarceration to frantically enlist the help of friends on the outside to find her a human rights lawyer or activist to get her out. Is she paranoid? But wouldn't she be? Her mother is denied the right to spend even the first night with her daughter who has never spent a night in any hospital let alone a locked psychiatric facility. They put her at the end of the ward and she asks to be moved closer to the nursing station because she is afraid. Because a man—another glassy-eyed inmate—had apparently appeared in the doorway of her room on a number of occasions to stare at her.

I become increasingly alarmed in the following 48 hours to hear she is taking on the staff and demanding to be released. "Julia, they will not like this. You must comply. You must. Your defiance will be interpreted as part of your illness. Tell me you understand what I am saying. You have to stop confronting them or it will not go well. Lie low for a few days, they don't have the resources to keep you in there long and there's a line up around the block waiting for your bed. This will pass; we'll get you out. I promise".

Julia is enraged with her mother the first day or two, refusing to see her when Mariana urges her daughter to relax and stay safe and quiet, for she believes her mother has colluded in keeping her there. Julia tells me she feels as though the entire staff is watching her and I tell her they are. I can't help feeling a sense of guilty relief that she is at least safe until we find out what the hell is going on. I call a close friend and colleague in Canada still working in the system for a consult. "Well kiddo, you know as well as me that the hospital doesn't want her leaving if she's at risk of hopping off a bridge and she'll be let out all too soon, that's the bigger concern". But is she really at risk? She's denied being suicidal ever since she arrived, but they don't believe her.

Julia is rational and articulate on the phone and grateful to hear my voice long-distance but sounds so vulnerable, young and far away. I ask if she knows what happened. She only remembers having anxiety and a migraine and has no apparent memory or insight into her state of mind when she was sectioned, which worries me. She's vague, regressed, drugged, not herself. Julia gives me permission to speak to the night nurse, Peter. I have already told her I would happily have a conference call

with the psychiatrist in her presence if she would like that. She would, she says. "Tell the nurse, tell the psychiatrist," I say.

Peter tells me they have her on two milligrams of Risperidone[106] and that she is starting to "settle" and become engaged in activities on the ward. I tell him she does not seem to be psychotic and ask for her diagnosis and why she is being held against her will. There's no diagnosis yet, Peter tells me, she's under observation. He also reminds me, not unreasonably, that it's to her benefit to be there as she'd presented with psychotic symptoms the night she came in. He assures me of this. "But there are countless people walking the streets with psychotic symptoms who have not been sectioned," I say. Peter is silent. He does not know when she will be released. He is courteous, soft spoken. In response to my request he says he'll try to talk to one of the doctors about getting her voluntary status but can promise nothing. He's also about to go on three days leave. Mariana is upset to hear this as she and Julia greatly value Peter's kindness. The day nurse, Mariana states, is a bitch.

The following day I speak to Mariana on Skype who has been waiting for a call from the psychiatrist for three hours. I have coached her to ask him about a release date, about the diagnosis, about re-negotiating Julia's certified status to a voluntary stay in hospital to ease her distress about being locked up. But also that she be allowed a day pass under Mariana's care, even for an hour's walk, to get her off a ward where she has been wandering for an unrelenting three days. Mariana writes down what I say and the call finally comes through.

Mariana does not want to tell the doctor too much, she's a refugee mother and she knows about imprisonment. She assures him coolly that Julia has no history of mental illness. I am uncomfortably aware of my friend's foreign accent and want this man to take her seriously. But the conversation threatens to unravel when Mariana raises her voice to inform him levelly that she is ESL[107] and that a nurse had twisted her words which resulted in Julia being perceived as being in less control than she actually had been. I want her to stay calm. Mariana holds the receiver to the screen of her computer for me to hear, but the male voice on the other end is blurred. The doctor wants to know if Julia has problems with power and control, with authority. He's a moron, I think to myself.

I get off Skype and phone the hospital to reassure Julia she will likely be released in a week or less, my voice upbeat and brittle. Julia tells me she has just been given a sedative by injection after a run-in with one of the nurses. I beg her to try to listen to me but her speech is slurred and slow and she tells me she's sorry but can't stay on the phone anymore because she needs to lie down. She is now being chemically restrained. I can't work, I can't think.

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[106] An anti-psychotic medication.
[107] ESL—English as a second language, meaning she is an immigrant.

When I call Julia the following day the transition has been successfully made. This young woman with a dancer's body and an angel's face, my friend, gifted, gutsy, funny, intelligent, politically motivated and aware, well-travelled, educated, and employed is now docile as a new born lamb. Expressing her gratitude for the kindness of the staff in a soft flat voice, she tells me it is a good place for her to be for now. She thanks me with a creepy formality for being so kind, as though we'd just been introduced. Mariana calls me later to ask what has happened. It doesn't make sense to her that her daughter has transmuted from a wild cat into this nearly inert creature seemingly overnight. "It's simple," I say. "Takes no time at all".

I try again another day, another call, another nurse. Her name is also Catherine. It takes me five or six tries to get through. It's Thursday morning. Julia has been there since Saturday night without receiving any formal psychiatric or psycho-social assessment or diagnosis. She has been held against her will without her own clothes, without any counselling services, certainly without legal counsel, even without her phone that they allow her to use only five minutes a day. Despite having no history of mental illness or addiction she has been denied even a single right to free movement while being chemically restrained for lack of compliance, and medicated with a potent anti-psychotic. It has taken a scant five days to reduce Julia to a shell.

I have a lot to say and measure my words, wanting so badly to sound professional. I introduce myself, explain my reasons for calling, my relationship to Julia, my PhD work on community mental health care, my background as a clinician and my concern that a terrible mistake has been made. The nursing notes that Catherine consults are all she has in the absence of an assessment. They don't reflect that Julia has a brother, two university degrees completed with distinction, a nice apartment in a beautiful part of town, a responsible position in a respected educational institution, close friends and a significant investment in creative endeavours, as an artist in her own right. They don't mention that her parents had been jailed in their country as political dissidents. Her father, having been imprisoned for a year and tortured, had stayed behind, while Mariana fled to Canada with the children to a city whose name she'd never heard before.

"You've got a superstar on the ward Catherine and you don't even know it," I say. "Don't you think that Julia's response to her certification was warranted?" Catherine wants me to know that Julia is in a state-of-the-art psychiatric facility only recently opened which provides her with the luxury of her own room and a private bath. "It's really very nice," she adds. "But how would you feel if you wound up in a situation like this, being locked up and drugged with no rights, can you imagine?" Catherine hesitatingly concedes she has thought about it and acknowledges it would be scary.

I ask if Julia has received any culturally sensitive care, or if she possibly could, while in hospital. "That comes later, in community mental health care," Catherine informs me. I don't argue, there's no point, I already know what kind of service will be available to Julia. I ask again about a pass for a walk outside, about having Julia's certification revoked to voluntary status, about when exactly we might expect an assessment and diagnosis. She has no idea how powerless I feel. Catherine is apologetic in explaining that doctors are on holiday and that they are short-staffed which is why Julia has not yet been assessed. She says this twice, possibly to exonerate herself and I hope this means I've made a dent. Later that day, Julia is given back her clothes and allowed to go outside for a walk with her mother.

The following day she is allowed a weekend pass to be with her mother from Friday night to Monday morning. Mariana calls me on Skype the moment they get home to show me her girl, my flower, flattened by drugs and subdued by the ordeal she has survived. Her vacant eyes smile dully into the camera and she tells me softly, in a child's voice, that overall it was good experience and she thinks it has helped but that it's nice to be home. She has really appreciated my help, she says again, and thanks me. I cringe to hear her speak to me like this, resisting the desire to appeal to her, "Julia, it's me! Don't say that".

She is released on Monday following the weekend on 2 milligrams of Risperidone that might be given as a starting dosage to someone twice her size who is suffering from hallucinations or schizophrenia. Julia has never had anything stronger than Tylenol[108] until this event. She returns to work part-time two days after her discharge, despite dire warnings from the hospital psychiatrist and her family doctor about her need to take an extended leave of absence and stay on the medication. Julia sleeps with all the lights on in the bedroom of Mariana's apartment for the first week and more after her discharge, and is unable to return to her own apartment. She manages to have a shower at the end of the first week out of hospital without having to ask her mother to stand outside the bathroom door because she is afraid. No wonder.

I want to believe that Julia will be able to see a psychiatrist in community mental health care well in advance of a likely waiting period of eight to twelve weeks as a result of my impassioned pleas to an intake nurse, called Gloria. She listens caringly while I bleed out the story over the phone and beg her assistance. But she also gently reminds me at the end of our conversation, "Catherine you know that the system is…" "Broken, yes, I know, Gloria, I know. It's broken. But please, please do what

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[108] Acetaminophen, found in Paracetamol in the UK, is sold under the trade name of *Tylenol* in North America.

you can, promise me you will do what you can. She has got to get off this
medication. Please help me".[109]

5.6.2 Critique and analysis

The implications of *My Flower* might identify a gap in Evans' analysis of wonder
worth considering further. As a philosopher and ethicist who is not a clinician,
Evans is scrupulously respectful of the medical professional and at pains not to
transgress. Yet, he may overplay this card by focusing on the dehumanization of the
patient as it relates to the *clinician's* exposure of the factory-like experience described
by Simone Weil.[110] This is the factory with its deadening routines, constraints, and
ethical indifference, its waste and inability to value the relational, which supposedly
turns the clinician into an automaton.[111]

There is more than a grain of truth to Evans' assertion and ample literature to
defend it. However, the gap between the well-heeled, well-resourced, well-educated
and employed clinician and her disenfranchised community mental health patient is
unbridgeable, making this comparison ethically disturbing and possibly misleading.
Weil herself identifies our dehumanizing propensity in claiming that, "everybody
despises the afflicted to some extent, although practically no one is conscious of
it."[112] Evans' work on wonder undoubtedly seeks to address the consequences of
such contempt. Yet he risks minimising the clinician's ethical responsibility by
blaming the institutional "factory" for impairing her, and the help seeker for boring
her.[113] This leaves the most vulnerable person in the therapeutic equation in second
place, *after* the ennui and dehumanization of the clinician.

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[109] In the year since her hospitalization, Julia has seen three psychiatrists and had two medication
changes that are still not adequately managing her symptoms. She continues to hear voices although to
our relief, has been diagnosed with a thought disorder rather than schizophrenia. This does not lessen
the disturbing impact of these voices although she continues to work full time and is attempting to
translate her experience through her painting. Julia is now actively engaged in the community of
"voice hearers" in a leadership role, and has been relentless in her efforts to rise above her current
affliction.

[110] H.M. Evans, 'Wonder and the Clinical Encounter', p. 130.

[111] Ibid.

[112] S. Weil, *Waiting for God* (New York: Harper, 1951), p. 40.

[113] Evans suggests the doctor's humanity is "tested" and "abraded" by the boring routine of caring for
unexceptional patients. "The dramatic patient encounter is exceptional. The nondramatic patient is
unremarkable. The unremarkable patient becomes routine … uninteresting. How does one respond
fully and attentively to an uninteresting patient … by what we might call ''patient-centered tedium''?
See: H.M. Evans, 'Wonder and the Clinical Encounter', p. 125.

There are two other problematic issues arising in Evans' perspective of wonder that deserve closer analysis and that I wish to challenge in the following two sections. The first concerns Evans' call for reciprocity in the clinical relationship and the second his suggestion that our definition for wonder, as it pertains to the clinical context, need not be sublime or terrifying and is *not* the same as awe.

5.6.3   Reciprocity and mutuality

In claiming the importance of *reciprocity* in the clinical relationship, Evans' interest in "embodied human agency" suggests the appealing notion of the body as the locus of wonder for the shared response of the clinician and the vulnerable help seeker.[114] Here, the collaborative possibility of "marvelling" at the body (or, even, the nature of the mind), suggests a skilful way of redirecting the clinician and the help seeker away from the vortex of pathology, institutional reduction and control of the medical machine. From this perspective, Evans accurately confirms my own wonder-full clinical encounters where intimacy, immediacy and reverence are palpable. Here, the help seeker is confirmed and revered through an intimate encounter with the clinician who—if only briefly—transcends the excruciating administrative tedium, micro-management and ever-declining resources of her work place.

Nonetheless, Evans' claim of even a modicum of reciprocity in the clinical relationship is tenuous at best although he suggests otherwise. "I see no reason suddenly to drop this reciprocal requirement of acknowledgment of the Other, simply because the project of the clinical encounter is an asymmetric one (that is, primarily conceived towards the benefit of the patient)".[115] Evans' focus on an asymmetry conceived for the help seeker's benefit does not make it so, nor is there is *any* equivalence between the clinician and the help seeker. The asymmetry *imposed* by the clinical hierarchy through the clinician's authority, unequivocally forecloses on any argument for reciprocity.

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[114] H.M. Evans, 'Wonder and the Patient'. pp. 47- 49.

[115] Ibid. p. 53.

Evans also references the work of Michelle Clifton-Soderstrom,[116] who employs a Levinasian perspective to assert the practice of medicine as "foremost an ethic," preceding even its scientific concerns.[117] Like Evans, she seeks an open and real dialogue between the medical professional and the patient. Unlike him, she denies the possibility of reciprocity in suggesting that, "the other needs me and calls to me as a weak master to a strong slave".[118] This allusion recalls Levinas' ethical vision that posits the unilateral and extreme responsibility of the strong for the weak, which in this case corresponds to the responsibility of the medical professional for the help seeker. Yet, even as a weak (clinical) master I will *never* be weaker than the strongest—*enslaved*—help seeker. Any argument to the contrary obfuscates the formidable legal power, especially of the community mental health hierarchy, in which the clinical relationship occurs.

The idea of reciprocity or mutuality in the clinical relationship is seductive and regretfully too substantial a subject to adequately analyse here. Part of its appeal surely lies in the clinician's wish to do no harm or *less* harm. However, this idea always precludes serious scrutiny of the clinician's morally ambiguous position *above* the help seeker, which a wonder-full, possibly *awe-full* perspective might help expose. That said, clinicians routinely attempt to subvert the reductive system in which they are also trapped, by attempting to meet the help seeker as another equally fragile human being. Carl Rogers proposed exactly this in identifying *mutuality* as one of his three core conditions necessary and sufficient for therapeutic change. While mutuality might appear to benefit both parties, however, the far greater benefit will *always* fall to the clinician. There are even greater moral dilemmas than this to consider beyond the lack of equivalence between the clinician and the help seeker.

During a public debate with Carl Rogers in 1957, for example, Martin Buber famously confronted Rogers on the unavoidable inequality of power in the therapeutic relationship that he believed prohibited true mutuality. This

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[116] Ibid. pp. 52-53.

[117] M. Clifton-Soderstrom, 'Levinas and the Patient as Other: The Ethical Foundation of Medicine', *The Journal of medicine and philosophy,* 28 (2003), p. 447.

[118] Ibid. p. 452.

observation, Brian Thorne has noted, struck at the core of Rogers' theoretical argument, which of course it does. Buber insisted that the mutuality Rogers claimed, while possibly capable of strengthening a person's individuality or identity, still failed to make her fully human. In the absence of true reciprocity, Buber suggested, the individual's "awareness of others" and her "development of the responsiveness which makes for social responsibility" would be impaired.[119]

Certainly, it is hard to imagine how a help seeker who has been re-identified as mentally ill, "treated" or confined against her will, medicated and globally stigmatized in every part of her life, could *easily* conjure sufficient agency to be or become socially responsible and engaged. Even, that is, with the help of a "subversive" clinician dedicated to establishing the possibilities of wonder in her practice, and to informing the help seeker's political awareness and agency beyond it. Psychologist, Rollo May, also criticized Rogers and humanistic psychology for its failure to address the issue of evil in the emotional material presented to therapists by their clients.[120]

There can be no real place for reciprocity in this discussion, much as the ethicist or ethical clinician might wish otherwise, as long as the asymmetrical relationship and the roles and laws governing this relationship prevail. But even beyond this asymmetry, or possibly because of it, thinkers like Buber and May have offered compelling critiques that point to the erosion of the help seeker's moral agency and awareness, which the most earnest call for reciprocity and mutuality cannot easily refute.

5.6.4   *Awe*

Evans' suggestion that wonder need not be sublime or terrifying and is *not* the same as awe poses another problem, for the reality of community mental health care can be all too horrifying, as *My Flower* shows. This reality is also normalized and neutralized through protocols and efficiencies conducted with equanimity and without question—by which I also mean professional *entitlement*.

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[119] B. Thorne, *Carl Rogers* (London: Sage, 1992), pp. 71-72.
[120] Ibid. p. 72.

Keen's observation that horror is incompatible with wonder confirms Evans' aversion to the inclusion of awe in his definition. Keen claims that horror threatens to "degrade or destroy, while we wonder at those things that promise to enrich and fulfill life".[121] Conversely, Quinn observes that in Latin, horror describes wonder, awe, reverence and stupor.[122] More relevantly, Quinn notes that horror occurs "when we encounter a universe governed by injustice," which we are surely attempting to address here. Yet if, as Keen suggests, horror is to wonder as desecration is to the sacred, his objection also serves my purpose.

Our narratives suggest that the divinity of this "transfigured" and innocent help seeker, who shines as stunning evidence of all I have ever wished for, is *precisely* what illuminates the horror of this injustice, and my part in it. If we wish to interrupt the clinician's *entrancement* with the status quo, it seems our definition of wonder would be incomplete without awe and ambivalence. Its inclusion need not refute Evans' call for wonder as moral refreshment but can broaden the continuum of interpretation to allow for the galvanizing impact of wonder that could impel the clinician to *stand with* the vulnerable help seeker *against* injustice. Evans does not whitewash his definition by suggesting that wonder will always be aesthetically pleasing or beautiful. Yet, his proposed containment of wonder to something less than cataclysmic—lest it impair the clinician's judgement or capacity to fulfil her duties--is still problematic. For, such judgement and capacity are *precisely* what we wish to challenge and revise.

Evans is well aware of the institutionalizing threat to wonder, which is why I wish to cut it free of any such confinement and allow for the presence of awe, horror and the sublime in its definition. Otherwise, we may look forward to the kind of colonization that will almost certainly reduce clinical wonder to an acronym—"CW"—or another "medical modality" or "application".

In limiting the boundaries of wonder, we risk negating the whole point of our project. This stupefying paradox and horrifying ambivalence has no equal within the reductive sphere. I am suggesting that the idea of wonder we are attempting to

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[121] S. Keen, 'Apology for Wonder', p. 30.
[122] D. Quinn, 'Iris Exiled: A Synoptic History of Wonder', p. 79.

harness for its ethical potential is one that must be capable of inviting the clinician to recognize the help seeker as her *self,* which appears to be a step beyond Evans' recommendation. That is to say, as I recognized my colleague in *The Nitobe Garden,*[123] and James in *James' story,*[124] and even the unfortunate man in *Ladies' Shoes,* who tried to decline his dialysis treatment.[125] The perspective of wonder we might always wish to keep should allow the clinician the "shock" of recognition. For this is one that communicates her priceless bond with the stranger to whom everything is owed *because* it enables her to *also* recognize the horror of the help seeker's plight and her role in its promulgation.

In the worrying absence of awe and ambivalence that Evans has suggested, I find a bias that favours the interests of the clinician and occludes the larger implications of institutional hierarchy and the *law*. If we formulate wonder as little more than refreshment for the dis-spirited or jaded clinician, we still turn a blind eye to the profound injustice at the core of the *de-moralizing* institution. We fail that is, to *re-moralize* or *awaken* the clinician, leaving her to continue meting out the injustice, albeit in a possibly more reverential way, while her *entrancement* with the status quo remains undisturbed and intact.

5.7 Conclusion

In asking what it means to see the vulnerable help seeker as myself, I have attempted a brief inquiry of wonder that has directed our analysis towards a definition that is awe-full, open and ambivalent. Through a limited examination of its etymology, I have drawn a number of parallels between wonder and praxis that suggest a surprising congruence between them. In searching for something of a template for *The Nitobe Garden*, I have also examined various formulations of wonder. Based on the work of contemporary scholars, these formulations highlight the disparity between definitions focussed on knowledge, experience, and acquisition or mastery. Altogether, however, they describe a movement towards closure or resolution as opposed to remaining resolutely open and unfathomable.

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[123] See: The Nitobe Garden (5.1.2).
[124] See: James' story (2.).
[125] See: Ladies' Shoes (4.2.2).

Concluding this chapter was Professor Martyn Evans' appraisal of wonder within the clinical encounter and the emerging field of medical humanities. His perspective is exceptionally sympathetic to the clinician and allied to the interests of our inquiry. In engaging with Evans' work, I have also raised issues of specific concern to the practice of community mental health, particularly regarding his argument for reciprocity, and his reservations about awe and the sublime to our clinical interests. The latter represent the very evocation of the wholly/holy Other in Emmanuel Levinas' ethical vision that we will examine next.

In closing, we cast back to the questions posed by Professor Gerard Loughlin to assert that wonder appears to have many, if not infinite, sources or points of entry.[126] Wonder emerges through what is beheld, but also through the wonderer. It may announce itself gradually over time as it did in *James' story* or arise cataclysmically as it did in *The Nitobe Garden*. Wonder may also infiltrate the heart and mind through one's intentional turn to the disciplines of meditation, contemplation and prayer. Some would argue that wonder speaks of something *beyond* while others, as we have seen, would insist that the only mystery is the one yet to explained, proven and claimed. I have suggested that wonder cannot be "biologised" or "psychologised" for these *are* reductions. Yet, wonder does not demand the use of religious or theological language for its expression, although the language of poetry, paradox and love are central to its evocation. Of all of these questions, the most interesting is whether we "have to try to indicate the level of the beyond" in our apprehension of wonder. It is this impenetrable "beyond" and the ethical vision of Emmanuel Levinas, to which we now turn for a closer look at the face of the stranger who is no stranger at all.

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[126] See Professor Loughlin's questions in the epigraph of: A brief genealogy of wonder (5.2).

Chapter 6.
Levinas and the wholly/holy other

"You know," Levinas once confided to Derrida, "One often speaks of ethics to describe what I do, but what really interests me in the end is not ethics, not ethics alone, but the holy, the holiness of the holy".[1]

6.1 Introduction

Emmanuel Levinas was a French philosopher and Talmudic scholar whose work focussed entirely on the ethical relationship.[2] Continental philosopher Jacques Derrida, who was more widely known than Levinas, contributed to his immense stature by writing about Levinas' work before he came to prominence. Derrida also established the second wave of Levinasian scholarship for which one is inclined to be most grateful.[3]

Levinas' radical work is now gaining currency in the fields of psychology and psychotherapy[4] and, one scholar has hopefully suggested, may enable psychology to shift its "immature and naïve" approach to morality and ethics.[5] As Levinas' vision confirms, the cost of continuing to conflate ethics with reason is hardly insignificant when the question of certainty is given primacy over the ethical, over "the question of the right".[6] Beyond psychology, there are widely diverging spheres of endeavour now investigating Levinas' transcendent ethical vision in growing numbers.[7]

Many prominent philosophers have taken Levinas' work seriously, among them feminist philosophers Luce Irigaray and Tina Chanter.[8] Religious philosopher, Grace Jantzen, also turned to Levinas' account of ethics in developing a "feminist imaginary" capable of

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[1] Derrida recounts a fragment of a personal conversation with Levinas. See: J. Derrida, *Adieu to Emmanuel Levinas* (Stanford University Press, 1999), p. 4.

[2] E. Levinas, *Ethics and Infinity: Conversations with Philippe Nemo. 1982* (Pittsburgh: Duquesne UP, 1985), p. 56.

[3] For a brief overview of Levinas' current impact see: P. Atterton and M. Calarco, 'Editors' Introduction: The Third Wave of Levinas Scholarship', in *Radicalizing Levinas,* ed. by Peter Atterton and Matthew Calarco (State University of New York Press, 2010).

[4] This special issue is devoted to Levinas. See: G. Sayre, 'Toward a Therapy for the Other', *European Journal of Psychotherapy & Counselling,* 7 (2005), 37.

[5] The author argues for the need for psychology to acquire moral relevance. See: R.N. Williams, 'Self-Betraying Emotions and the Psychology of Heteronomy', *European Journal of Psychotherapy & Counselling,* 7 (2005), p. 8.

[6] Ibid.

[7] Using the search term, "Levinas," in the EBSCO database revealed 9609 references ranging in subjects as diverse as corporate responsibility, literature, media, and psychology to name a few. Using the search term "Emmanuel Levinas" in Google Scholar produced 57, 000 references.

[8] S. Hand, *Emmanuel Levinas* (London and New York: Routledge, 2009), pp. 114-15.

addressing systemic violence.[9] Jantzen underscored the value of Levinas' work by describing as morally indefensible the discourse of religious philosophers who, prior to him, had focussed almost exclusively on the matter of one's own moral status. By emphasizing that status, rather than its particular human consequences, Jantzen insists that the recipients—the *victims*—of this self-centred morality have been disturbingly absent from the discussion. "The construal of morality is entirely subject centred," she observes.[10] In contrast, Levinas' focus is on the "other" and on my unequivocal ethical accountability to her. This emphasis has special relevance for those working in the healing professions because, as Jantzen accurately observes, clinicians know all too well the difficulty of keeping their hands clean and the urgent need for greater accountability.[11]

Levinas' focus, then, is on this holy human, wholly Other, who is my neighbour and my dear one. This is "the one and only" who Levinas also calls the "*loved one,* love being the condition of the very possibility of uniqueness".[12] By which he means *irreducible*; that which cannot be thematised, broken down into components or somehow assimilated, objectified, colonized or manipulated. Levinas' wonder-full vision succeeds in stepping over all theoretical abstraction and the ceaseless appropriative quest to know, believe or understand, by making the human relationship the starting point of philosophy. We begin, therefore, not with a "clinical strategy" to subvert the atomizing medical machine, which Professor Jane Macnaughton observes has proven so resistant to our ongoing efforts to give it a human face.[13] We begin with the possibility of a relationship with the holy, the holiness of the holy, and an irrevocable, primordial call that comes through the human Face of the Other. It is a call without beginning, precedence or end.

In this chapter, we begin with a snapshot of Levinas' life and proceed to a discussion of the two most significant influences on his work, notably Husserl and Heidegger. We will also examine how Levinas eclipsed his teachers and challenged Western philosophy with a revolutionary configuration of ethics that placed the relational prior to thinking and the conceptual. We will then analyse Levinas' formulation of the "Face" and the "Other" to

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[9] G. Jantzen, 'Becoming Divine: Towards a Feminist Philosophy of Religion ', pp. 231-53.

[10] Ibid. p. 229.

[11] Ibid. pp. 231-37.

[12] E. Levinas, *Entre Nous: On Thinking-of-the-Other* (New York: Cambridge University Press, 1998), p. 168.

[13] J. Macnaughton, 'Medical Humanities' Challenge to Medicine'.

illustrate the paradoxes and complications posed by the enigma of the Face within the clinical encounter. In addition, we will discuss the role that language played in Levinas' work as a tool capable of escaping reduction, and consider the meaning of his admonition to employ "disinterest" as an ethical path to the other. We will also consider that the yearning—the *wonder*—at the centre of Levinas' ethical evocation may be being apprehended all too well by clinicians in the course of their work, despite being chronically denied and mis-construed. Finally, Levinas' formulation of ethical responsibility as fundamentally asymmetrical will be analysed and followed by a brief feminist critique of his work before our chapter's conclusion.

6.2 Emmanuel Levinas: The man and his vision

> To speak of Redemption in a world that remains without justice is to forget that the soul is not the demand for immortality but the impossibility of assassinating, and that consequently, the spirit is the proper concern of a just society.[14]

Emmanuel Levinas was a Lithuanian Jew born in 1906, who received a traditional Jewish education before moving to France in 1923 to begin his studies. In 1928, he moved to Germany to study under Husserl and there discovered Heidegger whose work was to influence him profoundly. From an early age, he was influenced by the Russian classics and Shakespeare,[15] and credited his exposure to Russian novels with his eventual turn to philosophy.[16] Levinas later taught at various universities in France, including the Sorbonne, and died in 1995.

Having become a French citizen and served in the military in Paris, Levinas was drafted in 1939 but by 1940 was interned by the Germans in a Nazi prisoner of war camp and forced to hard labour. Although he managed to elude the concentration camp, Levinas' family and many of his friends perished at the hands of the Nazis. One commentator has suggested that a staggering 91% of Lithuania's Jewish population died at the hands of the Nazis. Among them, 30,000 from Levinas' hometown of Kaunas were murdered over a four month period

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[14] E. Levinas, *Difficult Freedom: Essays on Judaism* (Baltimore: Johns Hopkins University Press 1990), p. 101.
[15] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 22.
[16] T. Chanter, *in Feminist Interpretations of Emmanuel Levinas*, ed. by T. Chanter (PA: Pennsylvania State University Press, 2001), (p. 6).

by Nazis and Lithuanian nationalists who collaborated with the German forces.[17] The impact of the holocaust was to be foundational to his entire career.

Following the war, Levinas studied the Talmud with various renowned Jewish scholars before going on to publish some of his best known philosophical work and establishing himself as one of the most influential thinkers of the 20th century.[18] His exposure to the horror of Nazism, his Talmudic scholarship and his critique of Heidegger's work became the crucible for his philosophical response to a century that, into this 21st century, is still darkened by unremitting violence.

6.2.1 Husserl and Phenomenology

Husserl's phenomenology had a profound impact on Levinas in its attempt to establish philosophy as a "science of consciousness" that could eclipse the preoccupation with empiricism and theory by focussing on the meaning of perception itself.[19] This was not so much a movement as a method that sought to overcome the rationalizing and restricting limits of traditional philosophy. Phenomenology emphasized a direct apprehension of lived experience aimed at pure subjectivity that was a radical approach and practice rather than a system of philosophy. It was accomplished, Husserl claimed, by intentionally "bracketing out" or "suspending" everything but pure subjectivity so that the practitioner could return to the reduction of pure phenomenological insight.[20] This meant somehow resisting the influence of every construction, every social, cultural or religious assumption, assertion or imposition to get to the "truth" without explaining or theorising, in advance, the phenomenon being apprehended from "within".[21]

One commentator has suggested that phenomenology became the most important strand of European thought in the 20th century although it lacked cohesion and the prominence of a real movement. Yet, few of Husserl's students believed that what he was attempting could be achieved, nor did anyone really succeed him. Those who took his work further, including

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[17] S. Hand, 'Emmanuel Levinas', p. 170.

[18] E. Levinas, *Emmanuel Levinas: Basic Philosophical Writings* (Bloomington and Indianapolis: Indiana University Press, 1996), pp. 7-9.

[19] S. Hand, 'Emmanuel Levinas', p. 12.

[20] Husserl's "phenomenological reduction" describes the purity or essence of things. This is not to be confused with the "reduction" created by the assimilating or objectifying impact of the rational, which Levinas describes as "the same".

[21] D. Moran, *Introduction to Phenomenology* (London and New York: Routledge, 2000), p. 4.

Levinas, were to challenge and change Husserl's vision in significant ways. Having written his dissertation on *The Theory of Intuition in Husserl's Phenomenology*, Levinas was also instrumental in contributing to the emergence and popularity of phenomenology in France.[22] While he re-interpreted and re-oriented phenomenology's approach towards the *ethical*, Levinas still credited Husserl for his remarkable achievement:[23]

> No one combatted the dehumanization of the Real better than Husserl, the dehumanization which is produced when one extends the categories proper to mathematized matter to the totality of our experience, when one elevates scientism to absolute knowledge … Husserl's phenomenology has furnished the principal intellectual means for substituting a human world for the world as physicomathematical science represents it.[24]

Nonetheless, Levinas did not believe that the intentionality fundamental to Husserl's process went far enough to ensure the possibility of the transcendent and judged his work as ultimately flawed. Husserl may have intended to oppose traditional Western philosophy, but its roots were still evident in his philosophical process that made knowledge something to be grasped or possessed.[25] Even with intentionality, Levinas suggested, the very act of thinking interfered with the emergence of pure subjectivity.[26] Levinas disagreed with Husserl's idea of consciousness as something that "discloses" an adequate representation, insisting it must instead "*overflow*" the object in a way that makes it *un*-representable. "The welcoming of the face and the work of justice—which condition the birth of truth itself—are not interpretable in terms of disclosure".[27] Subjectivity could be no mere disclosure, for it required the overflowing welcome in which "the idea of infinity is consummated".[28]

6.2.2 *Heidegger and Onto-theo-logy*

Levinas' relationship with Martin Heidegger was more problematic both personally and philosophically because of Heidegger's involvement with National Socialism and Nazism,

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[22] Moran notes that French phenomenology developed through Emmanuel Levinas, Maurice Merleau-Ponty, Jean-Paul Sartre, Paul Ricoeur, Julia Kristeva, Gilles Deleuze, and Jacques Derrida. See: ibid. pp. 18-19.

[23] Ibid. pp. 1-18.

[24] See: ibid. p. 327. Cited from: E. Levinas, *Discovering Existence with Husserl* (Evanston, IL: Northwestern University Press, 1998), p. 131.

[25] D. Moran, 'Introduction to Phenomenology', p. 328.

[26] Ibid. p. 329.

[27] E. Levinas, *Totality and Infinity: An Essay on Exteriority* (The Hague, Boston, London: Martinus Nijhoff, 1979), p. 28.

[28] Ibid. p. 27.

but equally because Levinas was fundamentally opposed to Heidegger's thinking.[29] Its exclusive focus on the primacy of being and the problem of ontotheology, Levinas believed, reduced *God* to the limited sphere of being and thought. This essentially placed God on equal footing with the thinker.

> If Heidegger taught that the history of Western metaphysics is the history of the forgetting of Being, Levinas teaches that it is the history of the forgetting of the Other. Heidegger also forgets the Other; forgets the alterity that is beyond Being.[30]

In distinguishing between being as a noun and a verb, and in situating being within language itself, Heidegger's formulation along with that of all Western philosophy had, Levinas suggested, continued to forget the radical difference between being, beings and *beyond* being. The latter refers to the moment or *approach* of the transcendent that for Levinas *is* the ethical relationship. Where Heidegger claimed the I of Being, of what is properly mine and what is primary and authenticated by my death, Levinas asserted the I *only* in relation to the Other, for whom I am responsible but also *for whose death* I am responsible.

This forgetfulness is the remarkable blind spot in onto-theology and the consequence of thinking one can have "knowledge of God: theology".[31] In substituting onto-theo-logy for thinking and logic, and mistakenly equating God with being or being with God, our forgetfulness, Levinas suggested, led us eventually to science. This, he claimed, became the totalizing apparatus, "which pays attention only to beings, which subordinates them to itself, which wants to conquer and dispose of them, and which seeks power over beings".[32]

Another way of thinking had to be found which Levinas discovered when he asked if God did not signify the *other of being*? By which he meant the possible subversion of being and

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[29] The implications of Heidegger's involvement with the Nazi party are still contested. One commentator suggests that while Heidegger's involvement was far from innocent from 1933-4, there is insufficient reason to argue that the whole of his philosophy was corrupted by this episode. See: J. Young, *Heidegger, Philosophy, Nazism* (Cambridge University Press, 1998), pp. 1-10. Yet, the bald facts of Heidegger's behaviour are significant. See: S. Hand, 'Emmanuel Levinas', p. 15. Another scholar recounts being publicly humiliated by Levinas following his presentation on Heidegger that Levinas had agreed to help jury. The author suggests this reflects Levinas' historical rage towards Heidegger's Nazi involvement and his profound philosophical antipathy to Heidegger's work. See: W.J. Richardson, 'The Irresponsible Subject', in *Ethics as First Philosophy: The Significance of Emmanuel Levinas for Philosophy, Literature and Religion,* ed. by A.T. Peperzak (New York: Routledge, 1995), pp. 123-31 pp. 124-25).

[30] G. Loughlin, 'Other Discourses', *New Blackfriars,* 75 (1994), p. 20.

[31] E. Levinas, *God, Death, and Time* (California: Stanford University Press, 2000), pp. 121-23.

[32] Ibid. p. 124.

onto-theology that starts with "a certain" ethical relationship.[33] As early as 1935, Levinas was questioning the possibility of transcending ontology, which he addressed in his famous essay, "Is Ontology Fundamental?"[34] In it, he argued for a philosophy beyond ontology that pointed to a transcendence of the Good on which he was to build his primary critique of Heidegger's work. Levinas' project, to "think God as a beyond being,"[35] would occupy the rest of his life.[36] His two best known works, *Totality and Infinity* and *Otherwise than Being, or Beyond Essence,* were written as major critiques of Heidegger's notion of fundamental ontology.[37]

Jeff Bloechl has observed that Levinas' departure from Husserl and Heidegger sought to overcome what seemed to be their primary conclusion that "all experience refers properly to the self," which makes *the self* both irreducible and primary.[38] Levinas' deviation from this formula suggested a subjectivity that claims "a private and irreducible, ontological attachment" to being which is fundamental, inescapable and constant.[39] This, however, was "being" that engenders a chronic restlessness and exhaustion borne of all the efforts to resist "one's very self". For Levinas, the self is always constituted by what he describes as *the same*, by which he means that which is already reduced and limited through its own process and *not* as alterity or as the Other,

Levinas observed that even "[t]he most audacious and remote knowledge does not put us into communion with the truly other; … it is still and always a solitude".[40] Yet, the escape we seek is less from solitude than from *being*.[41] The real freedom from ontology's rationalizing appropriation that constantly leads us back to *the same*, is found in the

[33] Ibid. pp. 124-25.
[34] E. Levinas, 'Emmanuel Levinas: Basic Philosophical Writings', pp. 1-10.
[35] To think God beyond being is the project of Jean-Luc Marion whose commentary is beyond the immediate focus of this thesis. See: J.-L. Marion, *God without Being: Hors-Texte* (Chicago and London: University of Chicago Press, 1995).
[36] E. Levinas, 'God, Death, and Time', p. 160.
[37] P. Benson and K.L. O'Neill, 'Facing Risk: Levinas, Ethnography, and Ethics', *Anthropology of Consciousness*, 18 (2007), pp. 31-32.
[38] J. Bloechl, *Liturgy of the Neighbor: Emmanuel Levinas and the Religion of Responsibility* (Pittsburgh, PA: Duquesne University Press, 1999), p. 132.
[39] Ibid. p. 127.
[40] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', pp. 60-61.
[41] Ibid. p. 59.

relationship that originates between me and one particular person.[42] This might suggest a philosopher's view of "knowledge" or a certain kind of philosopher. In the work of someone like Plato, for example, knowledge is also social and arrived at through dialogue, bringing forth what in some sense *is* already known. Levinas' focus, however, is on the extraordinary relationship that awakens me with its traumatizing contrast between hidebound being and the holy. This relationship is one that claims me with a responsibility that "goes all the way to fission,"[43] where "I am sick with love".[44] This event can presumably apply to any relationship but is nothing like a reciprocal relationship of equals, as we shall see.[45]

Levinas' radical reformulation of philosophy, Derrida observed, went against the grain of philosophical thought from Plato to Heidegger.[46] It took aim at the whole history of European philosophy and its influence on Western civilization that totalized and reduced "otherness" to the *same* "originary and ultimate unity".[47] This totality, Levinas claimed, was all that was, and is, assimilated in the wake of Western philosophy's rationalizing and reductive grip powered by "the drive for 'representation'".[48] Ontology, Levinas insisted, was the root problem that reduced the intrinsic value of diversity, and the particularity of the individual, which leads to the harrowing outcomes of totalitarianism. Within this inquiry, these outcomes refer more to the mundane consequences of predictable institutional dehumanization, medicalization and asymmetry found in community mental health care in its many guises.

6.3 The Face of the Other

> [T]aking as my point of departure the face of the other, proximity, by hearing—
> before all mimicry, in its facial straight forwardness, before all verbal expression, in
> its mortality, from the depths of the weakness—a voice that commands: an order
> addressed to me, not to remain indifferent to that death, not to let the other die alone;
> that is, an order to answer for the life of the other man, at the risk of becoming an
> accomplice to that death.[49]

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[42] C. Barnett, 'Ways of Relating: Hospitality and the Acknowledgement of Otherness', *Progress in Human Geography*, 29 (2005), 9.

[43] E. Levinas, 'God, Death, and Time', p. 138.

[44] Here Levinas quotes the Song of Songs. See: ibid. p. 188.

[45] M.L. Morgan, *The Cambridge Introduction to Emmanuel Levinas* (Cambridge University Press, 2011), p. 8.

[46] J. Derrida, 'Adieu to Emmanuel Levinas', p. 3.

[47] E. Levinas, 'Emmanuel Levinas: Basic Philosophical Writings', p. x.

[48] D. Moran, 'Introduction to Phenomenology', p. 329.

[49] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 169.

6.3.1 *The Face*

The "Face," or what Levinas also qualifies as the approach[50] of the Face, alludes to "[t]he dimension of the divine," that "opens forth from the human face" through the face of the stranger, the widow, the orphan.[51] These are familiar tropes in Levinas' work, which he cited from the Hebrew bible and used to describe the proto-typical moral appeal of the weak to the strong.[52] Astonishingly, their inversion can also occur when the other is confronted by *my* brutality or disdain. Even those I oppress are capable of responding to *my* face and moral destitution.[53] This is a remarkable response, as one commentator has observed, that represents an act of essential freedom given the senseless irrationality of such generosity.[54] Elsewhere, Levinas confirms that I *am* responsible even for the other who persecutes me.[55]

In making this claim that might otherwise seem indefensible or even absurd, we also remember that Levinas is attempting to work within a phenomenological framework that is unapologetically subversive but that also aims to transcend. It may be challenging to confirm such claims, yet we can still appreciate Levinas' intention to awaken us to this this felt-sense. My argument does not pretend to explore or even defend all aspects of Levinas' thought. Yet, in drawing on his ethical vision I have been able to articulate and deepen what I have recognised—and embodied—in the relationship with the help seeker. Moreover, there are examples that confirm such claims, including Nelson Mandela's famous friendship with his own prison guards. This relationship shifted the political perspective of these men and contributed to their enduring bond of friendship with Mandela himself.[56] In Levinas' words, *this* is the "phenomenology of sociality".[57]

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[50] The term "approach" is found throughout Levinas' work and denotes what is beyond volition or anticipation, or in Levinas' terms, beyond being, knowledge or the rational. The "approach" implies or evokes the neighbour, proximity, the infinite, the "saying" and, certainly, the Face whose impact upon me is unbidden and absolute. Levinas suggests that, "[t]o be on the ground of the signification of an approach is to be *with another* for or against a third party, with the other and the third party against oneself, in justice. See: E. Levinas, *Otherwise Than Being, or, Beyond Essence* (Pittsburgh, Pennsylvania: Duquesne University Press 1998), pp. 5, 11-12, 16, 24, 30, 36, 47-48.

[51] E. Levinas, 'Totality and Infinity: An Essay on Exteriority', p. 78.

[52] E. Levinas, *Nine Talmudic Readings* (Indiana University Press, 1994), pp. 83-84.

[53] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', pp. 88-89.

[54] M.L. Morgan, 'The Cambridge Introduction to Emmanuel Levinas', pp. 18-26.

[55] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 106.

[56] K. Weingarten, 'Immersed in America: Life after a Trip to South Africa', in *Ethical Ways of Being,* ed. by D. Kotze, et al. (Chagrin Falls, Ohio: Taos Publication/WorldShare Books, 2012), pp. 25-36 (p. 32).

[57] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 169.

Interestingly, the Face does not refer to particular features, the arrangement of the eyes, nose, mouth or ears although it is an entirely human face. Levinas even suggests that to notice the colour of someone's eyes is already to be outside of a social relationship with the other, for this Face cannot be reduced to mere perception.[58] We recognize this Face by its "uprightness," its defencelessness, exposure and poverty that are exposed despite any efforts to hide who we really are. Levinas' evocation of "[t]he skin of the face" being the "most naked, most destitute," refers to its force upon me and the epiphany that calls to me.[59] While this face is vulnerable, "nude," laid waste, devastated it is also, paradoxically and in the same instant, exalted and *authorised* by what Levinas describes as an elevation or moral height that points to the eternal. This Face confirms my relatedness to the other—and also the "Other"—and the futility of my enormous, albeit pleasure-full, effort "to be". The call of this face inundates me with a responsibility that never ends, that "demands me, claims me, assigns me," but that also grants freedom—not from the Other, but from the burden of my *self*.[60]

> Transcendence signifies a movement of traversing (trans) and a movement of ascending (scando). In this sense it signifies a double effort of stepping across an interval by elevation or a change of level…The distance thus traversed by the gaze is transcendence. The gaze is not a climbing but a deference. In this way it is wonder and worship.[61]

Philosopher, Michael Morgan, suggests four possible philosophical interpretations of the "normative force" of this face. Firstly, as a "pluralist response" related to culture and history and having no one source or, secondly, as something emerging from our psychology as a "naturalist response" or intuitive impulse. Thirdly, as related to reflexivity, free choice, and the ability to engage in a rational process or, finally, as a conventional response that reflects the compulsions and values of a given society.[62]

Yet, none of these "ontological" explanations captures the enigma of the pre-conscious draw, "that strips consciousness of its initiative".[63] For, this is what announces my guilt even before my action and illuminates an ethical order manifested in, and expressed through,

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[58] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', pp. 85-86.
[59] Ibid. p. 86.
[60] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 147.
[61] E. Levinas, 'God, Death, and Time', pp. 163-64.
[62] M.L. Morgan, 'The Cambridge Introduction to Emmanuel Levinas', p. 9.
[63] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', pp. 58-59.

human relationship. Metaphysical abstractions, or what Levinas has called the "toys of our oratory," only achieve their meaning and purpose in the here-and-now of the face-to-face reflection of the transcendent.[64]

6.3.2   *The Other*

In simplest terms, Otherness is "the not me" and sameness is "the for me".[65] The relationship between the two constitutes an ethical relationship distinguished by the "deference of the Same to the Other," which is no longer *subordinated to ontology or to the thinking of being".*[66] In Levinas' work

there are various plays on this word. Hence, the "other" may allude to the other person for which Levinas uses the French ''l'autrui," as opposed to "l'autre" which translates as simply "the other". When capitalized, however, the "Other" can be understood as the transcendent "trace" of the eternal, of God.

In a riff on Hamlet's soliloquy Levinas suggests that, "[t]o be or not to be is *not* the question,"[67] for being and its self-interest are always secondary to the evocation of the "the Face of the Other". "Le Visage d'Autrui serait le commencement même de la philosophie". ("The Face of the Other person will be the actual beginning of philosophy").[68] But who or what, exactly, is this Other? This is a notion, Morgan suggests, that has been used by other philosophers over time to denote, for example, Plato's "Form of the Good," Plotinus' "the One," and Descartes' "infinite and perfect God". In Levinas' interpretation, the Other is the human being before whom I stand in a face-to-face encounter.[69] Morgan also observes the important distinction Levinas' made between seeing or perceiving the face and *encountering* it. The first can be viewed as "a mode of relation" but "the other is something else, something unique and originary and determinative".[70]

> This order steals into me like a thief, despite the outstretched nets of consciousness, a trauma which surprises me absolutely, always already passed in a past which was never present and remains un-representable.[71]

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[64] E. Levinas, 'Difficult Freedom: Essays on Judaism', p. 102.

[65] E.E. Gantt, 'Levinas, Psychotherapy, and the Ethics of Suffering', *Journal of Humanistic Psychology,* 40 (2000), 18.

[66] My italics. E. Levinas, 'God, Death, and Time', p. 127.

[67] Levinas' play on Hamlet's words underscores his perspective that the question of being is always superseded by the *relationship* in which the ethics of first philosophy rests. See: E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 10.

[68] E. Levinas, *Entre Nous: Essais Sur Le Penser-À-L'autre* (Bernard Grasset, 1991), p. 113.

[69] M.L. Morgan, 'The Cambridge Introduction to Emmanuel Levinas', p. 3.

[70] Ibid. p. 45.

[71] E. Levinas, *Collected Philosophical Papers* (Dordrecht, The Netherlands Martinus Nijhoff, 1987), p. 171.

Levinas' inconsistent use of capitalization for his terms has challenged his interpreters and translators. One commentator goes as far as to describe Levinas' writing at "infuriatingly sloppy"[72] for similar transgressions, and other inconsistencies and contradictions. However, the notion of "other" as a quality of differentness or "alterity" is one that always stands in opposition to that which is *the same*. This word play is evident throughout Levinas' work, where it is prominent even in the title of *Otherwise than Being or Beyond Essence.* Thus, otherness (alterity), the Other (the transcendent), and the other person (l'autrui), are entwined in Levinas' work, always pointing to the ethical that is at once profoundly and practically human, relational and infinite.[73]

6.4 A case study of the Face of the Other

> This otherness and this absolute separation manifest themselves in the epiphany of the face, in the face to face. Being a grouping quite different from the synthesis, it initiates a proximity different from the one that presides over the synthesis of data, uniting them into a "world" of parts within a whole.[74]

The Face at the centre of Levinas' formulation of ethics is arguably the *whole* work of community mental health care given the clinician's constant exposure to it and the extremity of its demand. Whether the clinician responds hospitably or remains entranced in the distancing and reductive sphere of clinical biases, projections and protocols, this is *the* Face "par excellence"[75] of community mental health care. Even before taking a seat in the consultation room, this Face claims me for a responsibility that my job description and clinical education have left me morally and practically unprepared, if not destitute. Nonetheless, this face cries out to me. It *howls* for understanding, for compassion, for safety, for respite, for comfort, for justice, for love, but also for its basic human rights—food, shelter, education, employment, above the hum of the factory floor, before a single word is uttered.

6.4.1 *Sharon*

> *A morbidly obese woman walks into my counselling room. She is short, her hair is unkempt and unwashed and she looks exhausted and rather fearfully at me. She is so heavy she has*

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[72] D. Moran, 'Introduction to Phenomenology', p. 322.

[73] See: E. Levinas, *Time and the Other* (Pittsburgh, Pennsylvania: Duquesne University Press 1987), p. viii. For a lovely encapsulation of infinity and its presence as testimony, see also: E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', pp. 105-10.

[74] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', pp. 185-86.

[75] "Par excellence" is a verbal emphasis found repeatedly throughout Levinas' texts.

trouble squeezing into the armed chair and has to lay back in it to make herself reasonably comfortable. Her strapped summer dress hangs on her shoulders like a large cotton sac and reveals the whole truth of her body. The dimpled skin on her chest and her arms is blemished and discoloured where she has picked her skin. She has been ravaged by significant childhood sexual abuse that continued into her teen years, spends most of her days in bed too depressed to get up, is living with crippling arthritic pain and the prognosis is bleak. A wheelchair looms in her future. She needs to work but cannot manage it physically or emotionally. Her husband earns a modest living but neither understands nor appreciates her anguish, and her children disrespect her and make her cry. She tells me she loves God but she feels utterly betrayed by Him and has been poorly treated by members of her church who she loved and revered.

Sharon is terrified to talk about wanting to kill herself for fear I will have her children taken away. I explain that the social services lack the manpower and incentive to take teenage children away from all the suicidal mothers in the land. We laugh ruefully together, but she is still afraid, vigilant. I promise her that no one will take her children yet I worry about their welfare and their inability to mother this broken woman.

One day Sharon shows me a bruise the size of a dinner plate she has made on her abdomen by pinching herself. It is a habit that mortifies her but that is not easy to give up because it soothes her. She needs permission to reveal this and wants me to coax her to show me the wound. I assure her I want to see it, and with no small dignity she lifts up her dress to show me the evidence because someone has to bear witness to this much senseless suffering. I am utterly silent in the presence of this massive purple wound, the ballooning flesh, the underwear, the revelation, and am in that moment overwhelmed by a dignity and anguish I find immensely personal and painful to look at.

From the early days of our meetings I incline myself towards this God lover and tell her, honestly, that whenever she enters the room she brings in a quality of wonder and beauty that often makes my eyes stream and for which I am profoundly grateful. Sharon looks anxiously, uncertainly, into my face to confirm my sincerity. I ask her if she can feel it in the room, the light, the spaciousness, this perfection. I call it "God" so she will know what I mean. She tells me she can, her face softens, and we sit together in the thick silence for a few moments

savouring the evanescence. This is the mystery that she herself evokes, understands and loves,
even while she yearns for it, even while it eludes her, and upon this we build a plan for her
next tentative step.

Levinas' formulation of the Face shines through Sharon's actual face, her body, her wounds, her anguish and defencelessness. The "uprightness"[76] of this face, as John Caruana observes, combines three aspects that constitute the sheer impact—the *shock*—of this face upon me that speaks of an integrity testifying to the "divine in the human drama".[77] Indeed, Sharon's dignity and gravitas were absolute.

In the course of my work, this Face discloses my wonder-full "rapport" and mediates my "professional" judgement. The implications of which are found in the enormity of my authority over virtually every aspect of her life or, possibly, the authority of someone above me in the clinical hierarchy. This is no exaggeration, for with a single phone call, letter, clinical note or consultation with another of her care-providers I could theoretically have Sharon's fragile life besieged by the power of the law at my disposal.

Conversely, I could also tell Sharon she did not "meet the mandate" and literally fire her from our care. Sharon is, after all, the prototypical "heart-sink" patient whose needs are beyond the capacity of the institution.[78] But then the Face commands me and I am thenceforth incapable of allowing her to suffer alone. This is a call that consigns me, ("[I]l y a comme un appel a moi"),[79] that "awakens" me to the violence I fear I might commit, or expose her to, despite my best intentions.[80] Here, the desire to protect this other even—or *especially*—from *myself* confirms a responsibility from which there is no release but which I am always at liberty to ignore.[81] In what he admits is an "extreme formulation," Levinas

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[76] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', pp. 130, 31, 48.
[77] J. Caruana, 'Not Ethics, Not Ethics Alone, but the Holy', *Journal of Religious Ethics,* 34 (2006), p. 562.
[78] See: The heart-sink patient in (3.6.3). See also: C.C. Butler and M. Evans, 'The 'Heartsink' Patient Revisited'.
[79] A paraphrased translation is offered in this paragraph starting with "rapport" and ending with "Il y a comme un appel a moi" which, literally translated, means "there is like a call to me". See: E. Levinas, 'Entre Nous: Essais Sur Le Penser-À-L'autre', p. 114.
[80] "An awakening to the other man, which is not knowledge," describes the enlightenment endowed by the face-to-face in Levinas' work. See: E. Levinas, 'Entre Nous: On Thinking-of-the-Other', pp. 168 and 88-89,12, 14, 18, 46, 220, 39, 40.
[81] In noting the various permutations of post-metaphysical thought which include "being-for-oneself, being-with-others, or being-in-the-world, Cohen observes that Levinas placed precedence on "being-for-the-other-person" above all else including, "being, essence, identity, manifestation, principle, in brief, over me". See: E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 10.

contends that, "[t]he face orders and ordains me. Its signification is an order signified,"[82] even if I am powerless to do more than stand by helplessly and say, "I am here".[83]

Levinas' evocation powerfully confirms the accuracy of my apprehension of Sharon's "transfigured" face, although this face shifted continually over the course of our work. In one moment it could evoke a wrenching tenderness and palpable sense of the divine. In the next, this face would relapse into the totalized perspective of a desecrated "heart-sink" patient that left me earnestly wishing Sharon would just go away. Yet, translating the ineffable into language is always problematic for there are *not* two different Sharons. These perceptions do *not* come at different times during our face-to-face meetings, nor are they conflated, nor are they separated—as if by a split screen image—nor, strangely, do they actually oppose each other, despite the enormity of the contrast between them.

We might say that Sharon elicited a sense of wonder on which I capitalized as a clinician wishing to maintain a more humanized regard for her. Conversely, we might suggest that she elicited my sense of horror and despair, guilt and exhaustion that I wished to soften under the cover—the protection—of a more wonder-full perspective. Yet, such interpretations fail to adequately explain the *relationship* because I am already in *up to my neck* with this woman before the question of how I am to help even emerges. That I need to help her, am compelled to help her, is unequivocal but in no way equivalent to my ability to do so. Yet, my desire speaks for itself, as does my ambivalence. Nor are these "evocations" somehow *imposed* upon me. Indeed, they are *not* divorced from a certain willingness or acquiescence on my part to what Levinas so exquisitely identifies as, the *welcome* of the face that is irresistible or nearly so. In this enigma that draws and repels me, I am confronted by a yearning that recognizes *my* need of this "Other". I am also shocked to recognize that Sharon is, very problematically, subordinate to me in every conceivable way by her life circumstances and the rules of the clinical game.

The enigma is partially clarified by, Levinasian scholar, Richard Cohen who observes that these two perspectives – ethics versus ontology—do *not* oppose each other along a shared continuum. They actually lie on different planes altogether with the one cancelling out the other. Yet, even this nuanced assertion of the primacy of the Other—of "what ought to be"—

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[82] Ibid. pp. 97-98.
[83] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 149.

fails to offer Sharon much if any protection. For, the elevated view of this desecrated other that is holiness is also fragile, tenuous, unstable and easily collapsed back to the "what is" by the reduction of ontology. That said, even the epiphany that Levinas calls the "anarchy" of the face is one that can "unsettle essences," "undo identities" and illuminate, if only briefly, what is "better than being".[84]

Sharon's divinity *is*, nonetheless, confirmed through her being in an account of "what is" that is subtle and blatant, beautiful and horrifying. This enigma does not represent separate perspectives or elements as much as it *includes* them; there is no barrier between them. Nor, I would suggest, does this enigma constitute a revelation as much as the shocking *recognition* of relationality to which I am tied inexorably and wonderfully—but also ambivalently. This is an ambivalence on which I appear to swing as if on a hinge, back and forth, between my desire and repulsion, my reverence and fear and ultimately, between justice and injustice. The extremity of Sharon's vulnerability discloses a responsibility beyond my ken or capacity for which I can also resent and blame her for my empty handedness and despair. The step to disgust and neglect—dehumanization and abuse—lies just beyond this perimeter. Levinas confirms the hairline proximity of divinity to horror, and his ethics of relationship to abandonment. Indeed, my clinical response to this face reflects philosopher Mary Jane Rubenstein's description of wonder as something essentially ambivalent where horror and holiness—far from opposing each other—are actually wed.[85] Whether I act for or against this Other, my responsibility is ineffaceable, my relationship unequivocal and always there beneath the veneer of my professional mask. Yet, this mask is constantly threatened, along with everything it represents and contributes to the project of my being, by a larger purpose whose call I can all too easily ignore within my clinical role.

6.5 The language of wonder

> It is a dazzling, where the eye takes more than it can hold, an igniting of the skin, which touches and does not touch what is beyond the graspable, and burns. It is a passivity or a passion in which desire can be recognized, in which the *"more in the less"* awakens by its most ardent, noblest and most ancient flame a thought given over to thinking more than it thinks.[86]

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[84] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', pp. 8-10.

[85] M.J. Rubenstein, 'Strange Wonder: The Closure of Metaphysics and the Opening of Awe', pp. 9-11.

[86] E. Levinas, 'Emmanuel Levinas: Basic Philosophical Writings', p. 139.

As Levinas' work matured, his writing became increasingly enigmatic and paradoxical in his ever more explicit attempts at "unsaying," to communicate his meaning. This implicates Derrida's influence on Levinas' writing, but also the complex and ongoing relationship of post-modern philosophy to negative theology and Dionysius the Areopagite, whose work had such influence on the development of the Christian mystical canon.[87] Of special interest to post-modern philosophers, and Levinas as well, are the linguistic strategies of negative theology used to "provoke the collapse of binary language".[88] The power of these strategies lies in their ability to create a space for the writer—but also the *reader*—to apprehend and testify to an event beyond being, "despite the constraints of social, political and ecclesial structures".[89] Levinas' work is renowned for the obscurity[90] of its language and its sometimes delirious excess aimed at protecting the uncontainable Other from ontological reduction.[91] As philosopher theologian Amy Hollywood might also suggest, this language promotes the social transformation Levinas' vision seeks to evoke, because it *preaches*.[92]

Derrida described Levinas' words as being "carried away" in a "discourse that opens each signification to its other".[93] Another commentator has suggested that Levinas used this language to illustrate the inadequacy of earlier arguments made by philosophers from Descartes to Heidegger, and to shock his reader into another way of seeing.[94] Certainly, Levinas' writing bears the distinctive hallmark of the apophatic in its paradoxical evocations that strain towards the ineffable. Still, the kataphatic is also present in the intense focus of this writing on relationship and the "sensory impressions" of the encounter.[95] Despite Levinas' efforts to overcome the limits of language and evoke the eternal transcendent, his linguistic brilliance also evokes a visceral quality that is profoundly *embodied*.

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[87] See, for example: C. Racine, 'Loving in the Context of Community Mental Health', p. 112; M.J. Rubenstein, 'Dionysius, Derrida, and the Critique of "Ontotheology"', *Modern Theology*, 24 (2008).

[88] Rubenstein's thoughtful work describes the complexity and controversy of this ever evolving issue. See: M.J. Rubenstein, 'Dionysius, Derrida, and the Critique of "Ontotheology"', p. 726.

[89] For a brief analysis of Eckhart's negative theology see: ibid. pp. 726-27.

[90] P. Benson and K.L. O'Neill, 'Facing Risk: Levinas, Ethnography, and Ethics', p. 32.

[91] S. Hand, 'Emmanuel Levinas', p. 59.

[92] See, for example: A.M. Hollywood, 'Preaching as Social Practice in Meister Eckhart', in *Mysticism and Social Transformation*, ed. by J.K. Ruffing (New York: Syracuse University Press, 2001), pp. 76-90 (pp. 88-89).

[93] J. Derrida, 'Adieu to Emmanuel Levinas', p. 30.

[94] M.L. Morgan, *Discovering Levinas* (Cambridge University Press, 2007), p. 157.

[95] J.K. Ruffing, pp. 4-5.

In his frequent allusions to the work of "unsaying the said," Levinas demonstrated what he means through the sheer wizardry of his language.[96] He employed this language to negotiate the Face, the Other and the complexity of the ethical relationship around the concretizing limitations of "being" and "the said". In "the said," the Other is already reduced, assimilated and waiting to be reborn in the "saying" through the immediacy of the human encounter in which one person addresses another in terms as simple as: "After you, sir". Even this, Levinas reminds us, testifies to the condition of being held hostage to the other which makes it possible for there to be "pity, compassion, pardon and proximity" in the world.[97] In Levinas' terms, "the saying" is essentially and always goodness, friendship and hospitality.[98]

Richard Cohen observed that Levinas acknowledged that only language had the power to "break the continuity of being or of history". [99] Despite his own use of paradox, hyperbole and exaggeration[100] that often reads like mystical poetry, Levinas' mistrust of poetry was well known and he typically associated it with "mystification, pagan magic, and sorcery".[101] He insisted that transcendence related exclusively to the holy, but not to the *sacred* to which he ascribed a kind of ecstatic and affective experience that, he believed seduces the self away from its larger purpose.

A thoughtful analysis by Caruana examines the connection between ethics and the holy in Levinas' work.[102] It relates to the primary teaching of Judaism, linking the human other and "the saintliness of God" to the maintenance of our human bond. Holiness, Levinas argued, is corrupted when the transporting ecstasy of the sacred and its solitary drive towards the divine derails us from our path towards the other, thus becoming a "form of violence".[103] Levinas' concern with the dangers of focussing on affectivity echoes those Christian theologians who decry the contemporary definition of the mystical as "an experience". That is, where the "mystical" is essentially reduced by the self for its own gratification. Consequently, it is divorced from the larger context of spiritual development and practice, mutuality, community, service and the original meaning of the mystical as a

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[96] See for example: E. Levinas, 'Otherwise Than Being, or, Beyond Essence', pp. 44, 181.
[97] Ibid. p. 117.
[98] E. Levinas, 'Totality and Infinity: An Essay on Exteriority', p. 305.
[99] E. Levinas, 'Otherwise Than Being, or, Beyond Essence', p. xii.
[100] M.L. Morgan, 'The Cambridge Introduction to Emmanuel Levinas', p. vii.
[101] L. Hill, "Distrust of Poetry": Levinas, Blanchot, Celan', *MLN*, 120 (2006), 988.
[102] See: J. Caruana, 'Not Ethics, Not Ethics Alone, but the Holy'.
[103] E. Levinas, 'Difficult Freedom: Essays on Judaism', p. 14.

contemplation.[104] Levinas was resolute that the only possible meaning of this transcendence is that which is fulfilled by the ethical terms of my obligation to my neighbour.

6.6 Choosing disinterest

Levinas' relational formulation is never about "thinking" or conceptualizing the other. His is not a rational metaphysics that mistakes the purpose of thinking about the ultimate truth, with Truth itself. The problem always lies with the ontological quest for certainty and its outcome—ownership, possession, mastery, ambition, appropriation and assimilation. This is what contributes, Levinas claims, to a "sense of the malignancy of being" and the "sadness of self-interest". Then he offers another way in suggesting we could *release* ourselves from the grip of self-interest for the "joy or accomplishment" in "disinterestedness." Disinterest, he insists, does not represent an emptiness, so much as a turning away from the self towards the suffering of the other who—*like me*—is struggling with the same disappointments and inadequacies of being and its ultimately lonely, destructive path.[105]

Disinterest necessitates the recognition and relinquishing of the (im)-morality implicit in the onto-theological that Jantzen describes as the "symbolic of domination," because the onto-theological predictably leads to violence and oppression.[106] In the context of our inquiry, this violence is below clinicians' awareness and committed unintentionally thereby leaving the perpetrators oblivious. Disinterest not *self-interest*, Levinas argued, is the way out of this ontological bind towards a "non-ontological notion of God" that begins in the relationship with the other.[107]

To simplify his point, Levinas compares the difference between being and responsibility to frivolous play and gravity. There is the harmfulness of being's frivolous play and its self-interests that are found in the privileges of wealth, fame and possessions. Yet, there are even greater possibilities to be discovered in responsibility to the Other.[108] These do not lie in some joyless self-sacrifice but in imagining beyond that which reduces our lives, the people

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[104] See: M.A. McIntosh, 'Mystical Theology: The Integrity of Spirituality and Theology', pp. 4-70.
[105] E. Levinas, 'Being in the Principle of War', in *Penser Aujourd'hui: Emmanuel Levinas*, (1991). <https://www.youtube.com/watch?v=- 1MtMzXNGbs> See: 00.7 – 00.8 minutes. [accessed 30 July 2016].
[106] G. Jantzen, 'Becoming Divine: Towards a Feminist Philosophy of Religion ', p. 234. Jantzen argues for the possibility of our divinization by drawing on the work of Luce Irigaray. Jantzen lays the problem of systemic violence and dehumanization at the feet of Christianity's focus on life after death at the expense of the living.
[107] E. Levinas, 'God, Death, and Time', p. 180.
[108] E. Levinas, 'Being in the Principle of War'. <https://www.youtube.com/watch?v= 1MtMzXNGbs>. [accessed 30 July 2016].

in them and the world around us, to a "series of means for further ends".[109] In terms of our inquiry, the need for such imagining can hardly be overstated if the clinician is to *respond* to the holiness of the clinical encounter as something other than an experience or "privilege" for her private—if mortified—consumption.

6.6.1 The Church

I'd come to London on a three and half hour train ride for a symposium where priests, psychiatrists and associated professionals were gathering to explore the links between the professional and the vocational. The Church was magnificent, the croissants fresh, the coffee plentiful. Gold tiles glittered from the dim recess of the apse, and the well-heeled audience took their places in the pews.

The opening speaker was a young doctor who was perfectly made-up and beautifully dressed. She spoke of the torment of her medical training for half an hour with a grimace of a smile on her terrified face that never once flagged. The other presenters were middle-aged and older men, successful physicians and clerics who could extemporize with their hands in their pockets. Media savvy, self-deprecating and at the peak of their careers, they could finally say whatever they wanted, and admit as much with an ironic smile. They reeked of authority and their focus was surprisingly personal and refreshingly regretful, even wistful.

Much of their talk and most of their stories were tinged with hushed reverence that borders on awe, the humble amazement and soulful gratitude for what we in this business get out of the encounter from those who come to us for help. Such sincerity should never stink of sanctimony but it almost always does. We like talking like this—when we can—because it's true, and we feel good, we feel special for seeing and saying what is hidden. We feel free and daring because this is dangerous territory and stands in opposition to much of what we're been trained to protect and believe and not admit. But we all know that when that wonderful thing happens, everything changes. When we actually see, when we know that utter perfection sitting in front of us with his stigmatizing label, his epic story and his smashed life that no one could ever fix, it's like discovering the Holy Grail, and we're confirmed and rhapsodic. "It's such a rare privilege this work, isn't it? Isn't it? Yes, it really is". This is always said as if for the first time, as though we've just noticed and we have a corner on the market that edifies us for that reason.

But the tribute never veered towards questions of power or its abuse. No one said a word about the differences in salary or status even between the doctors and priests, let alone the helpers and the helped. The only culprit ever mentioned was the "system" and we nodded our collective heads like congregants at a revival meeting each time another testimonial was given about the system that kept us from doing more, from doing enough. All the talk about the spirit-withering system added a lustre of virtue to the earnest lamentations of these powerful

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[109] T. Chanter, 'Feminist Interpretations of Emmanuel Levinas', p. 12.

men, and the rest of us for that matter, who genuinely wanted to pay homage to those who'd come broken and empty handed to our doors, with what trust and hope. But who'd somehow—marvelously, incredibly—resurrected us instead, not once but many, many, times.

There was a frisson of anarchy in the church that day that hinged on our communion with the one who is constantly revealed as more than an equal, as our teacher, as an unexpected and priceless gift, as this "great privilege". Yet, no one went further. No one talked about the injustice and our relationship with the social equivalent of "an untouchable," who we ourselves help create. But who nonetheless makes us well and on whose shoulders we stand. Who rescues us from the fray and holds the antidote to our own professional powerlessness, ennui and despair. No one remarked how we justify limiting the orbit of our effort to the homey boundaries of the consultation room and its many comforts. No one even hinted about who really pays for this intimate and affirming reward that allows us to be so very grateful with so little outlay. Not even me.

This question of "being" as opposed to "being- for-the-other" constantly begs the seemingly imponderable question that philosopher Philippe Nemo poses to Levinas: "But if one fears for the other and not for oneself, can one even live?" Which, Levinas agrees, is the ultimate question, but then he reframes it: "Should I be dedicated to being? By being, by persisting in being, do I not kill?"[110]

We may find Levinas' repeated allusions to killing, polemical or metaphoric. That we do confirms, for Grace Jantzen, the security of academics' cocooned existence and their collusion with violence despite their efforts to act against it.[111] The equivalent is true of the clinician vis-à-vis the vulnerable help seeker. For, the clinician's personal involvement in the violation and harm of others is appallingly real on closer investigation as the autoethnographic narratives in this inquiry are attempting to illustrate.

In Levinasian terms, in *any* terms, can it not—*should* it not—be argued that I have contributed in my professional role to the destitution, demoralization, degradation and *death* of the Other, no matter how peripherally, how legitimately, how "ethically"? Is this not the point of an argument for Levinas, for wonder, for autoethnography? That is, to reveal, interrupt, challenge and *name* what hides in the ample folds of the rational and the being that answers only to itself?

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[110] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 120.
[111] G. Jantzen, 'Becoming Divine: Towards a Feminist Philosophy of Religion', p. 239.

Yet, Levinas maps the ontological trap in which I am also caught, which protects, endorses and justifies my role, my institution and the culture from which they spring. Even my intention to "open to wonder" in the consultation room is tainted by my self-consciousness and the anticipatory satisfaction arising from what I already "know" or wish to confirm.[112] At the same time, Levinas' ethical formulation confirms my moral failure and my unfulfilled responsibility—in sum, my profound unconsciousness, my blindness, my *violence*.

Curiously, this moral clarity offers the consolation of a sliver of integrity in my unacknowledged—*invisible*—survivor's guilt and grief. I may not be vindicated but neither am I wholly dishonoured.[113] Derrida noted that Levinas himself spoke of survivor's guilt as a "guilt without fault and without debt; it is in truth an entrusted responsibility".[114] To recognize and claim what I know to be right and just in a morally compromising environment speaks of my ethical capacity to do just this. Even if such goodness is routinely sacrificed, *corrupted* and reconfigured by the institution[115] it also "consists of taking up a position in being, such that the other counts more than myself".[116]

Nemo objects to Levinas' response by observing that even in the animal kingdom a law prevails among all species that makes it impossible to live without killing, and Levinas asserts yet again: "In society such as it functions one cannot live without killing or at least without taking the preliminary steps for the death of someone". He then presses the point that the banality of our ability to kill does not diminish its significance. Which is why, Levinas concludes, the most important question is *not* "why is there something instead of nothing" but "do I not kill by being?"[117] Is there a more fundamental question than this for the clinician to ask?

6.7 Responsibility

> It is a passivity more passive still than any passivity that is antithetical to an act, a
> nudity more naked than all "academic" nudity, exposed to the point of outpouring,

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[112] E. Levinas, 'Otherwise Than Being, or, Beyond Essence', pp. 99-100.

[113] "I leave the whole consoling side of this ethics to religion," Levinas claims, in acknowledging the difficulty of the responsibility ethics claims over me. See: E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 108.

[114] J. Derrida, 'Adieu to Emmanuel Levinas', p. 6.

[115] Deck notes the professional trap that necessitates the continual re-construal of the incomprehensible into the "explicable and natural". See: A. Dueck and T.D. Parsons, 'Ethics, Alterity, and Psychotherapy: A Levinasian Perspective', *Pastoral Psychology,* 55 (2007), p. 277.

[116] E. Levinas, 'Totality and Infinity: An Essay on Exteriority', p. 247.

[117] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 120.

effusion and prayer… It is a vulnerability and a paining exhausting themselves like a hemorrhage, denuding even the aspect that its nudity takes on….It is the passivity of being-for-another, which is possible only in the form of giving the very bread I eat.[118]

In looking more deeply into Levinas' account of responsibility, we find in his notions of passivity, asymmetry and substitution, meanings that can seem almost indistinguishable from each other in their overlapping dynamic. The event they describe is not a quantitative progression so much as a *suspension,* a radicalizing moment of wonder. This is one that lays bare my concretized professional identity and a spontaneous "deference" which overflows with a sense of my indebtedness to this Other. This event is far more "dangerous" than "clinical" empathy in light of the asymmetry it evokes.[119] Such asymmetry, according to Levinas, also refutes Buber's *I and Thou* and a relationship of equals where there is an expectation that the other will acknowledge me as "Thou".[120] Any interest in reciprocity is the other person's business, Levinas insists, *not* his. "I am responsible without waiting for his reciprocity were I to die for it".[121]

Such asymmetry is beyond comprehension for it means I am responsible for the harm this other may do—or may have done—to another or even to himself or to me. This is in addition to anything anyone else may do, be doing, or have done to harm him, or anything that might befall him. I am solely and entirely responsible and no one can take my place in this responsibility, which makes me "un-substitutible," although *I* may be substituted for the responsibility of another. To clarify the point, Levinas employs a quote throughout his work taken from one of Dostoyevsky's characters: "We are all guilty for everything and everyone, and I more than all the others".[122] Such responsibility calls forth a passivity that is intense, acute, urgent, immediate, *full*. Derrida describes Levinas' remarkable evocation of such consciousness as, "the urgency of a destination leading to the Other and not an eternal return to self".[123] Indeed, there is nothing before me in this event but a raw, unequivocal yearning that is also paralysing. How can this be?

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[118] E. Levinas, 'Otherwise Than Being, or, Beyond Essence', p. 72.

[119] Macnaughton references the danger to the reductive power of the institution. See: J. Macnaughton, 'The Dangerous Practice of Empathy', *Lancet,* 373 (2009).

[120] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 105.

[121] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 98.

[122] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 105.

[123] J. Derrida, 'Adieu to Emmanuel Levinas', p. 2.

Michael Morgan is perplexed by Levinas' claim and asks what this passivity really means vis-à-vis the subject. He initially concludes that this passivity is *prior* to the free and active self. Then he reasons, the self is beyond freedom and consequently commanded by the Face even before understanding. This would mean that the self is not primarily "an actor or agent," although it can claim aspects related to its enjoyment and self-centred pursuits. Unlike responsibility, however, these interpretations are less relevant to Levinas' vision because they fail to demonstrate the social meaning of our existence as our primary purpose. Morgan then describes passivity as a "transcendental condition" that he suggests is "*a dimension* or *cluster of dimensions*" all too infrequently occluded by our life and culture. Ultimately, Morgan concludes this passivity is understandable only in the here and now, not through a temporal reading "back" to the time before subjectivity or action, thought, or being. It must be *now*, because "I am responsible for and to the other person "before I am a person".[124]

Morgan's observation confirms the immensity of the moral impact exerted by the divinized Other on the clinician. In these terms, the clinician is *wholly dependent* on the vulnerable help seeker to instruct her, show her, help her and guide *her* in becoming a person. We return to this theme in the following chapter in analysing the work of Jean Vanier. Morgan's analysis, however, is somewhat theoretically remote in its attempt to track the paradoxical origins and manifestation of this momentous and immediate obsession. Yet, clarification is found in Levinas' repeated allusions to my being held "hostage," "ordained," "chosen" or "*elected*" to this responsibility. All of which suggest the immediacy, transcendence and inviolability of this event, even if I cannot yet imagine what I am actually to *do*.

Nor is this election a privilege, Levinas cautions, but the hallmark of the morally responsible and it *is* "hard" he confirms.[125] It is hard to be "a substitution for another, one in the place of another" and called to account for something I did not do and would rather avoid having to pay for.[126] Mental health clinicians are constantly negotiating the riptide of this imperative, this "election," in their daily encounters with the destitute Other—the help seeker. Moreover, the clinician is revealed to herself time-and-again as morally compromised if not

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[124] M.L. Morgan, 'Discovering Levinas', pp. 155-60.
[125] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 108.
[126] E. Levinas, 'Otherwise Than Being, or, Beyond Essence', p. 18.

bereft, shameful, guilty, uncertain, timid. Yet, Levinas reminds us, this "anarchical provocation" also "ordains me to the other"[127] which means that even while I am held to account, I am also accepted, forgiven, understood, *consecrated*.

In eulogizing Levinas, Derrida introduced Levinas' notion of hospitality, which illuminates this paradox of indebtedness and holiness powerfully and satisfyingly. As Derrida observed, this passivity is hardly an "abdication of reason" but a sign of my receptivity.[128] This, in sum, is a welcome to *me*, the welcoming "host" who discovers to her stunned incredulity that *she* is the one being offered hospitality *in her own home*. It is the *Other* who shows me that it is not *my* home, that I am the guest and being hosted after all. Thus, "[t]he one who welcomes is first welcomed in his own home. The one who invites is invited by the one whom he invites. The one who receives is received".[129] This theme comes closest, in my view, to offering the most profound and accessible understanding of this wonder-full paradox of being held hostage and ordained, burdened and consecrated in the same instant.

6.8 Critique

> The ethical order does not prepare us for the divinity; it is the very accession to the divinity. All the rest is a dream.[130]

Levinas shifts the light of our inquiry on wonder away from traditional philosophical interpretations to an exclusively ethical formulation. Remarkably, this formulation enabled him to challenge the confinements of theology—or onto-theo-logy—and two thousand years of Western philosophy dedicated to the understanding and elaboration of our "being" and its place in the world. It is equally remarkable that his ethical account appears to have found sufficiently neutral philosophical and religious ground that it avoids polarizing his work.

This chapter makes no claims to offering a substantial analysis of Levinas' critics. But as a professional in a field ghettoised by female professionals, and an over-representation of female to male help seekers, I have more than a passing interest in Levinas' feminist

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[127] Ibid. p. 16.
[128] Ibid. p. 18.
[129] J. Derrida, 'Adieu to Emmanuel Levinas', p. 42.
[130] E. Levinas, 'Difficult Freedom: Essays on Judaism', p. 102.

interpreters.[131] Some of these scholars have taken Levinas to task for his male privilege, his heteronormative and prophetic language and conservatism, and for his marginalizing evocations of the feminine in his construal of alterity. The latter was first identified by Simone de Beauvoir[132] and then later by Luce Irigaray.[133] Irigaray attempted to correct Levinas by appealing to him to place the alterity of the feminine in a more equitable and co-creative position with the subject who transcends, rather than at the expense of *she* through whom he has, or *will*, transcend.

A comprehensive analysis of the feminist response provoked by Levinas' construction of eros as the feminine and alterity is beyond the remit of this chapter. Yet, it points very usefully to a similar and deeply problematic dynamic seen in the *The Church*[134] where the clinician "transcends" to her astonishment and at the entire expense of the help seeker. Thus, while the clinician may be humbled and dazzled, the help seeker is still left with little more, *nothing* more, while the clinician has altogether missed the claim made upon him by the Face. This is mistaken as yet another consumable to be assimilated, albeit gratefully, *on behalf* of the help seeker.

Other feminist scholars, like Tina Chanter, argue that the limitations of Levinas' work for which he been pilloried may also be misinterpretations.[135] These limitations may be insufficient to impugn the enormity of his contribution and its overall benefit to women, even if more analysis and development are justified. Still others have used Levinas to develop their own work and extend his scholarship.[136]

In addition to feminist concerns, other critiques about Levinas' work, suggest the need for more and greater analysis of his later work.[137] There is also a certain amount of

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[131] This is generally acknowledged to be roughly a two to one ratio. Admittedly, this is a complex formulation as these numbers are determined by many variables, including what appears to be women's greater willingness to seek help for emotional distress.

[132] T. Chanter, 'Feminist Interpretations of Emmanuel Levinas', pp. 2-5. See also: C.E. Katz, 'Reinhabiting the House of Ruth', in *Feminist Interpretations of Emmanuel Levinas,* ed. by T. Chanter (PA: Pennsylvania State University, 2001), pp. 145-70.

[133] See: L. Irigaray, 'The Fecundity of the Caress', in *Feminist Interpretations of Emmanuel Levinas,* ed. by T. Chanter (PA: Pennsylvania State University Press, 2001), pp. 119-44.

[134] See: The church (6.6.1).

[135] T. Chanter, 'Feminist Interpretations of Emmanuel Levinas'.

[136] See, for example: M. Joy, 'Levinas: Alterity, the Feminine and Women—A Meditation', *Studies in Religion/Sciences Religieuses,* 22 (1993).

[137] E.P. Ziarek, 'The Ethical Passions of Emmanuel Levinas', in *Feminist Interpretations of Emmanuel Levinas,* ed. by T. Chanter (PA: Pennsylvania State University Press, 2001), pp. 78-95.

disenchantment expressed about the applicability of his vision, about which he says very little. Levinas even admits we cannot yet know what such an ethic would actually look like. I will not discuss these limitations, however, for my focus is on the stunning ethical opening that Levinas *does* have to offer the discourse on community mental health care and the emerging dialogue on wonder in clinical care.

6.9 Conclusion

> The suspicions engendered by psychoanalysis, sociology and politics weigh on human identity such that we never know to whom we are speaking and what we are dealing with when we build our ideas on the basis of human facts. But we do not need this knowledge in the relationship in which the other is a neighbour, and in which before being an individuation of the genus man, a rational animal, a free will, or any essence whatever, he is the persecuted one for whom I am responsible to the point of being a hostage for him, and in which my responsibility, instead of disclosing me in my "essence" as a transcendental ego, divests me without stop of all that can be common to me and another man, who would thus be capable of replacing me. I am then called upon in my uniqueness as someone for whom no one else can substitute himself.[138]

We find in Levinas' metaphysical argument a riveting answer to the question: what is it to see another as oneself? While her face has no particular attribute that would distinguish her from me, her Otherness overwhelms me with its holy confirmation. This is the ethical that describes incorruptible possibilities and calls for neither "power or possession". The Other is irreducible and paradoxically recognizable as the one with moral height and mastery over *me*.[139]

What is needed to disclose this ethics, Levinas has shown, is a separation between the subject and this Other who is both the other person but also *the* Other who represents God,[140] in whose Face the "trace" of the infinite is found.[141] This trace is visible in the complexity of her entire humanity, her speech, her face. Even the nape of her neck[142] is capable of

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[138] E. Levinas, 'Otherwise Than Being, or, Beyond Essence', p. 59.
[139] E. Levinas, 'Totality and Infinity: An Essay on Exteriority', p. 51.
[140] E. Levinas, 'Emmanuel Levinas: Basic Philosophical Writings', pp. 7-11.
[141] "I am a testimony, or a trace, or the glory of the Infinite," see: E. Levinas, 'Collected Philosophical Papers', p. 170.
[142] Levinas apparently referred frequently in later years to Vasily Grossman's historical novel about Nazism and Stalinism. He alludes to Grossman's description of people lined up at a gate in the hopes of hearing word about their arrested friends: "each reading on the nape of the person in front of him the feelings and hopes of his misery". See: M.L. Morgan, 'The Cambridge Introduction to Emmanuel Levinas', p. 19.

contradicting "any totalitarian or absolutist form of economy".[143] This is a Face powerful enough to destroy the grip of the ego and leave the subject shattered and incapable of responding in anything less than ethical terms, although this imperative is never imposed.[144]

This relationship is unchanged, Levinas suggests, even when conducted in an institution where justice is exercised and I am required to make comparisons and choices to establish fairness. If justice mediates my action within the institution it does not diminish my responsibility even when I am confronted by competing demands. The origin of justice lies in charity and loving my neighbour which, as Chanter observes, is also a "commentary on the violence committed in the name of justice".[145] Levinas also confirms the inevitability of the institution while claiming that justice is safeguarded by the "initial interpersonal relation".[146] Indeed, the system itself is mediated through my relationship with the other person through charity, and cannot exist without justice. Charity is "warped" without justice.[147]

That the plea of this Face can be ignored, feared or misconstrued by genuinely caring, committed and educated clinicians as authorization of their professional "privilege," rather than proof of its obscenity, is not easily challenged. But neither should this be a surprise. For, the ontological ground of a mental health clinician's caring work necessarily reduces the other and excludes—and therefore distrusts—anything hinting of the metaphysical or requiring the suspension of belief. We repeatedly discover this in the language of comparison and quantification, in other words, by employing "the said" to claim sovereignty over "the saying" of what is right or ought to be.

In the clinician's de-moralization and distress, however, is found evidence of a greater moral possibility that engages her desire—her *compulsion*—to protect this fragile help seeker, as James' story amply illustrates. Poignantly, the answer does not lie in the inadequacy of the institution. It does not lie in the ineptitude of a colleague haranguing a patient for "non-compliance," or even in the failure of the psychiatrist still tinkering with medication for a deteriorating patient. The answer lies in the clinician *herself* and the stunning evidence of her

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[143]E. Levinas, 'Emmanuel Levinas: Basic Philosophical Writings', pp. x-xi.
[144] Ibid. p. xi.
[145] T. Chanter, 'Feminist Interpretations of Emmanuel Levinas', p. 8.
[146] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 90.
[147] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 121.

own apparent lack of trustworthiness. This is the threat the clinician poses the vulnerable help seeker that *awakens her* to the sickening oversight that Levinas' work addresses and remediates although admittedly with few guidelines.

This convolution lies in the genuineness of the clinician's horror residing so closely to her preference to protect her *self* at the expense of another. Nor should we imagine the clinician is unmoved or unaffected by the help seeker. Even so, the call of the Face challenging her moral indifference, or possibly her cowardice, does not take precedence simply or easily over her self-interest.[148] Hence, the clinician remains the primary beneficiary of even the therapeutic transaction. The vulnerable help seeker meanwhile is the means, the *mule*, carrying the clinician to this incomparable transcendence, this astonishment and wonder. To which, even in her hushed reverence, the clinician still finds herself somehow entitled along with every other professional privilege she enjoys.

Levinas reconfigures the very ground from which our questions emerge about why the dehumanization persists and how clinicians might better protect others from *themselves*. In doing so, he confirms that the real beneficiary of the therapeutic bond—so-called—is not the help seeker. Nor, ultimately, is the phenomenon of wonder we might so earnestly wish to "apply," *for* her. There are no simple answers for the clinician wanting to cultivate or maintain a divinized perspective of the help seeker within an institution constructed by the very reductions it *intends* to perpetuate and protect. Clinicians are still professionally and institutionally bound to a medically informed, reductive "practice" that reverberates in Nemo's question: How can I live if I put the other before myself? Still, growing numbers of clinicians are turning to Levinas to theorize ethical practice, and practices, "beyond being". This might eventually bring greater significance and morality to their clinical work and the institutions they represent and hope to change.

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[148] J. Caruana, 'Not Ethics, Not Ethics Alone, but the Holy'.

Chapter 7.

The possible or impossible of Levinasian praxis

Whether she looks at me or not, she "regards me;" I must answer for her. I call face that which thus in another concerns the I—concerns me—reminding me, from behind the countenance she puts on in her portrait, of her abandonment, her defencelessness and her mortality, and her appeal to my ancient responsibility, as if she were unique in the world—beloved.[1]

7.1 Introduction

Levinas' ethical vision is finding a place in clinical literature and an emerging therapeutic dialogue claiming that therapy may be creating more harm than good, is inadequate to the task or no longer relevant.[2] Certainly, this inquiry is attempting to illustrate the increasing evidence that therapy and community mental health care are operating out of an outmoded paradigm, lacking the capacity to address the real issues in people's lives, if it ever did.[3]

The difficulty of translating Levinas into ethical praxis also remains. As we have already discussed, Levinas does not develop his work through careful argumentation but through "semi-poetic, rhapsodic and grammatically elusive meditations around certain central intuitions or metaphors".[4] Philosopher Paul Davies observes that Levinas' "ethical language" actually prohibits an exit from "the scene of an enigma". It does so by indefinitely extending the paradox, which points back to philosophy's failure but never toward the answers that we seek from Levinas' powerful moral edict.[5] This enigma stymies the efforts of researchers attempting any clinical applications based on Levinas' vision. The problem is that even the *idea* of "legitimate scientific research" essentially totalizes Levinas' project, which is to subvert any such reductive endeavours.[6] Consequently, Levinasian scholars are of two minds as to whether, given the magnitude of this enigma, it can be even calibrated as a human response worthy of the call. Levinas himself suggests that the answer lies in

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[1] I have changed the gender of this quote from "him" to "her". E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 227.

[2] For a thought provoking conversation on the failure of therapy in the 20th century, see: J. Hillman and M. Ventura, *We've Had 100 Years of Psychotherapy and the World's Getting Worse* (San Francisco: Harper, 1992).

[3] R. House, 'Commentary: Taking Therapy Beyond Modernity? The Promise and Limitations of a Levinasian Understanding', *European Journal of Psychotherapy & Counselling,* 7 (2005), p. 104.

[4] R.P. Blum, 'Emmanuel Levinas' Theory of Commitment', *Philosophy and Phenomenological Research,* 44 (1983), p. 145.

[5] P. Davies, 'On Resorting to an Ethical Language', in *Ethics as First Philosophy: The Significance of Emmanuel Levinas for Philosophy, Literature and Religion,* ed. by A.T. Peperzak (New York and London: Routledge, 1995), pp. 95-104.

[6] R.P. Blum, 'Emmanuel Levinas' Theory of Commitment', p. 146.

"maturity and patience for insoluble problems," while conceding that to say as much is a "pathetic formula".[7]

> I do not know how to draw the solution to insoluble problems. It is still sleeping in the bottom of a box; but a box over which persons who have drawn close to each other keep watch. I have no idea other than the idea of the idea that one should have. … I have the idea of a possibility in which the impossible may be sleeping.[8]

Nonetheless, there *is* emerging scholarshipand exemplars to help us imagine Levinas' ethics into practice and this chapter focuses on a number of these.[9] We will begin with an analysis of Jean Vanier's work, whose engagement with intellectually disabled adults powerfully exemplifies the possibilities of Levinas' formulation of being-for-the-Other. We will also consider a number of examples to illustrate how Levinasian ethics is challenging clinical praxis and reordering institutional priorities to ensure the primacy of the vulnerable other.

The first half of this chapter, then, will examine the themes of practice and application through a comparative analysis of Jean Vanier's and Levinas' work. The second half will explore how Levinas' thinking is informing and interrogating clinical praxis, but also how it is being used in collaboration with the work of other thinkers to raise new ethical questions and refine others.

7.2 Turning to Jean Vanier and our need for the vulnerable other

> The heart is never "successful". It does not want power, honours, privileges, or efficiency; it seeks a personal relationship with another, a communion of hearts, which is the to-and-fro of love. This opening of the heart implies vulnerability and the offering of our needs and weaknesses. The heart gives and receives, but above all it gives.[10]

Emmanuel Levinas and Jean Vanier share a seemingly incontestable rationality that argues for the abandonment of the self to the other as the only way through the problem of violence and dehumanization. Both employ a view of the transcendent irreducible other, albeit from differing perspectives, to inform arguments that seem to reach strikingly similar and passionate conclusions.

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[7] The allusion of the box in which a lamb lies sleeping comes from Antoine de Saint Exupéry's *Le Petit Prince*. See: E. Levinas, *Alterity and Transcendence* (Columbia University Press, 1999), p. 88.

[8] Ibid. p. 89.

[9] See, for example: 'Special Issue: Levinas and the Other in Psychotherapy and Counselling,' *The European Journal of Psychotherapy and Counselling*, 7, (2005).

[10] J. Vanier, *Becoming Human* (Toronto, ON: House of Anansi, 1998), p. 63.

Jean Vanier is a Canadian humanitarian, theologian, philosopher[11] and son of one of

Canada's former Governor Generals, Georges Vanier.[12] Vanier, who is now 86 years old, has

dedicated his life to the cause of intellectually disabled adults and to extending, by his own

admission, an experiment of peacemaking into the world. His long friendship with activist

Daniel Berrigan[13] speaks to a life-long interest in peacemaking which Vanier has claimed

and demonstrated can be created by sharing one's life with the weak.[14] Vanier has also

sought to understand what it is to be part of a global community[15] and his contribution to

that dialogue has been considerable.[16]

Anyone coming to Vanier's work from a secular clinical perspective, however, might have

reservations about his conservative Catholicism. This has influenced his stand on abortion,[17]

his reported evasion of issues related to advancing women's role in the Catholic Church[18]

and his psychological interpretation of homosexuality as deviance.[19] Yet the immensity of

his work, the integrity of his message and his own emotional transparency are not easily

dismissed on these grounds.

7.2.1   A brief biography of Jean Vanier and a history of L'Arche

Raised a devout Catholic,[20] Vanier was later influenced by his mother's spiritual director and

Dominican priest, Philippe Thomas, who apparently was "removed by Rome for

unorthodoxy and for spiritual direction that was considered too mystical".[21] Interestingly,

Thomas—now deceased—has been accused only recently of sexually abusing a significant

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[11] Vanier's PhD was titled: Happiness as Principle and end of Aristotelian Ethics. See: J. Vanier and C. Whitney-Brown, *Jean Vanier: Essential Writings* (London: Darton, 2008), p. 26.

[12] George Vanier's career was in the military and the diplomatic services. With his wife Pauline, Vanier served as Canada's Governor General from 1957-1967). See: J. Dunne, 'Sense of Community in L'arche and in the Writings of Jean Vanier', *Journal of Community Psychology*, 14 (1986), 41.

[13] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 44.

[14] Vanier won the Templeton prize for 2015. See: <https://www.youtube.com/watch?v=qNxAVzICf-M> [accessed 30 July 2016].

[15] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 43.

[16] The web pages for Jean Vanier and L'Arche offer an insight into Vanier's many publications and initiatives, as well as the matrix of socially engaged activity and publicity that has gone beyond Vanier's guiding hand, although presumably not his vision. See: <http://www.jean-vanier.org/en/home> and L'Arche Canada: <http://www.larche.ca: 8080/ > [accessed 30 July 2016].

[17] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 48.

[18] J.L. Allen Jr, 'L'Arche Founder Reveals Face of Christ', *National Catholic Reporter Online,* (Nov. 01, 2002) <http://ncronline.org/>.

[19] For references to abortion and homosexuality, see: T. Kearney and J. Vanier, 'The Prophetic Cry: Interview with Jean Vanier', *The Crane Bag,* 5 (1981), pp. 81-82.

[20] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 17.

[21] Ibid. pp. 24-25.

number of adult women in his role as spiritual director over the course of almost three decades.[22] It was Thomas, however, who prompted Vanier towards his vocation during a summer sabbatical in France, when Vanier was away from his work as a young philosophy professor at the University of Toronto. Thomas introduced Vanier to the plight of the intellectually disabled in a local psychiatric hospital and, horrified by the dehumanization he found there, Vanier felt "called" to address the injustice. He and Thomas subsequently invited two men from this hospital to live with them in a run-down house they called L'Arche, in the hopes of re-humanizing their lives.[23] Soon Vanier's relationship with these men revealed his need *for them* as he began, in their company, to grapple with his own "human weakness" and "longings".[24] This is the weakness, he suggests, that "carries within it a secret power. The cry and the trust that flow from weakness can open up hearts. The one who is weaker can call forth powers of love in the one who is stronger".[25]

Vanier consistently attests to the ineffable in his appeal to the reader to abandon the culture of competition and become "downwardly mobile".[26] His voice is rationally compelling and unadorned, making his radical message all the more accessible. He draws liberally and emotionally on biblical allusions, the notion of Jesus's presence in the other, and on personal stories of intellectually disabled individuals who have forged his awareness and life. Vanier's writing is nothing like Levinas' prophetic and obscure language. However, the paradox at the centre of the relationship they both describe recognizes the primacy and holiness of the Other/other who does and *should* precede all else.

Like Levinas, Vanier's formulation of the relational extends beyond the simple notion of "service". Interestingly, the real role of the typically abled "assistants" who come to live in L'Arche communities is not to "help" so much as to enter into friendship, a "covenant of

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[22] In a recent inquiry undertaken by L'Arche, 14 witnesses and 10 victims offered reliable testimony that Thomas Philippe had sexually abused adult women to whom he was ministering as spiritual director between 1970 and 1990, two years before his death. Philippe apparently had a psychological and spiritual hold over these women that he used to enforce their silence. L'Arche has opened the findings of this investigation to the public. See: <http.//www.la-croix.com/Religion/Actualite/L-Arche-fait-la-lumiere-sur-la-face-cachee-du-P.-Thomas-Philippe-2015-10-15-1368960.> L'Arche's public response to this news is also detailed on the L'Arche website. See: <http://www.larche.org.uk/News/safeguarding-policies-and-practices > [accessed 30 July 2016].
[23] In French, l'Arche means "Noah's Arc".
[24] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 28. Vanier speaks of the "forces of darkness and hatred" in his own heart. "Elitism" he claims, "is the sickness of us all". Ibid. p. 75.
[25] J. Vanier, 'Becoming Human', p. 40.
[26] For a thoughtful discussion on altruism and ambivalence see: K. Reimer, 'Natural Character: Psychological Realism for the Downwardly Mobile', *Theology and science,* 2 (2004).

love," as brothers and sisters with the "residents," in order to share their lives. Not surprisingly, Vanier observes that it is often difficult to know who is a member of the community; all are in need and the shared hunger for relationship is the core of this need.[27]

The freedom claimed through the relationship Vanier describes is also fragile because it is freely chosen, not imposed, and because the typically abled who come to L'Arche tend not to stay for long, which is why Vanier calls his a "pilgrim community". Assistants in L'Arche homes face an arduous psychological process that involves effort, loss, disillusionment and a relinquishing of the self and its project.[28] They can feel overwhelmed by their insignificant "useless" offerings, dwarfed by the immensity of the need represented by the intellectually disabled whose lives they share.

Residents in L'Arche homes cope not only with profound disabilities, as many have also endured horrific life circumstances. Consequently, there is no great remediating solution or task to be accomplished beyond, "giving baths,[29] cleaning, cooking, eating, laughing, getting angry, praying".[30] Psychologist Kevin Reimer, who spent some time in L'Arche, reports with considerable sensitivity the ambivalence he found among assistants who had lived in L'Arche for over three years and who struggled psychologically in various ways in their altruistic roles.[31] Yet, such ambivalence does not necessarily dilute the alchemy of love that, Vanier observes, lies in the capacity of the broken individual to reveal her beauty and to heal *and* disturb the strong in the same moment.

7.2.2 *Downward mobility*

Vanier insists on the importance of climbing to the bottom of "the ladder of human promotion to be with the weak and the poor".[32] This metaphor relates to Jesus washing the feet of his disciples and confirms the importance of resisting the seduction of "self-mastery and domination," which thwarts inclusion and friendship, and especially *communion* in Vanier's work. Becoming downwardly mobile means we are finally free to be with others as

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[27] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 103.

[28] J. Dunne, 'Sense of Community in L'arche and in the Writings of Jean Vanier', pp. 47-49.

[29] The body, touch, holding, the act of bathing are fundamental in Vanier's theology of the body that alludes to the vulnerability of Christ's body as the answer to the pyramid—the structure of hierarchy. See: P.A. Comensoli, 'Descending the Ladder: The Theological Anthropology of Jean Vanier's Key Metaphor', *Journal of Religion, Disability & Health,* 15 (2011), pp. 120-23, 27.

[30] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 102.

[31] K. Reimer, 'Natural Character: Psychological Realism for the Downwardly Mobile', pp. 94-96.

[32] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 103.

opposed to being at the top, "where one deigns that others may be".[33] The striving and rewards of being-for-the-self find no purchase with the vulnerable, unselfconscious, present-centred nature of those with intellectual disabilities. As one observer has noted, this population has little access to "cultural devices" used by the typically abled to prop up the meaning and value of their lives. Instead, they are almost entirely dependent on relationship to know and express themselves and to claim the same dignity and stability as anyone else.[34]

Vanier's language turns to the mystical when he insists that learning to be with the pain of another, or even our own pain, requires that we be "touched by God"[35] or feel "the kiss of God".[36] He uses the allusion of the Wedding Feast as the Kingdom of God and describes God as the Lover.[37] Similar allusions are made throughout the mystical canon to capture the inexorable, embodied draw of the divine.[38] Richard Kearney also reminds us that despite his Judaism and self-proclaimed atheism, Levinas also employed the face of Christ as the prototypical Face of the Other, which further illustrates the shared orientation of these two philosophers.[39]

Vanier's central argument is inspired by the Christian Beatitudes that allow him to identify the weak and the poor as gifted spiritual teachers because of their level of suffering. [40] His claim is further supported by his sympathy for Aristotle's view of friendship based on shared character and values.[41] The theme of friendship and fraternity also underpins Levinas' work, although Simon Critchley has criticized Levinas' "classical politics of friendship" which appear to occur "between brothers, free equals who happen to be male".

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[33] P.A. Comensoli, 'Descending the Ladder: The Theological Anthropology of Jean Vanier's Key Metaphor', pp. 119-20. See also: J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 84.

[34] J. Dunne, 'Sense of Community in L'arche and in the Writings of Jean Vanier', p. 47.

[35] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 115.

[36] Ibid. p. 154.

[37] Ibid. pp. 159, 61.

[38] See for example: 'The Language of Love in Christian and Jewish Mysticism', in *Mysticism and Language*, ed. by S.T. Katz (New York: Oxford University Press, 1992), pp. 202-35.

[39] Kearney to Levinas: "What do you think of when you think of the face of the other? He said, "Christ," and I said, But you're a Jew, and he said, "Yes. But Christ is the suffering Jew par excellence, for us Jews too". He's one of us, kind of thing. And he said it in a wonderfully ecumenical way obviously". See: R. Kearney, 'The God Who May Be', in *Ideas,* ed. by David Cayley' (Published: Canadian Broadcasting Corporation, 2006), pp. 1-22 (p. 19).

[40] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', pp. 105-09.

[41] P. Cushing and T. Lewis, 'Negotiating Mutuality and Agency in Care-Giving Relationships with Women with Intellectual Disabilities', *Hypatia,* 17 (2002), p.177.

[42] It is not my intention to analyse Aristotle's view of friendship in the work of these two thinkers but to indicate their deeply shared interest in a theme that powerfully informs their respective visions. It is worth noting, however, that Critchley identifies as highly problematic Levinas' "*androcentric* conception of friendship, fraternity and political community, where the feminine is the essential, but essentially pre-ethical, opening of the ethical basis of community".[43] This was an issue identified in the previous chapter by some of Levinas' feminist critics.[44]

Vanier's focus on friendship engages closely with the day-to-day practicalities of living and working in what is essentially a spiritual community. Regardless of religion, and L'Arche communities now represent a broad spectrum of religions worldwide, a faith tradition is at the centre, no matter how inclusively practiced. This focus informs the notion of friendship, mutuality and interdependence between the strong and the weak in a living environment where a sense of the divine is intentionally cultivated, celebrated and recognized. Vanier's construal of friendship offers a simple and practical antidote to injustice and dehumanization in the care of vulnerable populations. Yet, such friendship is untenable in the secular hierarchy of community mental health, although Professor John Swinton argues to the contrary. Swinton is greatly influenced by Vanier's thinking and, as a leader in the field of theology and disability, his claim for the need for friendship in the care of the mentally ill an appealing one.[45] His perspective also illustrates the dilemma revealed by his argument, which is briefly touched on in the following digression and examined more comprehensively in the following chapter.

7.2.3 *The red herring*

Swinton's work embraces Vanier's vision and "[t]he primary emphasis within L'Arche…on friendship and mutuality-in-community".[46] It is a formula Swinton claims for the "disabled" in arguing for a quality of "belonging" he would like to see extended beyond the idea of

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[42] A brief synopsis of these problems which tend overlap may be found in: S. Critchley, 'Five Problems in Levinas's View of Politics and the Sketch of a Solution to Them', *Political Theory*, 32 (2004), 173-75.

[43] S. Critchley, 'The Other's Decision in Me (What Are the Politics of Friendship?)', *European Journal of Social Theory*, 1 (1998), pp. 269-70.

[44] See: Critique (6.8).

[45] See for example: J. Swinton, 'Who Is the God We Worship? Theologies of Disability; Challenges and New Possibilities', *International Journal of Practical Theology*, 14 (2011).

[46] J. Swinton, 'The Body of Christ Has Down's Syndrome: Theological Reflections on Vulnerability, Disability, and Graceful Communities', *Journal of Pastoral Theology*, 13 (2003), 75.

simple "inclusivity," particularly within the Church.[47] Swinton also extends this formula to the sphere of community mental health care and the "evil" of dehumanization that harms not only the help seeker but the clinician as well. However, in forwarding the idea of friendship and recommending love as the "solution" to clinical distancing and dehumanization, Swinton appears to recant at the same time.[48] He does so by acknowledging the need for caution given the possible dangers of blurred boundaries and the implications of misunderstanding and misconduct that could potentially harm the help seeker. In conceding as much, Swinton confirms the real possibility of "using" the help seeker. That is, of mistaking love for an invitation to abuse the vulnerable help seeker, which the reductive clinical environment would seem to ensure. Yet, friendship and love that might require such vigilance are not in the order of a perspective that would *elevate* the other above the clinician, and claim the clinician's whole responsibility.

The call for love and friendship does not, cannot go far enough in addressing the problem of clinical dehumanization, as Swinton's proviso seems to confirm. The reductive clinical environment and hierarchical interests of the institution—and by default—the clinician, are *justified and occluded* by the norms of "clinical distance" and "objectivity". Swinton's suggestion that carers should love, but not too closely—or dangerously—is the standard defence, if not the apology, that appears to protect the clinician and the institution more than the vulnerable help seeker. The interests of the reduction come *first*, along with the hierarchy that reifies it, while the expressed concern for the welfare of the objectified help seeker would have us believe otherwise. Either way, the help seeker is at real and significant risk, whether from the dehumanizing indifference and reduction of clinical distance or in the event of the friendship that Swinton prescribes, *but only to a point*. This is the red herring that chronically deflects a closer examination of what lies *beyond* the defence of "clinical distance" and how much the institution—and the clinician—have to *lose* by challenging the balance of power with a call to friendship and love, about which Vanier seems very clear.

The attitudes and agendas of community mental health care and a community like L'Arche are arguably worlds apart, but hardly antithetical. Vanier identifies five attitudes towards

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[47] J. Swinton, 'From Inclusion to Belonging: A Practical Theology of Community, Disability and Humanness', *Journal of Religion, Disability & Health,* 16 (2012).
[48] J. Swinton, 'Does Evil Have to Exist to Be Real? The Discourse of Evil and the Practice of Mental Health Care', in *Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group,* (London: 2002).

the intellectually disabled useful to our discussion of community mental health care and the "mentally ill". In Levinasian terms they describe the graded shift of the advantaged *I*, or clinician, from being-for-the-self to being-for-the-other. At one end of this continuum disability, or in terms of our inquiry *mental illness*, is viewed as disorder or deviance to be "suppressed" by the clinician. While at the other end, or on another continuum altogether, a transcendent perspective represents an irreducible holiness Vanier claims can lead an individual to God.[49] "People with disabilities are necessary for the wholeness of the body of humanity," Vanier claims, not only to maintain its integrity but also to point to its fractures.[50] Similarly, the idea of mental illness is all too often a sign—the canary in the coal mine of a violent and indifferent world. In this way, Vanier identifies my personal need for the vulnerable help seeker *and* his elevation and primacy over me. This also mirrors Levinas' notion of asymmetry and the responsibility of the *I* for the *Other.*

7.2.4 *Yearning for the vulnerable other: The ultimate paradox*

My *need* for the vulnerable other is possibly the most difficult, radical and persuasive aspect of Vanier's argument. The implication being that the strong may actually *not progress* or evolve, may *not* overcome their own darkness, violence and loneliness[51] *without* the help of the weak and the destitute. In saying as much, Vanier may come dangerously close to diminishing the horror of the lives of the people he cherishes by essentializing them and idealizing them for his own purposes. Similar concerns have emerged about Teresa of Calcutta whose popularity and legacy, some have suggested, were products of a media tour-de-force. For, Teresa, it has been suggested, could have significantly increased the medical care, living conditions and comfort of those in her care given the vast financial donations at her disposal. If, that is, she had been less intent on valorizing the beauty of the suffering face of Christ[52] in the lives of those she served, rather than actually responding to it. [53]

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[49] For a brief overview of five "attitudes" towards disability described by Vanier, which I would argue are equally relevant to attitudes to mental illness, see: J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', pp. 47-48.

[50] Ibid. p. 48.

[51] The issue of loneliness from either the side of the weak or the strong is a constant refrain in Vanier's work synthesized here: J. Vanier, 'Becoming Human', pp. 5-34.

[52] S. Larivée, C. Sénéchal, and G. Chénard, 'Les Côtés Ténébreux De Mère Teresa', *Studies in Religion/Sciences Religieuses,* 42 (2013), pp. 10-12.

[53] P.M. Thomas, 'Pointing Fingers at Mother Teresa's Heirs', in *Forbes India,* (Aug. 13, 2010).

Vanier walks a similar tightrope as a humanitarian super-star with a rich network of international connections both secular and religious that has supported his cause for decades. His eventual canonization is already a source of speculation and his ethical reputation remains remarkably unblemished.[54] The witness of ordinary citizens participating as "assistants" in L'Arche communities also confirms their own transformative process as well as the comfort, order, peace, and hospitality found in the homes they share with this population.[55] The work of L'Arche and other projects emerging from it has also survived close scrutiny across decades. Meanwhile, Vanier's legacy continues to grow even into advanced old age as he continues to broadcast a message compelling us to see our own poverty of spirit. His deceptively simple mantra echoes Levinas' ultimate question: "Should I be dedicated to being? By being, by persisting in being, do I not kill"?[56] Vanier says it somewhat more simply: "Elitism is the sickness of us all".[57]

Vanier's emotional transparency may be the crowning achievement of his life's work. His willingness to stand as a family member beside those he champions while acknowledging the enormous challenges of living with and *through* this population, speaks not just to his integrity but also the burden and pain of being-for-the-other.[58] In confessing the "humiliating darkness" of his own rage, despair and loneliness that he has been forced to confront through his relationships with this vulnerable population, Vanier articulates the anguish and the rewards of accepting the invitation of the face.[59] That he may do so strategically to humanize his own image, to widen his sphere of influence and to place the possibility of his efforts within the reach of mortals less extraordinary or privileged than himself, does not necessarily compromise the integrity of his message.[60] Vanier's prescription never attempts to hide the withering implications of a responsibility that can make the self-interested project of striving, upward mobility, pleasure and a possibly lonely but unencumbered freedom, look wistfully alluring by comparison. Indeed, philosopher

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[54] J.L. Allen Jr, 'L'arche Founder Reveals Face of Christ'.

[55] See, for example: <https://vimeo.com/11093809> [accessed 30 July 2016].

[56] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 120.

[57] J. Vanier and C. Whitney-Brown, 'Jean Vanier: Essential Writings', p. 75.

[58] For a flavour of the psycho-spiritual process of the assistants, see: J. Dunne, 'Sense of Community in L'arche and in the Writings of Jean Vanier', pp. 46-47.

[59] Ibid. p. 52.

[60] For a brief summary of the ways Vanier attempts to claim his place at the bottom of the ladder of success despite his celebrity, see: D. Todd, 'Jean Vanier: The Path to Spiritual Liberation', *The Vancouver Sun,* (Mar. 5, 2001).

Catherine Chalier acknowledges that Levinas' view does not mean we are necessarily happy to be burdened by such responsibility and that we "will most likely try to forget it".[61] Regardless of our ability or interest in remembering, philosopher Adriaan Peperzak reminds us that within such responsibility lies our heart's *desire*.

> Desire transcends economy by desiring the other—not for satisfaction or consolation, not as a partner in love, but as the one whose face orients my life and thereby grants it significance. In desire I discover that I am not enclosed within myself, because I am "always already" to and for the Other, responsible, hostage, substitute.[62]

Desire and love are anathema to the therapeutic relationship, operating as they do through the paradigm of "the same," where any hint of desire is reducible to the bogie-man of abuse, or impending abuse.[63] Yet, desire and love are implicit in the daunting enormity of responsibility commanded by the Face. Consequently, the clinician must *ensure* that its magnetic appeal never seriously challenges her position and authority *over* the vulnerable help seeker. She must do this at almost any cost, even of her *own* moral convictions, despite the undeniable evidence of the violence before her. This is how a clinician can continue to violate the other even when she looks into her eyes.

7.2.5 *Daisy-May*

> *May, who lived alone and was about 65, tiny, grey-haired, unremarkable, and complaining, was telling us about the insignificant details of her past week in a defeated voice while we listened. My colleague and I were running a CBT[64] group in the windowless meeting room and checking in with each member of the dozen people sitting around the table to see how well everyone had managed their goals for the week, before getting the session underway.*

> *I began to take interest in what May was saying as she started to recount actually getting herself out of bed several mornings in a row, having a shower, getting dressed, forcing herself to make and eat breakfast and not allowing herself to go back to bed and to sleep. The people around the table were becoming equally interested in what was a significant deviation from her habit of staying in bed until lunch and in her pyjamas until dinnertime. Yet, there was no sense of victory in her report, no pride or elation about this accomplishment or its possibility. At the end of the brief monologue, she stopped for a moment before looking around the room*

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[61] C. Chalier, 'The Philosophy of Emmanuel Levinas and the Hebraic Tradition', in *Ethics as First Philosophy: The Significance of Emmanuel Levinas for Philosophy, Literature and Religion,* ed. by A.T. Peperzak (New York: Routledge, 1995), pp. 3-12 (p. 10).

[62] A.T. Peperzak, *Ethics as First Philosophy: The Significance of Emmanuel Levinas for Philosophy, Literature and Religion* (New York: Routledge, 1995).

[63] C. Racine, 'Loving in the Context of Community Mental Health', pp. 113-14.

[64] CBT stands for cognitive-behavioural-therapy.

to include everyone in the unanswered question she had posed herself that week. After doing everything the manual had said to do and making a commitment to the group, knowing something had to change, she was left with an unanswered question.

"But then what?" she asked in a plaintive voice, clearly needing an answer, deserving an answer. "So I do all of this, I make all this effort. I'm finished reading the paper by 7:30 in the morning and I don't allow myself to turn on the TV. But then what?" She searched the faces of her peers. "Do you know what I mean? What's the point? I don't know what the point is". The room was silent. I met my colleague's eyes and we shared a small bitter-sweet smile before looking away from each other and back to May who was waiting. Smooth as silk my colleague congratulated May for her significant revolution, expressing regret that we couldn't explore that issue here and glossing over this important question, the only question really, by asking the next person for his report.

May looked puzzled or possibly chastened by my colleague's kindly but dismissive response and I watched her gaze soberly down at the table in front of her, looking still and small. When her neighbour started to speak, I heard my own inner voice leap to May's defense with no small vehemence and conviction. "You got that right sister. You got that dead right," I thought, looking at her, reading her humiliation and wanting so badly to take it away. When she finally looked into my face I smiled lovingly, I hoped, wanting her to catch my warmth, my alliance with her. But she looked away quickly, possibly imagining that I was patronizing her which, I suppose, I was.

Philosopher Richard Kearney has suggested that Levinas' view of the transcendent while accurate is also too austere for his taste in its namelessness and awe. "We all need creature comfort, and we need a name to pray to and a story to tell and to fit into when we talk about our relationship to the divine".[65] In this respect Vanier's work, focused as it is on the person of Jesus and especially celebration, possibly balances and softens Levinas' formidable transcendence. Still, Vanier's example shows what it can mean to respond practically to the Face of the one who confirms me. Those working within a more secular framework may feel the need to weigh carefully Vanier's conservative Catholicism against his example. Yet he undeniably and amply demonstrates in very practical terms what it *can* mean to answer the call of the Face. That is, to bring the Other home, bind her wounds, hold her, feed her, live with her, celebrate and suffer with her because he—*we*—cannot live without her.

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[65] R. Kearney, 'The God Who May Be', p. 20.

7.3 Bringing the Other into community mental health care

> [H]erein lies possibly the main challenge when using Levinas' ethics in science and research: How to maintain the radicalism of his critique of the symbolic order when this is to be communicated in a scientific context that expects clarification of statements and ideas?[66]

In the remainder of this chapter, we will discuss invention and change as they relate to Levinas and community mental health care, and to those collaborations emerging between Levinasian ethics and the work of other thinkers. I draw on a sampling of these to illustrate the breadth of the discourse and to highlight the challenges and possibilities of "applying" Levinas' a-theoretical approach.

7.3.1 Standing up for the Other

Nurse educator, Débora Vieira Almeida, identifies the complexity of standing up for the other from the opening paragraph of her timely call for a Levinasian perspective to humanize clinical care. Almeida contends that our difficulty in understanding humanization in health care stems from the absence of a theoretical framework that could allow us to discuss the issue at a scientific level.[67] Her reference to the scientific and the theoretical might seem to overlook Levinas' central project of seeing through and overwhelming the categorical, yet Almeida is well aware of the problem she is tackling.

> [H]ealth professionals deal with distinct dimensions in their practice: that of ontology, a dimension which knows and takes possession of the other (to know a pathology, the treatment, for example), and that of the alterity, which will never be understood due to being beyond the limits of comprehension of an I health professional. [68]

Almeida addresses the problem by proposing a theory for humanization based on a Levinasian model that translates the "I-other relationship in and through the act of caring".[69] She rehearses Levinas' I-Other relationship from the perspective of the "I-health professional". Almeida wants to show how Levinas' ethical vision could shift the clinician's sense of *role* to one of *relationship*, and the notion of illness and treatment to *Other and to*

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[66] B. Nordtug, 'Levinas's Ethics as a Basis of Healthcare–Challenges and Dilemmas', *Nursing Philosophy*, 16 (2015), p. 51.
[67] D.V. Almeida, 'Humanization of Health Care: A Reflexive Theoretical Essay Based on the Philosophy of Emmanuel Lévinas', *Text Context Nursing, Florianópolis*, 23 (2014), p. 768.
[68] Ibid. p. 771.
[69] Ibid. p. 769.

caring. In translating Levinas' notion of "being held hostage," Almeida also recommends that the "I-health professional" become the "hostage of the guarantee not to treat it as an object".[70] Yet, can such a guarantee be made, let alone transacted, if being held hostage is mediated by *desire*, *imagination* and a yearning *beyond* clinical reduction or its imposition?

Almeida also posits the idea of the infinite as a type of knowledge "different from that which the *I* can grasp in the sense of dominating". By which she presumably means, "knowledge which teaches humanity to the I".[71] Yet, does it or can it or, as Levinas might confirm, would such knowledge simply give way to its totalizing implications? In other words, would this simply enable me—once again—to refresh myself at the fountain of this wonder-full Other and continue on about my clinical business without fulfilling any larger responsibility to *her*?

It would be unfair to judge Almeida's attempt to bring clinical relevance to Levinas' ethical vision as less than bold, yet how Levinas' ethics are to be taught, practiced and applied within her theory is still in question. Almeida's translation is relevant to clinical care and true to Levinas' formulation, but her efforts fall short of illustrating how they are to be *applied*. Still, her contribution invites the clinician to consider that there is, and must be, another way of apprehending the help seeker which is a valuable argument in itself, if only in articulating an "ought" against "the way it is".

Research like Almeida's leaves me to wonder if the largest part of Levinas' seduction does not lie in his confirmation of the sanctity of the clinician's *desire.* That is, in this "holy" apprehension that is so conspicuously absent in clinical literature, given the bald challenge it poses the reduction and the power structure behind it. But if so, then what? Almeida concludes:

> To conceive of the other towards the "I health professional" … demands that the technical and scientific knowledges of the professional be submitted to the demands of the other, demands that the public policies always have the purpose of serving Other justly, attributing a character of singularity to the concept.[72]

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[70] Ibid. p. 774.
[71] Ibid. pp. 772-73.
[72] Almeida's paper is translated from Spanish to English, which might explain the absence of the article "the" that would otherwise precede "Other". Ibid. p. 774.

These noble sentiments are in perfect accord with our inquiry and we might readily imagine them being endorsed by the ethics committee of any community mental health centre. Yet, in saying as much, Almeida appears to re-iterate the obvious rather than plumbing the boggy depths of the reduction she is trying address, or illustrating *how* her theory would work *in practice*.

7.3.2   Cultural competence under the Levinasian microscope

It seems that the ethical integrity of any given application is accurately determined by simply examining it through the lens of Levinas' "Other". As we shall see, even an application theorized and construed as ethical can be revealed as another reduction in disguise. Social work educators Adital Ben-Ari and Roni Strier discuss this ethical tromp l'oeil in their examination of the growing interest in the notion of "cultural competence". This is an idea emerging in clinical care and community mental health care which appears to reflect a Levinasian ethos.

Cultural competence emphasises the institution's growing awareness of the need for clinicians to deal more sensitively, knowledgeably and justly with difference. This includes the difference in people's socio-economic and life circumstances, their culture, age, sexual orientation, gender, religious or spiritual practices and beliefs. The strength of this theory supposedly lies in its interest in recognizing and addressing the embeddedness of such difference in the quality of care an individual is likely to receive.[73] Yet, Levinas' work speaks to interests greater and subtler than these in his claim of an irreducible alterity. As Philosopher Jeffrey Bloechl observes, this alterity—this otherness—represents no particular cultural or religious framework, despite Levinas' own Jewish heritage and scholarship. The *moral* issue always takes precedence over the cultural or epistemological.[74]

Consequently, Levinas' view does *not* chime with the assumption that cultural competence is a "necessary and sufficient condition for working effectively with differences". Nor can it be "taught, learned, trained and attained,"[75] as Ben-Ari and Strier have themselves

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[73] A. Ben-Ari and R. Strier, 'Rethinking Cultural Competence: What Can We Learn from Levinas?', *British Journal of Social Work,* 40 (2010), p. 2156. For a brief analytic summary of cultural competence see: A. Kleinman and P. Benson, 'Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It', *PLoS medicine,* 3 (2006), 1675.

[74] See: A. Kleinman and P. Benson, 'Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It'.

[75] A. Ben-Ari and R. Strier, 'Rethinking Cultural Competence: What Can We Learn from Levinas?', p. 2158.

concluded. Cultural competence has nothing to do with my encounter with the other who opens me to my moral identity and ethical yearning in an event, "announcing my having already been found".[76] The notion of cultural competence is shown to be a fallacy and an essentially reductive exercise that *generalizes* the help seeker, even while it presumes to specify and honour difference for her benefit.

This does not diminish the clinician's need to understand and respect cultural or religious difference, or excuse ignorance of these subjects. To assume the *ethical* priority of cultural competence, however, is to miss the point that even the most refined understanding of cultural or social differences still reduces the help seeker to another category. Cultural competence shares nothing in common with the transcendent "trace of the *who knows where*"[77] that inheres in each of us and has no generalizable parts.[78]

7.3.3 It's not about self esteem

> The possibility of sacrifice as a meaning of the human adventure! Possibility of the meaningful, despite death, though it be without resurrection! The ultimate meaning of love without concupiscence, and of an *I* no longer hateful.[79]

Levinas' vision illuminates the naivety of a "therapeutic" perspective that makes the vulnerable help seeker the centre of her own universe and a therapeutic focus on the *self* both limiting and dangerous. The need to redirect this focus could hardly be clearer, or more urgent, when cherished notions of what constitutes the "therapeutic" or "best practice" are revealed in ways large and small to be anti-social if not ludicrous.

> *A colleague from down the hall, a psych nurse, comes into my office and looks around the room before addressing me. "Do you have handouts for your patients?" She gives me a brief smile but seems in a bit of a rush and doesn't sit down to tell me what the matter is. "Uh, handouts?" I say, uncertainly, standing up from my chair and looking around the room to see if she'd seen something I'd somehow missed in my own office. "Yeah, you know, just a one-pager. I need something on self-esteem". "Self-esteem?" I say, echoing her question as though I am deaf or unfamiliar with her language. "Yeah, I've got a patient in with me right now with low self-esteem who could really do with a hand-out, just a one-pager, that's all I need.*

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[76] J. Bloechl, 'Liturgy of the Neighbor: Emmanuel Levinas and the Religion of Responsibility', p. 37.

[77] E. Levinas, *The Levinas Reader* (Oxford: Basil Blackwell, 1989), p. 90.

[78] Bloechl suggests that Levinas' ethical formulation cannot be reduced to the Jewish themes or inspiration found in his work although such correlations have been made. Levinas himself claimed that his own work did not represent any specific dogma or religious tradition. See J. Bloechl, 'Liturgy of the Neighbor: Emmanuel Levinas and the Religion of Responsibility', pp. 7-9.

[79] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', p. 227.

Don't you have one?" "Ah, no, actually," I say. She is looking at me quizzically, waiting for a reasonable answer that might account for such an unprofessional oversight. Perhaps she thinks I'm simply out of hand-outs and need to print some more. It is inconceivable to her that I, a therapist, would not have a tool as basic as this to give people with low self-esteem, given that virtually everyone who comes into this place supposedly suffers from it. It's a term I never use, it's meaningless, it's demeaning, I hate it.

I feel slightly flustered as I watch her walk towards the door. "Would you like me to see your patient?" I ask, following behind her, trying to be helpful, but realizing with a sinking heart that my offer may have just offended or alarmed her. "No, no, no, no". She says quickly, confirming my fear, and raising her palm to stop me from continuing. "I just thought you might have something…" There's another pause. "Yes, well, uh, I don't," I say, stating the obvious. The situation is not getting any better and I don't know why I feel so sheepish. She looks at me appraisingly from the doorway and asks, "What do you do?" "What do I do? For self-esteem issues you mean?" "Yeah, what do you do for your patients?" Not having a reasonable answer on the tip of my tongue, and seeing just how far apart we are on this issue, I say the only thing that comes to mind. "I talk to them". I might also have added, "I sit with them". But I didn't want to sound like a complete idiot.

7.3.4 *Helping the vulnerable help seeker find the Other*

Psychologist, Richard Williams, laments psychology's lack of moral maturity and its naivety and failure to address the ethical in any way that could promote moral development and behaviour. Levinas' work, he argues, offers an escape from psychology's "irrelevance and obscurity" because it does not conflate ethics and reason.[80] Moral relevance could be cultivated, Williams suggests, through a psychology dedicated to metaphysical questions related to the interests of intelligence, morality, agency, intimacy and a sense of the good.[81] Williams also affirms psychology's legitimacy as a defensible enterprise by suggesting that Levinas did not refute contemporary ontology, so much as redirect it away "from its own excesses". Levinas' provisional acceptance of "phenomeno-logical/hermeneutic ontology,"[82] Williams claims, is what rescued psychology from its reductive, deterministic history. On this last point, I am less persuaded given the enormity of the reductive problem we are confronting here. Yet, I concede that any serious *de*-legitimization of community mental health care is also far enough in the future to justify examining approaches that could help turn the help seeker towards the Other.

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[80] R.N. Williams, 'Self-Betraying Emotions and the Psychology of Heteronomy', p. 10.
[81] Ibid.
[82] Ibid. p. 11.

Williams proposes one therapeutic approach based on a theory developed by Terry Warner, with appealing Levinasian overtones. Warner, an American businessman, philosopher and devout Mormon, argues persuasively for the need to understand the socially destructive implications of self-deception that predictably cause us to blame and misuse others. His perspective is sympathetic to Levinas' in claiming that our ability to take responsibility liberates us from the burden of our self-deception and enables us to love the other and to see her as she truly is.[83]

Warner offers several examples to illuminate his meaning and the most intriguing and counter-intuitive concerns the plight of a young woman. Wounded by her father's life-long indifference, she is left feeling deeply unloved and emotionally paralysed. Spending her 20s going from one therapist to the next, she finally approaches her bishop who advises her to ask her father's forgiveness for holding him so far outside her heart. Stunned and outraged by this suggestion, the young woman eventually discovers her culpability in this prescription. She goes to her father to ask his forgiveness without any expectation and he begs her forgiveness instead. This mends the tear in their relationship and the young woman's bitterness is transformed, allowing her to function in the world again. The outcome of this drama might well be dismissed, or closely queried by a sceptical therapist, and with good reason. Yet, Warner cautions that his theory offers no formula or panacea.

> It is important to notice that nothing I've said implies that this girl was "bad" or "sinful" in her refusal to love her father. I've not even said that she should have loved him. The point is she felt she should. In not doing so, she was betraying a moral sense that was not someone else's, but her own.[84]

Warner's work suggests a creative way of coaxing the individual away from the trap of her self-focused and oppressive inner process to the larger picture of her inter-subjectivity that reveals the relational possibilities of loving and being-for-the-Other.

Taking a different tack towards an argument for the other, philosopher Richard Cohen suggests that Levinas was unequivocal in flatly contradicting the psychological perspective

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[83] C.T. Warner, 'Feelings, Self-Deception, and Change', *Issues in Religion and Psychotherapy,* 8 (1982).
[84] Ibid. p. 24.

of his day that interpreted "need as lack".[85] Arguably, this view still prevails in theorizing our drive to control or fulfil ourselves socially, materially or spiritually. Yet, Levinas claimed this drive does *not* represent our need for satisfaction and gratification but our desire to escape ourselves through the transcendent. It represents "the desire for the truly other—escape from self-enclosure".[86] Here, then, the problem of being and existence is found not in its lack but its *surfeit*.

Cohen also suggests that Levinas' account of responsibility could be relevant to those at risk of suicide, who cannot recognize the hell of their own self-absorption and despair as their unfulfilled desire for the other. Yet, Cohen fails to account for the efficiency of the institution—and even the well-intended clinician—to mediate against such a view, given the profound vulnerability of the help seeker to the anti-socializing impact of community mental health care. This is significant considering the frank insufficiency of institutional diagnostics, prescriptions and treatments to provide something—*anything*—substantial enough to confirm the help seeker's sense of relatedness, responsibility or *place*.

Williams' and Cohen's recommendations are additionally complicated by the lack of any clear consensus on what even constitutes "recovery," or "mental illness".[87] Cohen, however, speaks volumes when he observes that mental health is "not simple conformity to social conventions…but responsible participation in the moral dimensions of social life, which may mean standing on one's own against certain social conventions".[88] The delicacy and difficulty—the risk—of responding to such a moral imperative cannot be underestimated when the clinician stands against the cultural conventions of the institution she serves. These risks all too clearly articulated than when the clinician confronts by the naïve expectations of the vulnerable help seeker.

7.3.5 Safe as in Church

Please don't talk yet… I understand… you're beside yourself…would you like to take your coat off? Please sit down…that's it. Do you want to put your purse on the floor? Would you

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[85] Cohen alludes here to Levinas' dissatisfaction with Freud's view of the libidinal drive that Levinas apparently argued had failed to suggest its "ontological origins". R.A. Cohen, 'Book Reviews of Emmanuel Levinas (2003) on Escape. ', *European Journal of Psychotherapy & Counselling*, 7 (2005), 110.

[86] Ibid.

[87] S.J. Onken and others, 'An Analysis of the Definitions and Elements of Recovery: A Review of the Literature', *Psychiatric rehabilitation journal*, 31 (2007), 17-18.

[88] R.A. Cohen, 'Book Reviews of Emmanuel Levinas (2003) on Escape.', p. 112.

like a drink of water? Let's take a minute shall we? Please don't apologise…this is the place to let these tears go…would you like some Kleenex? Yes, I do hear you, your husband, the children, the job, the attempt, the whole thing… I hate to stop you from talking but I don't want you say too much until you know who you are talking to. It seems like an interruption and you've waited weeks to get in here and it's our first meeting and you're spilling over … but I work by some rules you need to understand. There will be time to talk… take some nice big breaths…that's it. You've been crying like this for a week? But look what you've been through. You almost died. I am so sorry for your pain … we'll wait until you're ready … but don't talk yet… I'm trying… to protect you.

She stops suddenly to look at me, her hand on the Kleenex she is still holding to her nose, the question clear in her startled eyes.

No, no, I'm safe, of course I'm safe. Don't I look safe? Check me out, look at me…Hi there!…Of course I am. But… there are things we have to talk about first, so you can decide what you want to tell me, but also, what you might…not want to say. Do you understand what I'm telling you? This is really important. Do you understand what I'm trying to say?

The isolation, loneliness and purposelessness plaguing the "mentally ill," point not only to the reductive institution and its dehumanizing Achilles heel, but also to the problem of the self-loathing *I* and the therapeutic focus on the self. From this angle, the help seeker's responsibility to the other is *denied* through her entrancement with a reductive "therapeutic process" that keeps her blind to even its possibility. In sum, there should be little doubt that the idea of "recovery" needs to move away from the notion of remission or ideas of "improved functionality," and focussed on the social.

7.3.6 *Levinas collaborates with other ethical orientations*

Levinas' work is also emerging in collaborations with other ethical conversations and practices relevant to community mental health care and beyond. Two such examples are briefly examined here that touch on Buddhist practice and on an alternative therapeutic approach called "Focusing".

In the first example, Martyn Kovan, a Buddhist writer and ethicist, has suggested a collaboration of Levinasian ethics and Buddhism that he believes could help develop a fruitful theoretical hybrid. This could allow two differing but compatible ethical orientations to address their separate weaknesses and build on their respective strengths.

Buddhism's rise in North America already describes an impressive and growing influence in psychology and medicine.[89] As an ethical practice, Buddhism also supports Levinas' project of uncovering and addressing the ontological roots of violence by identifying our indelible connection to each other.[90] The Mahayana Buddhist practice of "taking all blames into one"[91] or the Theravada practice of the Brahma Viharas,[92] are but two practices sympathetic to Levinas' perspective of an un-substitutable responsibility for the other. Such practices are gaining interest in clinical literature and being developed as applications used in widely differing medical contexts from psychiatry to oncology.[93]

Kovan is hopeful the collaboration he is suggesting will shed more light on the ambiguity of situations representing differing yet equally defensible ethical positions. Levinas' work, according to Kovan, does not adequately address this ambiguity despite Levinas' unequivocal stand on personal responsibility and our collusion in all forms of violence.[94]

> [V]iolence is not… the storm that destroys a harvest, or the master who mistreats his slave, or a totalitarian state that vilifies its citizens, or the conquest and subjection of men in war. Violence is to be found in any action in which one acts as if one were alone to act: as if the rest of the universe were there only to receive the action. Violence is consequently also any action which we endure without at every point collaborating in it.[95]

Kovan seeks a nuanced answer concerning who, or what, may be more or less ethical. To clarify the problem, he offers a riveting analysis of a life and death situation between an American Buddhist peace activist and two Burmese Buddhists on opposing sides of the

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[89]For examples of such work and its ambitions see: J. Kabat-Zinn, 'Mindfulness-Based Interventions in Context: Past, Present, and Future'.

[90] See, for example, S.G. Hofmann, P. Grossman, and D.E. Hinton, 'Loving-Kindness and Compassion Meditation: Potential for Psychological Interventions', *Clinical Psychology Review,* 31 (2011).

[91] See: P. Chödrön, *Comfortable with Uncertainty: 108 Teachings* (Bouler, CO: Shambhala Publications, 2008), pp. 180-81.

[92] See one author's argument for loving her students that shows the overlap between Levinasian inter-subjectivity and the Buddhist practice of "Metta". This practice comprises loving-kindness, compassion, sympathetic joy, and equanimity which are described as the "four abodes" of the Brahma Viharas. See: M.J. Hinsdale, 'Choosing to Love', *Paideusis,* 20 (2012). For a more comprehensive definition of each of these abodes see: C. Eppert, 'Heartmind Literacy: Compassionate Imagining & the Four Brahmavihāras', *Paideusis,* 19 (2010), 21-23.

[93] See: S.G. Hofmann, P. Grossman, and D.E. Hinton, 'Loving-Kindness and Compassion Meditation: Potential for Psychological Interventions'.

[94] M. Kovan, 'Violence and (Non-) Resistance: Buddhist Ahiṃsā and Its Existential Aporias', *Journal of Buddhist Ethics,* 16 (2009), 46.

[95] E. Levinas, 'Difficult Freedom: Essays on Judaism', p. 6.

Burmese revolution.[96] Each man appears to have a defensible ethical position, but how from a Levinasian perspective do we judge the merits of each one? Kovan argues that this weakness in Levinas' ethics calls for a closer collaboration with Buddhist ethics. Our ability to refine and answer such questions through the collaborations Kovan suggests, are certainly of interest to mental health clinicians who are chronically confronted by the competing ethical interests of their practice.

In another collaboration, research psychologist, Kevin Kryka, combined strategies reflecting Levinas' work with that of philosopher psychologist, Eugene Gendlin, who developed a counselling modality called "Focussing" in the 1960s.[97] Levinas and Gendlin's work are not identical, but Kryka notes their similarities. Gendlin, for example, claimed the primacy of a "felt sense" of the pre-conceptual as something that "orders our living" but that is not constituted by "units of thought or feeling however familiar".[98] Gendlin also recognized the constraints of language, and a process of being and thinking that continually foreclose on the subtler but undeniable presence of an inner *I*. This construal mirrors a Levinasian perspective of an ordering principle that may seem familiar, but that ultimately precedes thought and feeling, and is occluded by language. A more extensive analysis is needed to synthesize the similarities and differences of these thinkers, but the most significant comparison to be made is between Gendlin's "I" and Levinas' "Other".

Using strategies informed by the work of Levinas and Gendlin, Kryka developed an approach to support the successful negotiation of a potentially volatile dialogue between Jews and Palestinians. Using Gendlin's "First persona approach," Kryka focussed participants away from the "content" of their emotionally charged historical issues towards

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[96] M. Kovan, 'Violence and (Non-) Resistance: Buddhist Ahiṃsā and Its Existential Aporias', pp. 39-40.

[97] See: E.T. Gendlin, *Focusing* 2nd edn. (Toronto, New York: Bantam, 2007). "Focusing" is an alternative approach to therapy developed by Eugene Gendlin in the 1960s that radically questioned the role of science and therapy, and even the validity of the therapist's role in creating therapeutic change. Gendlin proposed an embodied approach to the awareness and mediation of psychological distress and self-destructive patterns of behaviour. Arguably, this is less a "therapy" than a subtle phenomenological practice that instructs practitioners how to access pre-conscious or unformed feelings or intuitions that are driving and disturbing their lives and emotions. The process helps an individual pay minute attention to his or her embodied responses. In my view, Focussing shares much in common with Buddhist mindfulness and concentration practices in its cultivation of steady awareness and a relaxed willingness to observe and experience the moment-to-moment response of the body/mind to its thoughts, feelings and sensations. The University of East Anglia is the leading academic centre for Focusing Studies in the United Kingdom

[98] K.C. Krycka, 'Levinas and Gendlin', *Existential Analysis: Journal of the Society for Existential Analysis,* 20 (2009), p. 97.

the "process" of the I. He enhanced this approach by bringing in a Levinasian perspective that would help participants discern the "*myth of equality* and the *totalizing impulse* of Being and Existence".[99]

These examples illustrate collaborative possibilities between Levinas and thinkers sympathetic to his worldview that could encourage researchers to think creatively about bringing Levinasian ethics into clinical literature. As we have seen in the second half of this chapter, clinicians and clinical educators are pursuing research related to issues of practice and application by employing—or attempting to employ—Levinasian ethics. Such initiatives can only expand Levinas' sphere of influence and enable those pursuing his vision to keep it at forefront of this emerging "therapeutic" dialogue.

In terms of community mental health care, the problem of attempting to negotiate an ethical relationship with the help seeker without actually challenging the foundations of the institution remains unchanged and unchallenged. For, there can be no morally relevant praxis as long as the supremacy of the clinician's power and authority—even her *moral* authority to assert a Levinasian ethics, is assumed.

7.4 Conclusion

> To accept being, in other words, is to fall prey to a philosophy of success, the worship of the real, a fatalism without moral resources, for it boils down to saying that what is, by virtue of its appearance as being, is what must be.[100]

In this chapter, we have explored possibilities for a "wonder-full" approach to clinical care based on Levinasian ethics that began with an examination of the divinizing work of Jean Vanier. Yet Vanier offers no fail-safe and is well aware that small spiritual communities are always vulnerable to danger and darkness. The emerging critique about Mother Teresa's questionable financial management of donated money is but one example,[101] the horror of a Jonestown story is another.[102] Nor is there any refuge, even for L'Arche, as it confronts evidence that Vanier's spiritual director, Thomas Philippe, who helped launch L'Arche, also abused women seeking his spiritual direction. Yet we remember Vanier's example of

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[99] Ibid. p. 95.
[100] R.A. Cohen, 'Book Reviews of Emmanuel Levinas (2003) on Escape. ', p. 111.
[101] See: S. Larivée, C. Sénéchal, and G. Chénard, 'Les Côtés Ténébreux De Mère Teresa'; P.M. Thomas, 'Pointing Fingers at Mother Teresa's Heirs'.
[102] J. Dunne, 'Sense of Community in L'arche and in the Writings of Jean Vanier', p. 50.

integrity and tenderness that shows how the vulnerable other can be allowed to claim her place as the arbiter in a relationship, that not so much topples hierarchy as *dissolves* it.

Thus, the work of the "assistant" in L'Arche homes—and perhaps the clinician in some unforeseen future—constitutes not therapy but covenant, not service but relationship, not authority but responsibility. At the centre are communion and the willingness of the helper to acknowledge her own fragility and submit to the moral elevation of the Other, despite the sacrifice involved. Vanier's work powerfully illustrates how the vulnerable other can actually *prohibit* my antisocial behaviour by offering no alternative than a one-for-the-other relationship for which the help seeker is almost incomprehensibly better suited. This truth echoes in Levinas' observation that "[t]he essence of discourse is prayer," [103] because such "religion" can be spoken without mention of God or the sacred, and need not imply either mysticism or theology.[104]

In this chapter, we also examined how Levinas' vision is suggesting therapeutic approaches and applications aimed at protecting the vulnerable help seeker and liberating her from an excessive focus on the self. We considered the compelling work of Terry Warner who, like Vanier, employs the suffering face of Christ as the prototype for our "clinical" concern. Regardless of religious or spiritual orientation, this face speaks to the shocking immediacy of the call of the vulnerable other. It is also true that we may *never* respond to this call with a technique or application but only our limited selves, only relationship, only responsibility. Yet, the probability of such an ethical encounter is easily pre-empted by the secular "therapeutic" process. This is one that is so fraught with busy-ness and purposefulness, that it subordinates alterity to "empirically defined themes" and "successful therapeutic outcomes".[105]

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[103] A debate about prayer in clinical practice was provoked by American psychiatrist Harold Koenig. Prayer is an exceptionally difficult notion to introduce in this context and is reduced to pragmatic therapeutic "goals" to justify its use, even by its most sensitive proponents. "Prayer should never be a matter of routine. The timing and intention must be planned out carefully with clear goals". See: H.G. Koenig, 'Religion and Mental Health: What Should Psychiatrists Do?', p. 203. See two responses to this article in: C.C.H. Cook, 'Spirituality, Secularity and Religion in Psychiatric Practice: Commentary On... Spirituality and Religion in Psychiatric Practice', *The psychiatrist.*, 34 (2010); M. King and G. Leavey, 'Spirituality and Religion in Psychiatric Practice: Why All the Fuss?', *The Psychiatrist*, 34 (2010).

[104] E. Levinas, 'Entre Nous: On Thinking-of-the-Other', pp. 7-8.

[105] A. Dueck and T.D. Parsons, 'Ethics, Alterity, and Psychotherapy: A Levinasian Perspective', p. 276.

That Levinasian ethics is finding its way into clinical discourse is remarkable considering the threat it poses to the reductive machine. Yet the research is still in its infancy although the possibilities are promising and *compelling* if not rather daunting. As one commentator has noted, the "infinite and relentless burden" of Levinas' responsibility cannot be "resisted" or watered down simply because of its extremity or inconvenience. To oppose this responsibility is to oppose "otherness and its demand," whose integrity cannot be altered or refuted without "promoting one or another form of disrespect".[106] Yet the opposition of the dominant discourse still poses an apparently insurmountable challenge to this demand. Even scholars attempting to remediate the most worrying aspects of a clinician's violating, derogating, irrelevant and infantilizing enterprise, are still failing to censure the authority of clinicians themselves, or the stone wall of their endorsing institution.

Levinas was not attempting to negotiate with 2000 years of philosophy but to replace it with the "single idea of absolute primacy for the ethical relation".[107] The responsibility that Levinas asserted places precedence on the clinician's responsibility to the help seeker over all other therapeutic interests. For psychology to do less, in attempting to increase its moral relevance by inviting Levinas into the dialogue, is to misappropriate and misrepresent his unequivocal ethical stand.

Levinas' position is remarkable in its unimpeachable capacity to raze all prevarication or critique aimed at protecting one's own position as an *I* connected to the institution. This is the defence embedded in the presumption of the *pre-eminence* of the therapeutic role and the institution and, less obviously, in the authority and priviledge preferred by the clinician. Curiously, this defence echoes even in the scholarship of even those whose ethical courage must be gratefully acknowledged for bringing Levinas into the therapeutic dialogue. Yet, Levinas' vision is not panacea to which we may turn for solace and easy answers when confronted by our own sense of impotence within the institution.

Simon Critchley claims that those of us who are now turning so hopefully to Levinas must also be vigilant lest we become his disciples rather than his critics. It is "all very nice" he remarks, that Levinas' work has extended far beyond his own field of philosophy, but too much of this scholarship, Critchley insists, is confined to "exegesis, commentary,

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[106] J. Bloechl, 'Liturgy of the Neighbor: Emmanuel Levinas and the Religion of Responsibility', p. 4.
[107] Ibid. p. 5.

comparison with other thinkers, and…homage". Indeed, Critchley's call for a "passage from ethics to politics"[108] comes none too soon for community mental health care and it is to this theme we now turn in our concluding chapter.

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[108] S. Critchley, 'Five Problems in Levinas's View of Politics and the Sketch of a Solution to Them', pp. 172-73.

Chapter 8.
The politics of need and desire

As I turn and find my neighbour in proximity—in the turning—who I am most particularly becomes definitive in the proximity as well as in my word of response. In this turning and finding my neighbour to whom I belong… is where I will be with God or without God, where I will feel bereft or liberated in a fleeting absence of God. Here is where values feel their value, where the important things in life stand out, where rituals speak in silent, life giving meaning, where one knows nonreflectively how to live and die.[1]

8.1 Introduction

This thesis claims that wonder can interrupt the institutional entrancement of the clinician by awakening her to the vulnerability of the help seeker through a stunning perspective that confirms a profound moral relationship. It is a claim we have hopefully come some way in analysing through a Levinasian interpretation of wonder and illustrating through the epiphanic power of autoethnography. Both have illuminated the devastating reduction of the help seeker within a marginalized clinical population that also fuels the cultural and corporate interests of the institution and its many stakeholders.

In moving towards this conclusion, I have also been concerned that wonder appears to be a failed quantity that slides too predictably off the Teflon surfaces of community mental health care. That is to say, wonder still fails to enable the clinician to protect the vulnerable help seeker from the combined institutional assault of medicalization, asymmetry and dehumanization.[2] Wonder may make a powerful moral impression but apparently not one substantial enough to destabilize the institution. Nor does it significantly affect the reasoning of all who maintain its boundaries.

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[1] C.E. Scott, 'A People's Witness Beyond Politics', in *Ethics as First Philosophy: The Significance of Emmanuel Levinas for Philosophy, Literature and Religion,* ed. by A.T. Peperzak (New York: Routledge 1995), pp. 25-35 (p. 31).

[2] See: Chapter 3.

Indeed, both inside and outside institutional walls the entrancement with the "creep of mental illness" is ongoing. Its territories continue to expand as it becomes ever more "normalized" despite the undiminished stigma that continues to anathemize the "mentally ill". Moreover, the label of mental illness comes with its own seductive rewards, particularly for those on the lower rungs of the socio-economic ladder involved with community mental health care. The most obvious of these may be guardedly described as "humane respite," and a constellation of social resources—including "free" medication—and someone who will listen no matter how briefly or helplessly. Sociologist Philip Strong has argued for these rewards although I have suggested they come at a very high price.[3]

If the haunting moral plea of wonder fails to overcome the truculence of the dominant discourse within community mental health care, its capacity to help the clinician interrogate and apprehend the reductive system is unparalleled. Wonder does not *oppose* or argue so much as it *contrasts*, *contradicts*, *corrects,* and *illuminates* by revealing the moral relationship and exposing the clinician to an almost irresistible ethical invitation beyond her ken but achingly familiar.

Nonetheless, our earnest call for the remediation of clinical reduction and clinical distance is not without irony. For, this wonder-full "exposure" utterly shifts the power dynamic by *relocating* the clinician *below* the help seeker and confirming a stunning proximity. Here, the clinician may discover herself—in Levinasian terms— in a position of obeisance that very problematically *melts* her authorization, status and privilege within a hierarchy that the clinician has no intention of forfeiting. Indeed, none of her professional or cultural markers would ever call these into question. Nonetheless, this radical moral correction illuminates the fraudulence of the mental health clinician's work, her institution, her education and perspective, and her immediate relationship with the vulnerable help seeker. Yet, the reductive system is so well defended that the impact of wonder may leave the clinician moved but also confused, hamstrung, apparently incapable of acting on the help seeker's behalf. Consequently, the clinician can be left distrusting herself, feeling incapable

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[3] See: The thesis of medical imperialism (3.3.2).

of even discerning between the Other and the reduction. That is, of discerning between the moral and the immoral, the responsible and the irresponsible, evidence of which can be found in abundance in *James' story*.[4]

Here lies the dissonance at the heart of this ethico-political matrix that I have confronted throughout this inquiry and that continually forecloses on *any* substantive argument attempting to go *beyond* the reduction. The consequence of which is found in the predictable and maddening defilement of wonder itself. This is discovered in the conflation of *proximity* and *abuse,* where the ethical proximity of the Other is conflated and confused with the threat of her *violation* and abuse. Yet, our conflation is inadequately interpreted, or ignored, even by those researchers arguing for greater ethical protection of the vulnerable help seeker from the reductive system. Nonetheless it prevails, leaving the soundest arguments for proximity diluted and defiled before being absorbed back into the reductive bog.

We must also remember that Levinas conceded that the vision for which he argued throughout his career was beyond the reach of a change that still lies in potential. "I have the idea of a possibility in which the impossible may be sleeping."[5] As noted earlier this limitation has not stopped thinkers and researchers in growing numbers of fields of endeavour from trying. This includes Professor Martyn Evans' thoughtful work on wonder that we examined in some detail.[6] Yet, others suggest that Levinas' work is too obscure to be adequately interpreted for any "purpose".

This inquiry appears to sit midway between these two opposing perspectives of the "possible" and the "impossible," which is not to negate wonder's power or promise or the value of our attempt to see beyond the obstacles in its way. Nevertheless, the obstacles are complex and fascinating in the context of community mental health care and the therapeutic relationship. These obstacles are the focus of this concluding analysis and of what we might described as the enslavement of a notion we are attempting, in some ways, to wheel up to the institutional walls like a Trojan horse. Yet, as we discover, wonder too is trapped in the same reduction as the help

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[4] See: Chapter 2.

[5] E. Levinas, 'Alterity and Transcendence', p. 89.

[6] See especially: Chapter 5.

seeker. The problem resides in the totalizing capacity of the reductive framework to colonize and defile *whatever* lies in its path, including those ethical strategies specifically aimed at its subversion. As Luce Irigaray compellingly suggests, our failure to adequately understand this problem is at the root of our inability to solve it with "secondary ethical tasks".

> It is not a matter of changing this or that within a horizon already defined as human culture. It is question of changing the horizon itself – of understanding that our interpretation of human identity is both theoretically and practically wrong.[7]

Like Levinas, Irigaray is not suggesting how this new horizon would be, or should be, practically implemented but her admonition is unequivocal and offers a very clear direction forward. "If we fail to question what cries out to be radically questioned, we lapse or relapse into an infinite number of secondary ethical tasks," and such tasks, she accurately observes, will not "remove the exploitation".[8]

Connected to the obstacle of this conflation is the conscription of the help seeker as the mule of wonder. Here, the clinician construes her dazzled apprehension of the help seeker as an "experience," a *consumable* that may overwhelm her with gratitude and awe but remains for her sole benefit. Yet, the clinician is also likely to find herself intimidated by the dominant discourse and tightly constrained in even attempting to bring a notion like wonder into the conversation. The ultimate heresy is to *see* let alone *speak* or *act* beyond the reified—concretized—self-serving boundaries of the clinical enterprise. For this enterprise all but refutes the sanctity of the clinician's bond to the one to whom—as wonder so accurately insists—she *belong*s.

8.2 Wonder's enslavement

> It is not by chance that the history of Western philosophy has been a destruction of transcendence.[9]

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[7] L. Irigaray, *I Love to You: Sketch for a Felicity within History* (New York: Routledge, 1996), p. 20.
[8] Ibid.
[9] E. Levinas, 'God and Philosophy', in *Emmanuel Levinas Basic: Philosophical Writings* ed. by A.T. Peperzak, S. Critchley, and R. Bernasconi (Bloomington and Indianapolis Indiana University Press, 1987), pp. 129-48 (p. 130).

8.2.1 Thou shalt not love

I have been battling with the daughter of a chaotic and chronically suicidal mother who is under the care of my colleague, a nurse who has worked off and on with this woman for four years or more. This woman's child, barely 21, has made it through the first cut of intake and been assigned to me. She is now spitting bullets in my office because I am refusing to support her bid for mental health care in our Centre, which would entitle her to receive social assistance to which she believes herself entitled because, as she edgily informs me, she is unwell. "You are not ill," I essentially and carefully tell her. "You need an education, employment and a better support system, not psychiatry, antidepressants and a welfare cheque". It takes the best part of an hour to finesse this message to avoid appearing unsympathetic or negligent to her or to my manager who this young women will likely call to complain about me.

Surprisingly, my argument is supported by my team but the young woman isn't having it and insists on another consultation, this time with her unemployed boyfriend in tow. She has no idea the suffering that lies well ahead of her, given her mother's profound instability and all that has gone before. I will not add to it by handing her over to a system that will make it almost impossible for her to motivate herself towards any real autonomy or recognition of her potential. Yet, I resent her for trying to take advantage of a service she does not require.

I wander down the hall to my colleague's office to discuss the matter, feeling caught in the moral vice of wanting this girl to fulfil her life and annoyed by her presumption, but also her willingness to leverage her mother's situation for such a wretched pay-off.

I lean against the doorframe of my colleague's office while she talks to me from her desk about this young woman's mother and the role she has played over the course of several years with this tragically self-destructive woman and her family members. My colleague has been a constant, having attended this woman through many crises, visited her in her home and in hospital, and comforted and advised her family. It seems that the frequency of crises is beginning to lessen and the unstated hope is that my colleague's intervention has counted for something. Curiously, my colleague does not express the merest hint of impatience or ambivalence towards this woman. Her steady and unquestionable devotion and the significance of her place in this family constellation seem indisputable.

It's risky but I ask anyway, I want to know what she thinks. "Do you love her?" I say. She pauses before answering. The question is unnerving, it should not be asked, it could mean anything, she does not like it, I have transgressed. "No, of course not," she answers shortly, while I come around from another direction to clarify the integrity of my meaning. "No," she protests again, looking at me, "No". Then,

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looking down at her desk she says, "I do not love her, I am her nurse," as though she might be trying out these words to test them for accuracy. And again, more forcefully, "I am her nurse," she says, looking up at the wall in front of her desk long enough to signal that it is time for me to go.

8.2.2 *Proximity and the conflation of violation: A closed loop*

The enigma of the clinician *belonging* to the help seeker, of her *desire* and *need* for the vulnerable other, is the most radical and problematic. For it ruptures the status quo and opens the clinician's awareness to ultimacy and the astonishing *possibility* of a very different kind of ethical relationship. Yet, not without the alarm being raised in the same instant by the spectre of violation that plagues such a notion within the reductive sphere. Resistance is predictable, swift and daunting. What about boundary violation? What about the clinician's abuse of power? What about the clinician having sexual feelings for the help seeker or of even "loving" her? What about the danger of role reversal? What about clinical distance? Is *some* distance not required for the clinician to be of any value to the help seeker? To which I can only agree.

More intriguing is *why* the clinician suddenly becomes such a high and *imminent* danger to the vulnerable help seeker whenever the issue of proximity is raised to address the issue of clinical reduction? For this risk is presumably present in every single clinical encounter conducted behind closed doors. Moreover, we may confidently assume the unquestionable ability of every educated and licenced clinician to *fully* comprehend *why* she is never to mis-use her power or position to violate the help seeker for her own gratification, sexual or otherwise. It is a rule so fundamental as to be elementary, redundant, even patronizing. Yet proximity, not power, remains the focus of concern about the boundary violations that occur so predictably.[10]

Interestingly, gross clinical violations can be presented as though there is some good-enough psychological explanation why they occur and are *tolerated.* That is, without effectively shutting down the entire enterprise of mental health care as

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[10] For an example of such literature see: D.M. Norris, T.G. Gutheil, and L.H. Strasburger, 'This Couldn't Happen to Me: Boundary Problems and Sexual Misconduct in the Psychotherapy Relationship', *Psychiatric Services,* 54 (2003).

currently practised institutionally or privately. That they fail to do so might support the argument that the great concern about "proximity" has always been a red herring. If proximity posed that great a threat to the help seeker, then why not simply eliminate the one-on-one consultative process? This could be implemented, or legislated easily enough with a much greater focus on group therapy models. Or, it could be instituted through protocols requiring assessments and therapeutic sessions to be transacted in the presence of family members, close friends or even clinicians in training. Conversely, there could be far greater emphasis placed on the development and legitimization of peer counselling models that have already proved their mettle.

It is not my intention to problem solve so much as to demonstrate the speciousness of the argument. Strategies like these could buffer many problems arising from the intractable power differential played out in the "private" consulting room while providing other substantial benefits. Among them would be a relaxation of the stranglehold on the notion of "mental illness" as something so exceptional and exclusive that its care is best conducted in private.[11] Such strategies could also lighten the financial burden of a chronically underfunded system of care, help shorten wait lists and allow the institution to offer more service to greater numbers of people.[12]

Yet, arguments against the strategies I am suggesting are predictable, including the purported inviolability of patient confidentiality. Of course, this argument falls apart in the current reality of computerized patient files and a case management model of care. Indeed, the free-flow of patient information within the system at large, among team members of the mental health centre, and staff members providing additional resources from outside the system, certainly *seems* to destroy any notion of confidentiality capable of dignifying the help seeker.

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[11] I have argued elsewhere in this inquiry that the notion of confidentiality is for the legal protection of the institution and essentially meaningless to the person it is supposed to protect.

[12] An inside joke among clinicians was that patients who were wait-listed for so long that they turned down service when they were finally contacted, were actually better off. Such refusal for service occurred because the help seekers' crises had passed or they had found other resources or were simply no longer interested, or possibly too disillusioned by systemic indifference to bother.

There is also the argument upholding the centrality of the "therapeutic" relationship that ostensibly requires the protection of privacy for it to be properly developed and maintained. In an environment like community mental health care, however, any semblance of the "psychotherapeutic" tradition characterised by a protracted "relationship" with one clinician, has long since been replaced with "short-term," "solution-based" and "cognitive" modalities. This is true even for those individuals suffering from SPMI (serious and persistent mental illness), generally viewed as requiring longer-term care. In addition, the help seeker is very likely to be shunted from one clinician to the next in the chaotic bustle of institutional care which makes any substantial notion of a "therapeutic bond," tenuous at best.

In sum, the simple strategies I have forwarded here provide but an example of how the institution could easily reduce the supposedly *dreadful* risk that looms in the shadow of proximity. Although, as I have re-iterated, the physical proximity found in the one-on-one clinical relationship is woven, without question, into clinical praxis.

8.2.3 Violation "A"

The issue of *gross violation* that might be identified here as violation "A," should be briefly clarified to understand what is being *primarily* conflated with ethical proximity. This amounts to the imposition and toleration of the gross exploitation of the help seeker through an abuse of power motivated entirely by the clinician's self-interest and gratification. It is no more complicated than this, despite whatever protestations might arise concerning the impoverished or over-extended clinician and the many burdens she carries that might cause her to lose her way.

> [D]iscussions of boundary problems sometimes focus on the "bad apple" model: boundary problems and sexual misconduct occur only with a few bad apples, and the simple solution is to kick those persons out of the field. This simplistic view misses a central point of our discussion: boundary issues arise in all therapies and for all clinicians, apparently irrespective of the number of years of experience, and even for those practicing only psychopharmacology. The relevant question is whether the difficulties can be successfully surmounted.[13]

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[13] D.M. Norris, T.G. Gutheil, and L.H. Strasburger, 'This Couldn't Happen to Me', p. 518.

We have seen that the straightjacketing of the reductive system limits the clinician's ethical ability to subvert or work against the reductive institution on the help seeker's behalf. However, we risk excusing the clinician from her unequivocal responsibility when we begin to enumerate the many causes of *gross* boundary violation. There is only *one* cause and to argue to the contrary is to deny the clinician's accountability, the inadequacy of the system to protect the help seeker, and the primacy of the help seeker's human rights.

Of all the violating concerns, there is possibly none more hypnotizing or scandalous than sexual violation and, I would argue, it is around this violation that the clinician tiptoes the most carefully. Not surprisingly, there is only a modest amount of research on issues related to the sexual abuse of patients in the field of psychology as well as on love and loving in clinical practice. Pope et al. corroborate the great taboo of acknowledging having sexual feelings for a client and the resulting dearth of systematic research in this area.[14] It follows that there would be a corresponding dearth of literature on love (proximity) in the therapeutic relationship that is not interpreted as counter-transference and indeed this is the case. The statistics speak for themselves.

An example of the statistics on the sexual abuse of vulnerable help seekers reported by one group of researchers, estimates that 5% to 10% of psychotherapists engaged in "sexual intimacies" in the course of their work as professionals.[15] Unsurprisingly, the occurrence of such abuse has a devastating impact on the help seeker.[16] An earlier prevalence study found that an average of 8.3% of men and 1.7 % of women working as psychologists and social workers had been similarly involved with help seekers.[17]

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[14] K.S. Pope, P. Keith-Spiegel, and B.G. Tabachnick, 'Sexual Attraction to Clients: The Human Therapist and the (Sometimes) Inhuman Training System', *American Psychologist,* 41 (1986), 150-51.

[15] Ironically, the term "sexual intimacies" is here used to describe the abuse of power and trust in this research that is earnestly aimed at highlighting and eradicating the problem. Such terms might otherwise, and reasonably, imply a symmetrical relationship of mutuality, trust and consent which this is not.

[16] K.S. Pope, 'How Clients Are Harmed by Sexual Contact with Mental Health Professionals: The Syndrome and Its Prevalence', *Journal of Counseling & Development,* 67 (1988), 224-25.

[17] Ibid. p. 222.

Confirming the gravity of the situation, another study demonstrated that false allegations related to such incidents were found in only 4% of the 958 cases where such abuses had been reported.[18] While the authors candidly admit that issues of validity make it necessary for such studies to be cautiously interpreted, their work shows remarkably high numbers. In this large study, there was a 50% return rate on a survey sent to 1320 respondents in California. Of these, 647 professionals reported having seen at least one client who disclosed being previously engaged in "sexual intimacy" with a former therapist, with a total of 958 clients with such history being reported among them.[19]

The issue is fraught, particularly when researchers like Norris et al. and Pope et al. have called for more and better clinical education with respect to sexual violation. But the reader may be excused for wondering *how* this industry could ever imagine itself fit for the task it sets itself when its own practitioners have yet to learn how not to heinously exploit the vulnerable help seeker in their "care". If the "relevant" question really is "whether the difficulties can be successfully surmounted," as Norris et al. have claimed, I would suggest it comes very late in the day and, for that reason, has already been unequivocally answered.[20]

Whether more education would actually help is another issue beyond the remit of this inquiry. The main point is that even if these statistics were halved, *quartered*, such research illustrates the appalling threat posed by the clinician's power. That this threat has yet to bring the practice of mental health care to its knees is remarkable and speaks to its own privilege. Norris et al. note that after suicide, the greatest numbers of malpractice suits are attributed to boundary violation and sexual misconduct among mental health providers.[21] In returning to our conflation, we can begin to appreciate just how averse the clinician may be to the apprehension of proximity under investigation, and how easily conflated it can become with the

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[18] K.S. Pope and V.A. Vetter, 'Prior Therapist-Patient Sexual Involvement among Patients Seen by Psychologists', *Psychotherapy: Theory, Research, Practice, Training,* 28 (1991), 429.
[19] Ibid. p. 431.
[20] D.M. Norris, T.G. Gutheil, and L.H. Strasburger, 'This Couldn't Happen to Me', p. 518.
[21] Ibid.

very real threat of violation. This is the very threat, paradoxically, that our notion of proximity is meant to address and subvert.

8.2.4   Violations A, B and C

Yecheskiel Cohen, who has written on love in the context of clinical practice, suggests that sexual feelings are actually less troubling for therapists to acknowledge and for this reason can be used as a *defence* against feelings of love.[22] This is a compelling argument given our Levinasian perspective of wonder that points beyond institutional praxis and norms and consequently beyond the clinician's capacity. Contributing to the ambivalence and confusion that the experience of love can create in clinical work is that, "many psychological writers tend to identify love with sexuality."[23] Still, if love's appeal and its attending desire are reduced to sexual attraction, as Cohen suggests, then our problematic conflation is simply reasserted.

> [T]he experience or feeling of love is not necessarily the result of drive energy but … another form of love, a nonerotic form…whose existence is difficult …to prove by … science. [E]rotic-driven love is directed toward an object or objects, whereby its aim arises from the wish that the object gratify…the subject. [N]onerotic…love is teleological…directed toward the object, the individual, for his or her sake, and not for that of the loving subject. The most characteristic form of love in this genre is that between parents and children.[24]

Cohen's strategic response to our problematic conflation *sidesteps* the misconstrual of desire as a sexual reduction by associating it with *parental love*. This solves the problem but unfortunately infantilizes the help seeker and maintains the dominance of the (parental) therapist. Nonetheless, he formulates such love as being "beyond science," *purposeful* and, most significantly, aimed at the interests of the *other* rather than the self-gratification of the therapist. Cohen's argument might suggest how this conflation could be challenged, by defining a type of relationship beyond the (scientific) reduction that is not inevitably or solely for the clinician's gratification.

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[22] Y. Cohen, 'Loving the Patient as the Basis for Treatment', pp. 144-46.
[23] Ibid. pp. 140-41.
[24] Ibid. pp. 141-42.

This is but one type of negotiation a clinician may attempt in addressing the conflation under analysis that points to the most feared—gross—category of violation described here as type "A". Its possibility provokes the clinician's hypervigilance and purportedly represents the industry's greatest and gravest concern for the welfare of the vulnerable help seeker who *must never be violated* but who *is*, routinely and predictably. This occurs, not only through type "A" violations, of course, but also those violations *underwritten* in praxis and perpetrated in broad daylight as responsible and ethical clinical treatment. These type "B" violations lie along a very broad continuum of the ethically questionable, as we saw in *Ladies' shoes,* where the main character was denied the right to end his own dialysis treatment. [25] At one end of this continuum, however, we might find the fragile 18-year-old James being soundly humiliated in his first psychiatric consultation for "pretending" to have read or understood a book of Kant's work that he carried around with him like an amulet.[26] At the more extreme end would be my young friend, Julia,[27] incarcerated last year and chemically subdued in a "state-of-the-art" Canadian psychiatric unit against her will for a week without even a formal assessment. When I called the hospital to appeal for her rights, her sympathetic nurse wanted to assure me that in this lovely new institution, Julia was privileged enough to have a private room with its own toilet.

Stigma, the third type of violation—violation "C," was examined in chapter 3 in some detail.[28] We revisit it here to underscore a violation so appalling that even clinicians dread its impact on their own professional lives. Stigma represents a horrendous ongoing hermeneutic injustice for the help seeker, about which she is likely to have exceptionally little understanding in entrusting herself to the care of the institution. Conversely, a clinician knows full well that an admission of mental illness is likely to result in significant stigmatization by her own professional cohort.[29] The aversion to mental health diagnoses among health professionals, and

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[25] See: Ladies Shoes (4.2.1).
[26] See: Chapter 2. pp. 25-26
[27] See: My flower (5.6.1).
[28] See: Stigmatization (3.6.2).
[29] See: A.J. Gray, 'Stigma in Psychiatry', *Journal of the Royal Society of Medicine,* 95 (2002), p.72.

their concealment of mental illness in themselves and their families, apparently

contributes to the suicide rate among medical students and young doctors.[30]

Despite the ideal of the wounded healer, few mental health clinicians are willing to

concede such vulnerability publicly.[31] Stephen Diamond's hyperbole about the

recent "shocking and courageous public confession" of American psychologist,

Marcia Linehan, is a case in point. Linehan, whose work with self-harming women

brought her international recognition, spoke out about her own significant

psychiatric history only near the end of her career because she did not want to "die

a coward".[32] Her story made headlines in North America and testifies to the

enormity of the fear of stigma that she avoided throughout her career.[33] Linehan's

example also crystalizes the violation of a stigma so dreaded that rather than claim

membership with those she treats, a clinician will hide behind the socially

distancing manoeuvre[34] of the clinical reduction to avoid the very stigma she reifies

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[30] Ibid. p. 74.

[31] In my years of education and work in this field, I have heard of only two mental health professionals within my "extended" workplace in British Columbia who publicly acknowledged having "mental illness". Frederick Frese, an American psychologist, is one of very few clinicians to speak openly about his own serious and persistent mental illness in an attempt to invite other professionals to acknowledge their diagnoses and psychiatric histories. See: F.J. Frese and others, 'Integrating Evidence-Based Practices and the Recovery Model', *Psychiatric Services*, 52 (2001), p. 1468.
According to Frese, only a tiny minority of clinicians are willing to take this professional risk. Frese himself has acknowledged knowing only ten people among 137,000 members of the American Psychological Association to speak openly about their psychiatric histories. See: H.P. Lefley, '"Prosumers" and Recovery', *Psychiatric Services,* 64 (2013).

[32] See: S. Diamond, 'Linehan and Jung as Wounded Healers', in *Psychology Today,* (Dec. 30, 2011); B. Carey, 'Expert on Mental Illness Reveals Her Own Fight', *New York Times,* (Jun. 23, 2011).

[33] Linehan's book was used in my Centre in running DBT (Dialectic Behavioural Therapy) groups for (mostly) women who were required to understand, and *agree,* with their diagnosis of Borderline Personality Disorder in order to be accepted into a therapy group. This diagnosis is one of the most derogating and damaging to the mostly female cohort to which it is attributed. See: M. Linehan, *Cognitive-Behavioral Treatment of Borderline Personality Disorder* (London, New York: The Guilford Press, 1993).

[34] The need for professionals to address this issue is briefly discussed in: N. Sartorius, 'Iatrogenic Stigma of Mental Illness: Begins with Behaviour and Attitudes of Medical Professionals, Especially Psychiatrists', *British Medical Journal,* 324 (2002).
See also: O. Wahl and E. Aroesty-Cohen, 'Attitudes of Mental Health Professionals About Mental Illness: A Review of the Recent Literature', *Journal of Community Psychology,* 38 (2010), p. 58. In one review discussed in this paper, 14 of 19 studies showed that while mental health professionals held more positive views about mental illness than the general public, some negative attitudes prevailed throughout. "Negative attitudes were particularly apparent for social distance measures (and) tended to be similar to the public in being reluctant to accept those with psychiatric disorders within their social and occupational circles".

in others.[35] As we have seen, it is type "A" violations—those criminal or abhorrent ethical breaches of trust perpetrated for the clinician's gratification—that tend to be the most readily conflated with the supposed threat of proximity. Nonetheless, types "B" and "C" are arguably more insidious, woven as they are so tightly into "ethical" praxis and authorized by the privilege of the clinician that they become invisible. These are violations that come in through the back door, so to speak, while our horrified focus remains on violation "A," and the convenient notion that this is all the clinician really has to fear and avoid in her "care" of the vulnerable help seeker.

8.2.5 Too much of a good thing: Another conflation

Another perspective of our conflation emerges through the expressed concern that our wonder-full ethical notion could lead to unskilful practice that might harm the help seeker with its *excess*. Here the fear is raised about the clinician who with the best of intentions might still violate the help seeker by "over-reaching" ethically or emotionally.

Birgit Nordtug offers the example of a clinician who, in using a Levinasian framework to treat an eating disordered population, could harmfully impose "limitless love and care" on the help seeker.[36] As Nordtug reasonably argues, such an approach could dangerously stifle or smother someone from this exceptionally fragile clinical population. Yet, I would suggest that such an approach would be an unskilful response to *any* form of emotional or psychological suffering. More relevantly, Nordtug appears to have mis-interpreted Levinas' formulation of responsibility as something that could be somehow imposed or forced on *anyone*.

> The Other is radically other than I which is why she cannot be subsumed under totality or egoism. Nor do I dominate her in apprehending her. She always transcends my ability to bring her into my possession or my own

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[35] Linehan's late "confession" is all the more troubling because of the extremely derogating implication of the "Borderline Personality" diagnosis represented by the cohort with whom Linehan specifically worked.
[36] B. Nordtug, 'Levinas's Ethics as a Basis of Healthcare–Challenges and Dilemmas', p. 61.

identity. The desire for the other is not based on satiation…My initial response is a generous impulse. It is ethical.[37]

Clifton-Soderstrom's summary statement above, neatly underscores the impossibility of Levinas' ethical vision being "imposed," which Nordtug's conflation appears to deny. It is also important to remember we are not dealing with a binary equivalent here with the choice between distance and intrusion that might seem to lie at opposing ends of a continuum. This ethical responsibility is *beyond* neglect *or* imposition in a Levinasian formulation of wonder that finds me consecrated by *and* indebted to the help seeker through her proximity to *me*. Proximity and violation are indeed—and very problematically—*conflated* within the reductive sphere. However, they are *not* antithetical to one another as extremes located at opposing ends of a continuum because *they are on different planes altogether*.[38]

If my unskilful response reflects the gross nature and methods of the legalistic and reductive frame in which my work is transacted, my imposition on the help seeker cannot be blamed on this ethical vision, but on the laws and reduction from which it emerges. Despite the radical clarity and draw of this ethical vision, I am still conditioned and constrained within the reductive sphere of my education, my institution and my world. All the more reason for the clinician to cling to an ethical vision of this wonder-full proximity and the practice of what *ought to be*.

8.2.6 *Beautiful Girl*

> *It was the second time in many months that the eating disorders therapist had asked me to meet with this young woman who was struggling with grief. My interest in grief and loss was known around the Centre and I was pleased to be asked. The knock came at my door. Did I have time? I did. We walked to my colleague's office and I greeted the downcast young woman whose face I hardly remembered from our first encounter. But the story came back as she reoriented me to its details while I sat and gazed at the girl, this lovely young tree being felled by her own misery. She had no idea how perfect, how beautiful she was. She had struggled with an eating disorder and was still contorted by the sorrow of her sister's tragic and unexpected death. She*

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[37] M. Clifton-Soderstrom, 'Levinas and the Patient as Other: The Ethical Foundation of Medicine', p. 452.

[38] See: E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', pp. 8-10.

felt abandoned by her mother who was half demented by the loss of her dead child while confronting the possible horror of losing her only other child to an eating disorder. The abyss, this young woman believed, could neither be crossed nor circumvented. There was nothing to turn to but time for its distant hope, and even that could not be guaranteed if she believed herself incapable of enduring.

The three of us sat together for little more than half an hour but it was long enough for the thing to emerge, this wordless space, deeply quiet but definite as the latch of a door being opened. There was no emotional outburst, no lusting after outcomes. For what could be said, after all, that she had not heard a hundred times in the course of her therapy? Pauses ensued, during which she filled in a few more spaces of the difficult story. My colleague and I, the witnessing women, sat grave faced, empty handed and disturbed by the extreme suffering of this broken girl we could not even hold in our arms. Yet, the opening continued to deepen through the play of our quiet voices, our attention, the acknowledgment of the mystery of such annihilating sorrow, the possibility of enduring, the preciousness of life—her life.

At one point the room became stagey with thick sunlight that strayed through the cloud cover of the overcast day and fell through the office window that was reinforced by thick black bars. The girl's long brown hair cascaded around her shoulders like a halo, its silken sheen momentarily captured by the sunlight, her tear-stained face iconic, her young hands quiet in her lap, the tissues she held like white flames.

I spoke a long while; it felt like a soliloquy memorized by heart, and told her what I knew and had to believe, which was little enough. But I was in the thing with her, we were swimming together in its vastness and the presence was all around. When I had finished saying what there was to be said, a moment came when the tender joy washed fully and finally over me, drawn up as it had been from this deep well. Then I said the only thing left to be said which was clinically inappropriate but wholly true. "Beautiful girl," I said, as though she was my own, as though I might never see her again and she met my eyes. Having nothing further to say and because it seemed that my part was done, I wished her well, said goodbye and left the room.

My colleague later commented on those two words she had noticed, above everything else, that had said more than they might seem to mean. Something about them and their saying had stayed with her that she wanted to explore.

It was months later in the noisy crush of our big city fair, on the midway amidst the screaming rides, the flashing coloured lights, the smell of frying food, that a lovely young woman rushed up to greet me, smiling, waiting expectantly for me to be equally happy to greet her. She was only vaguely familiar but her delight showed how clearly she remembered me, intimately enough to greet me like some long lost friend. I had to ask her to remind me who she was, but even this couldn't quell her

joy in our unexpected reunion. Then she told me how it had all worked out, that it was better now, there was possibility and happiness and I had been part of that process and discovery for which she was so grateful.

I walked away from our encounter dazed, incredulous to have been found here, amid the deafening noise and glare of a midway at dusk by this beautiful girl. In whose life I had played so insignificant a role, whose name I had not even remembered, but who had come so far to recognize and bless me.

8.2.7   *Palliation, transformation, mis-interpretation*

Throughout this thesis, the issue that has continually emerged is whether wonder should be understood as a refreshing *palliative* for the beleaguered clinician or as something transformational and morally galvanizing. I have suggested that palliation is not sufficient to *transform* the clinician's perspective, fire her moral outrage or allow her to confront the horror of the help seeker's plight to which she contributes so greatly. Yet, in the example of *Beautiful Girl* the question of transformation or palliation is transcended. This story illuminates the ineffable in a moment of radiance and communion that makes this question irrelevant because it *melts* the constraints of the reductive imposition, the arbitrariness of the differing roles of the characters, and the insufficiency of the therapeutic paradigm altogether. It does so to such an extent that all three characters are significantly "moved," or possibly refreshed *and* transformed. *Something happens* beyond the orchestration, imposition or control of any of the three players. A deeply satisfying—*socializing*—result occurs and not immediately, but also over time.

Yet, I would re-assert that our Levinasian construal of wonder is no mere palliative nudge but a cataclysm of proximity capable of shattering the clinician's entrancement with the status quo, if only briefly. Even if this cataclysm can only toss the clinician back up against the closed door through which even Levinas was unable to venture, it might at least keep her from running back through the institutional door of least resistance. This is the door behind which the mental health clinician hides and defends herself, and the status quo, from the *real* danger posed by this proximity and the help seeker's ethical call. For this is the call that evokes the clinician's overwhelming yearning and compels a reverence that utterly

contradicts the security of her privilege and the legitimacy of the enterprise in which she colludes.

In returning to Nordtug's example of the well-meaning but intrusively "responsible" clinician, we confront the real possibility of the clinician's failure to communicate or transact the ethical response she apprehends and intends. Such failure might even be predictable but Nortug's analysis still errs in conflating proximity with violation. For, we could equally credit our well-meaning clinician for her integrity and courage in *attempting* to counter-balance violations A and B, and C, no matter what the outcome. Even if our "misguided" clinician only wanted to assuage her sense of professional guilt, helplessness or fear in the face of the suffering of an eating disordered patient, I would argue that this attempt at an ethical response should not be dismissed. Otherwise, we risk vilifying, diminishing or overlooking the morality of her *desire,* and of conflating violation with proximity yet again.

More importantly, we risk dismissing the ethical potential of Levinas' vision in our therapeutic project altogether. Nordtug concludes that the risks involved in employing Levinasian ethics in a therapeutic context make his work ultimately unsuitable for our purposes because the possibility of misinterpretation is too great.[39] The risk, she claims, is that clinicians or theorists bringing his work into the therapeutic conversation are not immune to errors of interpretation or the temptation of making Levinas fit into *their* theories. But I would counter that the conversation with Levinas' ethical vision has hardly begun and for that reason cannot—*must not*—be so quickly dismissed on those or similar grounds. I would add that none of these concerns, including the question of whether wonder is best understood as moral refreshment or ethical and political transformation, indicate that the problem lies with Levinas or the ethical construal of wonder.

The difficulty clinicians may have, and surely *will have*, in learning to interpret, speak and practice an ethical language in and against the reductive clinical environment cannot mean they should not try. Moreover, great care and

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[39] B. Nordtug, 'Levinas's Ethics as a Basis of Healthcare–Challenges and Dilemmas', p. 62.

discernment will be required in negotiating not only the risk but also the *fear* of harming the help seeker. This is always the deal breaker most likely to provoke the clinician's premature dismissal of the radical ethical possibilities under consideration. The consequence of which will almost assuredly re-consign her to the proven and familiar "ethics" of the institution and praxis where the help seeker's reduction is reified and her dehumanization ensured. However, the enigma that is my responsibility is surely never the problem, nor can I ever be finished with it as Levinas claims. "[A]s responsible, I am never finished with emptying myself of myself."[40]

8.2.8   Tigers above, below and on all sides

When we begin to look, evidence of this conflation emerges wherever an attempt is made to *increase* the ethical integrity of practice by *decreasing* the distance between the clinician and the help seeker. How researchers stick-handle this problem is fascinating given the intractable nature of the conflation and the variety of solutions forwarded for its subversion. These "solutions" are all the more fascinating given the researcher's chronic fear that any attempt to address the issue of clinical distance will be *mis-understood* as potentially violating. Whatever solution is offered must *never* appear to pose a risk to the help seeker or, more importantly, to erase the line that *separates* the clinician from the help seeker. This is the line must be constantly monitored and defended, ostensibly for the protection of the help seeker but ultimately, I am arguing, for the benefit of the system.

In the opening vignette of this chapter, evidence of this threat is discovered in the stony resistance of my colleague to my query about her love for a self-harming patient, to whom she has been devoted for so long.[41] Yecheskiel Cohen responds to this threat by *reconfirming* the clinician's dominant role in the guise of the benevolent parent. But, as previously noted this can only be accomplished at the expense of the help seeker who now, in addition to being systemically reduced, is infantilized as well.[42] Birgit Nordtug's response to the threat is to deflect it by raising the concern of the possible violation perpetrated by the well-intended but

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[40] E. Levinas, 'God and Philosophy', p. 144.
[41] See: Thou shalt not love (8.2.1).
[42] See: Violations A, B and C (8.2.4).

unskilful and over-reaching clinician, and to dismiss the possibility of proximity as well as a Levinasian approach to care on these grounds.[43] Professor John Swinton has confronted the threat of conflation by forwarding the solution of friendship while acknowledging that his argument will likely raise the same defensive arguments we have already discussed here.[44] Swinton's notion of friendship leans heavily on Jean Vanier's model and is both compelling and humane. But such friendship cannot be transferred to the enterprise of community mental health care where the clinician's power *is* law. To imply otherwise is not only to spin our wheels in the kind of secondary ethical tasks Irigaray warns against, it is to deny the absolutely breath-taking *legal* power wielded by any clinician in the institution. Interestingly, even Clifton-Soderstrom, who speaks entirely for a Levinasian approach to ethical medical care, cannot resist acknowledging this conflation by assuring the reader that what she intends with her Levinasian orientation is *not* for the gratification of the clinician. Yet, within the reductive framework, *it will be* for her gratification and self-interest, for it cannot fail to be.

It does not matter if the researcher assures the reader that she means proximity in an *ethical* way, a *good way*, intended only for the help seeker's benefit and the subversion of the reductive institution. Because the frame in which this argument is constructed and which, ironically, *motivates* the researcher to urge her colleagues ethically forward in the first place, also requires her to continually warn them back again. *Get close! Not too close*! Because everybody knows what happens when we get too close. Or do we? The conflation triumphs nonetheless. For, the dominant discourse *deflect*s any notion greater than itself to the default position of its own common denominator. This leaves even the most hallowed and radicalizing notion of proximity as an abuse of power in the making because *there is no other* frame of reference. This effectively pre-empts the safe passage—*any* passage—of even a notion like wonder to its moral fruition. By which we mean the larger—unknown—ethical implications of this *wonder-fully* elevated vulnerable help seeker to the abject and *ambivalent* clinician who confronts her.

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[43] See: Too much of a good thing: Another conflation (8.2.5).
[44] J. Swinton, 'Does Evil Have to Exist to Be Real? The Discourse of Evil and the Practice of Mental Health Care'.

So great is the aversion to this taboo—this *firewall*—against proximity, that the clinician might actually appear to *prefer* the help seeker's reduction if only to avoid the risk of appearing to harm her. The even greater concern for the clinician is that she will be seen as a threat to the institution which could cost her everything. The alternative is for the clinician to continue to acquiesce, to *comply* with the reduction that will deflect, defile and dilute even her most genuine efforts on the help seeker's behalf while undermining her sense of integrity and trustworthiness.

If the clinician is not to assume the wonderful clinical encounter for her own private and exclusive consumption, however, the proximity with which we are struggling will have to propel the clinician towards the work of change that will come at a significant personal cost. The implications are suggested in *Tread lightly!* For, I am reprimanded by my managers for commenting in my clinical notes on the distress of a disabled client who was being humiliated by his probation officer.[45]

8.2.9   A ride on the mule of wonder

> The distrust of introspection, of self-analysis, in our psychology, is perhaps only a consequence of the crisis of love and religion; it derives from the discovery of the true nature of the social.[46]

The wonder-full proximity for which we are calling in this inquiry is, on closer investigation, scarcely if ever absent in even the most mundane and minute transactions between the mental health clinician and the help seeker. It features so prominently, that the clinician might appear to be continually falling over the ethical issues it raises although these may not be immediately apparent. Yet, from the angle we are about to examine, the clinician's failure to ethically respond seems incomprehensible. This is because, the wonder that ignites the clinician's moral fire, confirms her yearning and extends its tender reception to her, is under the aegis of the very person she is at greatest risk of harming.

In turning to wonder for moral authority, I discover myself *under* the authority of the least endowed for help with the task of remembering *who I am* so I can avoid harming her, and *she tells me*. The help seeker's misplaced trust in me and in the

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[45] See: Tread lightly! (3.4.2).
[46] E. Levinas, 'Entre Nous: Essais Sur Le Penser-À-L'autre', p. 23.

institution cries out for my protection. Her willingness to nakedly, and unwisely, bare herself in seeking a reason and respite for her pain exposes her defencelessness that demands I dignify and protect her. *Nothing* is concealed. She is terrifyingly innocent of the machinations of an institution about which I am all too aware and which she desperately needs to understand at what is likely to be one of the lowest ebbs of her life. The "service" and "treatment" that await her, if she is successful in getting through the doors of the institution, will be endured at no small cost and without her full understanding of what she is undertaking.[47] In sum it is here, in this horrifying subtext, where the clinician discovers the help seeker's authorization and prescription for a very different kind of dis-ease to which she may not easily respond, if at all.

Herein, the enslavement of wonder is discovered again in a remarkable contortion of the awe-struck clinician believing that the *privilege* of accurately *seeing* the vulnerable help seeker is the end point of the moral vision. That is to say, that her experience and expression of awe are a sufficient response to the help seeker's question—her *plea*—that remains *ignored*. How can we account for this astounding oversight? It appears related to the problem of the reduction beyond which the clinician cannot see, let alone imagine. Yet, if this is so, the clinician will only ever perceive the "Other" as a special privilege—hallowed perhaps—but meant entirely for *her* gratification.

This remarkable convolution might seem to constitute the fatal flaw of any argument for wonder in clinical care, for here, the help seeker becomes the *mule* who takes the clinician to and through the wonder-full encounter. This intractable problem lies not with wonder but with the reductive system we wish to subvert that continually clones wonder to its purpose and perspective.

In failing to recognize wonder as the unequivocal ethical relationship Levinas describes, the clinician unknowingly submits the help seeker to an altogether invisible but *scandalous* level of mis-use. For, having survived everything she has endured as a result of her reduction, the help seeker now becomes a radiant source

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[47] See especially: Chapter 2.

of inspiration and gratitude for the dis-spirited and de-moralized clinician. The echoes of which were heard in the reverential murmurs of the clinicians and clergy described in *The Church*.[48] Indeed, clinicians can hardly resist sharing such enchanting experience even while it jars with the implications of ownership and the shame of "privilege". Nonetheless, the clinician surely will find in the help seeker the respite to her own self-interest that she may earnestly *wish* to relinquish but will likely fail to release. Instead, the help seeker is edified through a spiritual "experience" that humbles and overwhelms the clinician while leaving the help seeker empty-handed of everything except, perhaps, the clinician's reverential expression of gratitude for the "privilege" of "serving" her.

This is the problem identified by feminist critics of Levinas' work, especially Luce Irigaray, who as previously noted, attempted to correct Levinas' formulation of the Other.[49] His interpretation of alterity that he equated with the feminine is what enables the transcendence of the subject. As Irigaray has shown, this transcendence occurs at the expense of the feminine whose position remains subordinate and unchanged. We find an equivalent dynamic within the therapeutic relationship where this transcendence is accomplished *on behalf of* the clinician. Here, the subordinate help seeker—transfigured or luminous though she may appear to the reverent clinician—remains nonetheless outranked, disadvantaged and exploited.

There is no clinical equivalent or response for this peerless reception that is ultimately "consumed" as a reward by the clinician for her privileged exposure to the vulnerable help seeker's most compelling injury—*the reduction itself*! This injury is the one to which the clinician inevitably contributes and from which she *always* benefits. Of course, the clinician's response also *de*-moralises her because it constricts and defiles her relationship to the help seeker before it begins. This leaves wonder and the clinician herself as totalized as the help seeker, bonsaied to the size of the very reduction she wishes to address. This is the reduction into which wonder must *be made to fit* so as to pose no threat to anyone, least of all the clinician and the hierarchy in which she is situated.

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[48] See: The church (6.6.1).
[49] See: Critique (6.8).

As we have seen, it is very difficult to find a clear demarcation between the different "types" of violation we have examined here. They bleed together, the illegal and the legal, the gross and the implied, the unjustifiable and the legally defended. Consequently there appears to be little or no difference between the violated and the treated, the stigmatized and the rehabilitated, the exploited and the revered. These violations are devastating to the vulnerable help seeker. They are also devastating to the clinician standing in the shadow of the institution holding a broken moral compass while the promise of ethical proximity is erroneously and predictably cast as the prime suspect of violation.

8.3 Awareness, resistance and language

To see, speak and act beyond this conflation, clinicians must develop greater awareness, but the challenges are great. Patti Lather suggests that "piercing through the theory and the jargon and arriving at a greater understanding of social forces" is something we can only achieve with advanced education.[50] Still, this kind of education does not lead the primary interests—or inform the methods—of a medically driven reductive enterprise like community mental health. Instead, it separates the individual from her story and social context in order to accurately— *scientifically*, *measurably*—isolate and identify pathology and predict outcomes. *Any* clinician seeking the awareness Lather describes will have to work very hard to go against this grain, if only to *see*.

Similarly, Grace Jantzen suggests that members of oppressed groups—and those labelled mentally ill surely qualify, including those who represent them—must exert real effort to become conscious of the situation in which they are mired. This will not occur, Jantzen observes "by simply contemplating but by being willing to work for liberation," which necessitates putting oneself in harm's way by working for justice with "its concomitant risks".[51]

These are risks associated with the clinician's moment-to-moment decision to look away, to endure, to keep her moral outrage and distress to herself, to decline the

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[50] P. Lather, 'Issues of Validity ', p. 76.
[51] G. Jantzen, 'Becoming Divine: Towards a Feminist Philosophy of Religion ', p. 121.

invitation to engage on behalf of the help seeker. They are also associated with her professional armature, groomed by institutional indoctrination and girded by her authority and legal power. This armature, burnished by the entrenched practices of "clinical" distance enables her to apply theories, labels and acronyms to people enduring lives of penury, complexity and humiliation she is never likely to experience. Thus, can our clinician manipulate any affiliative emotion or gesture as a tool for *her* benefit.[52] She is insulated from being even *touched* by an awareness of this help seeker as *herself,* and of something *beyond* that calls in this wonder-full language into the unknown.

Conversely, the clinician is finely tuned to the exquisite resonance of this wonder-full ineffability that offers such reward and consolation within the de-moralizing institution. The therapeutic alliance, so called, may well be the most gratifying aspect of this kind of work, to which Carl Rogers' oeuvre fully attests. Professor Martyn Evans' appeal for a place for wonder as moral refreshment also testifies to this enigmatic and ethical call, through which the clinician may become "more nearly complete as a result of hearing and understanding".[53] Yet, the clinician's moral response to this resonance remains problematic and unresolved. Firstly, because it is so tightly conflated with the fear of violation but also, because there is no language within the reductive sphere capable of reflecting the integrity of this kind of consciousness.

8.3.2   *The language of proximity: A final digression*

The theme of language has recurred throughout this inquiry[54] particularly in the context of Levinas' work, and in the conflation under analysis given its connection to the thorny issue of eroticism.[55] Bernard McGinn's excellent essay on the language of love in mysticism provides some clarity on this issue.[56] As he explains, some mystical writers are infamous for the language of erotic love they used to capture

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[52] For an exceptional synthesis of this this issue, see: M.T. Taussig, 'Reification and the Consciousness of the Patient'.

[53] Here, Evans refers to his own ecstatic response to a piece of music. H.M. Evans, 'Transfigurings: Beauty, Wonder and the Noumenal', p. 7.

[54] See especially: (1.3.1, 1.3.3, 3.4.1, 6.5, 7.1).

[55] See: The language of wonder (6.5).

[56] B. McGinn, 'The Language of Love in Christian and Jewish Mysticism'.

the ineffable—a quality beyond "the usual categories of knowing and loving".[57] Indeed, notions of desire and need, of tenderness, belonging and *wonder* abound in mystical literature to describe the union with God.[58] This issue impinges sufficiently on our discussion to justify a few observations related to the clinician's chronic anxiety about proximity.

According to McGinn, the connection between the erotic and the evocation of the divine in mystical literature is still under scrutiny and not fully understood. He suggests, that in Christianity and Judaism this connection reflected a view of God as both lover and love. For example, the early influence of the *Song of Songs* was, among other interpretations, understood to describe the relationship of God to the individual.[59] Far from representing some distant abstraction of goodness or of sexual sublimation, these evocations attempted to translate something both transcendent and deeply personal. The embodiment of such desire is not necessarily more important than other forms of love, McGinn cautions, but possibly more powerful—absolute—in its evocation and more valuable, for that reason.[60]

Such language also reminds the clinician—and *should* remind her—that there is *nothing* "appropriate", or "objective" or "safe" in discovering oneself reverent or awed in the presence of the vulnerable help seeker. Far from being neutral, this event announces a revolution that subordinates the *clinician* to the help seeker whose priority within the institution, as we have seen, falls below even the administrative staff answering the phones. This extraordinary subordination is one to which Levinas' work fully attests. For, unlike the *clinician's* institutionally assigned height that distances *and* reduces the help seeker, this wonder-full height asserts the help seeker's *proximity* and alterity, or as Robert Gibbs reminds us, her *perfection*.

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[57] Ibid. p. 226. p. 226.

[58] See also Don Cupitt's description of how medieval mystical writing attempted to evoke union with God in the terms of female sexual response. D. Cupitt, 'Mysticism after Modernity', p. 25. See also: C.W. Bynum, *Jesus as Mother: Studies in the Spirituality of the High Middle Ages* (Berkeley, Los Angeles, London: University of California Press, 1982), p. 138.

[59] B. McGinn, 'The Language of Love in Christian and Jewish Mysticism', p. 206.

[60] Ibid. p. 205.

"Height stands as the dimension of perfection, largely because of the asymmetry and the general sense of the escape of the other from my horizon." Levinas, Gibbs notes, shifted the emphasis of height to *proximity* in order to avoid limiting the transcendent to the idea of height.[61] Height does not evoke ethical transcendence as much as the idea of closeness, the *approach* of the face, or the nearness of the Other and the responsibility this implies.[62]

This proximity also refutes any notion of "mutuality" or "reciprocity," the former being an integral aspect of Carl Rogers' theory of change.[63] For no mutuality can ever be found in this "wonder-full" transaction as an imaginary meeting point of "equals" discovered somewhere between the downward trajectory of the awed clinician, and the upward trajectory of the elevated seeker. No matter how "elevated" the help seeker may appear to the stunned and humbled clinician, it is always within the clinicians' capacity, indeed her jurisdiction and mandate, to exploit and harm. Moreover, as Levinas reminds us, my responsibility is unilateral and always trumped by any question of reciprocity. "I am responsible without waiting for his reciprocity were I to die for it."[64]

Thus, the language of love, desire and need is the "language of proximity," a language with a long history within the mystical canon that has subversive and contemporary implications for this inquiry. Yet, this language also poses a tremendous challenge to the clinician ever vigilant of its double meaning, given the problem of the conflation we have analysed. Yet, this language that Levinas employs in his ecstatic flight of words is one from which clinicians can also learn and *discern*. Far from representing a violating threat, it confirms an ultimate social bond and a unilateral responsibility that annihilates the clinical reduction.

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[61] Levinas asks: "Rational theology, fundamentally ontological, strives to take account of transcendence in the domain of being by expressing it with adverbs of height applied to the verb being; God is said to exist eminently or par excellence. But does the height, or the height above all height, that is thus expressed belong to ontology?" See: E. Levinas, 'Collected Philosophical Papers', p. 154.

[62] R. Gibbs, 'Height and Nearness: Jewish Dimensions of Radical Ethics', in *Ethics as First Philosophy: The Significance of Emmanuel Levinas for Philosophy, Literature and Religion,* ed. by Adriaan T. Peperzak (New York, London: Routledge, 1995), pp. 13-23 (p. 16).

[63] See: Reciprocity and mutuality (5.6.3).

[64] E. Levinas, 'Ethics and Infinity: Conversations with Philippe Nemo. 1982', p. 98.

8.4 Conclusion

> By virtue of its intentional structure gentleness comes to the separated being from the other. The Other precisely reveals himself in his alterity not in a shock negating the I, but as the primordial phenomenon of gentleness…The welcoming of the Face is peaceable from the first, for it answers the unquenchable Desire for Infinity".[65]

There is much to be done in bringing wonder into the clinical conversation when the ethical proximity of the Other is at such risk of being conflated with violation. Yet, the moral clarity of wonder is still unparalleled in interrogating the reductive scheme and illuminating the moral confinement against which Luce Irigaray rails in assessing the current state of affairs:

> Is not what is offered already within a horizon that annihilates my ability and my will? ... I am, therefore, a political militant for the impossible, which is not to say a utopian. Rather, I want what is yet to be as the only possibility of a future.[66]

In working towards this unknown possibility, Levinas' wonder-full vision shows the clinician the profoundly moral implications of even the slightest "clinical" exchange such as we find in the example of *Daisy May*.[67] May asks the group why she should bother getting up in the morning when her monumental efforts to do so have yielded no reward and left her as isolated and ignorant as ever. In response, I concede my private support to May through a shared, conspiratorial glance I hope will assure her of my alliance. But my gesture reduces her once again because I allow her to be humiliated.

In failing to publicly acknowledge May's courage and the accuracy of her observation, I protect myself, the therapeutic program in which she is enrolled, and the institution, all at her expense. This example illustrates the ethical enormity of the clinician's connection to the help seeker in even the most incidental transaction. It also illustrates the clinician's blindness, insincerity and naivety in apprehending the defenceless help seeker whose proximity is *always* there and whose entreaty the clinician is always ignoring, running from, or unravelled by. For, as I note in the

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[65] E. Levinas, 'Totality and Infinity: An Essay on Exteriority', p. 150.
[66] L. Irigaray, 'I Love to You: Sketch for a Felicity within History', p. 9.
[67] See: Daisy May (7.2.5).

story of *Sharon*, "I am already in *up to my neck* with this woman before the question of how I am to help even emerges".[68]

It would be unfair and untrue to suggest that such private acts of heresy are lost on the help seeker or not some credit to the clinician. Although, such gestures might be more accurately construed as apologies or confessions of moral cowardice, for the clinician's privilege and power remain unscathed. This poignant truth was clarified near the end of my work with James in my final heartfelt attempt to liberate him from his institutional oppression.

> *Ultimately it seemed to me that my most important task was to help James recognize and reclaim his place in the human community. I wanted him to grasp that we – the world around him—needed him to join us for his own benefit, certainly, but even more pressingly for ours. In one of our final meetings, logic spun on its head the day I carefully explained to James that the very system he had come to for help was the same one that created and maintained his sense of exile – both inside and outside institutional walls. He listened carefully, quietly, the day I played that card, placed the final revelation of institutional complicity in his hand. "Do you understand me, James? Do you understand what I'm saying?" He was so young. Yet, even with this confession I could not sidestep my personal role in his alienation despite what had been my best intentions and many attempts to subvert and resist the institution. Paradoxically, and painfully, my sense of guilt was further complicated by the very love that had emerged and driven my desire to keep him safe and help him understand and touch the transcendence he sought.*

Here again the help seeker—James—is conscripted as the mule for this clinician's wonder. Despite accepting the ride ambivalently, even regretfully, I still ask him to absolve me of my guilt when I suggest that he can do more than I can do, either for myself *or* him. I am obliquely encouraging him to challenge the system by resisting it, by not falling prey to a reduction that I help impose. This system also rewards me even while it casts doubt on the value of the "metaphysical passion" James pursued and brought to our "therapeutic" conversations, to my great benefit and joy.

From whatever angle we examine wonder, it seems this consecrated "welcome home" of the clinician by the help seeker is deadlocked, its very prohibition enforced by a clinical relationship and a reductive enterprise that denies and

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[68] See: Sharon (6.4.1).

distrusts even its possibility. Such is the enormity of the threat posed *not* to the vulnerable help seeker but to the *clinician and the institution*. For what is hidden and must never show is what this relationship means *to the clinician.* The clinician can only warily state what this relationship means to her for many reasons, chief among them the anathema of potential abuse and her daunting authority over the help seeker.

Such defensiveness might arguably confirm the clinician's unstated discomfort with the imbalance of power she reluctantly or ambivalently holds. Yet, if we are to heed Levinas' denial of reciprocity and assert the elevation that is proximity, there can be no argument that the clinical relationship in community mental health care will ever be defensible. Indeed, the desecration of the holy Other is completed where the primary argument for clinical distance is upheld even less by the horror of harming this vulnerable help seeker than of actually loving her.

This fatal flaw remains almost unaccountably elusive to the question raised by medical humanities scholar Professor Jane Macnaughton who asks "why it is that the humanities (including philosophy) have not managed to lay the 'killer punch on medicine's atomistic viewpoint."[69] Her question suggests the need for the reductive viewpoint to be somehow "out-gunned," by all who, not incidentally, race to defend its primacy.

Paradoxically, the solution resides not in a punch but in a sigh, a tender vulnerability, a whisper expressed in the welcoming regard of this defenseless help seeker. Her nobility is both instructive and inviolable despite my pathetic attempt to shield myself from her beauty and protect her from my violence. Above all, the *welcom*e of this help seeker's face demands a response from the clinician beyond gratitude and awe. By which I mean, something greater than the grotesque assumption that somehow, by simply noticing, feeling and articulating the "great privilege" of being called by the face of the other, the clinician has somehow morally responded to it.

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[69] J. Macnaughton, 'Medical Humanities' Challenge to Medicine', p. 927.

Nor would I agree that wonder is a secondary ethical task, although our limited approach to its "employment"—its "application"—enforces its current diminution.[70] Macnaughton's suggestion that the solution lies in the revisioning of medicine echoes Irigaray's warning. Such revisioning must also build on analyses related to the difficulty we have *seeing* this reduction and of *conceding* the real personal costs of having to undertake what we are not yet willing to sacrifice. As it stands, the transcendent notion of wonder delivers much less than we might reasonably expect while constantly referring us back to the issue of its enslavement and exploitation by the clinician and the authorizing institution.

For this reason, we must take care in promoting any definition of wonder for the purposes under consideration. To assume wonder's potential as an antidote to clinical reduction, or refreshment from the impact of this reduction, is to miss the larger point. This is the point discovered in the predictable defilement of *anything* introduced into the clinical dialogue to counterbalance the status quo, no matter how pristine or novel. Evidence of which is continually discovered in the clinician's implacability and inability—through torpor, fear, uncertainty and ambivalence—to step beyond her role or the confinement of the authorizing institution, into the relationship to which wonder calls her. We may agree that the final evidence for an ethics of wonder capable of surpassing the help seeker's reduction lies tantalizingly close to the paradox of the clinician being *found* by the Face of the other. This is still not close enough to ensure the success of our wonder-full project, which is to *protect the help seeker from the clinician*.

Wonder *annihilates* the cherished illusion that the most, and *only*, needful member in the clinical relationship is the vulnerable help seeker. This is the lie laid bare by the transfigured face of the help seeker who is *not* served first and best by the clinician within a hierarchy that subordinates and reduces them both. Paradoxically, the clinician's recognition of her need and desire for the help seeker, as Vanier has shown, is the most subversive in challenging the clinical reduction and the

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[70] Amy Hollywood observes that both Simone de Beauvoir and Luce Irigaray note that individual change is impossible without societal transformation. See: A.M. Hollywood, 'Beauvoir, Irigaray, and the Mystical', p. 174.

hierarchy that ratifies it. It is a powerful and persuasive notion for any ongoing consideration of wonder towards which Levinas' vision continually points. It is also an admittedly slippery notion to grasp and sell within a hierarchy that requires the reductive framework to survive.

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