Careers in Mental Health!
A Diagnosis of Mental Illness is the Only Qualification You Need.

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"because you never know, it may very well be that literature is uniquely positioned to reveal much more about life than life is about itself." (Vyacheslav Pyetsukh, The New Moscow Philosophy, Twisted Spoon, Prague, 2011, p51)

I don't know much about science. Although I studied mainly science subjects at school, I found them, frankly, tedious; too inflexible, or so I thought at the time. I preferred to make things up. Good training as it turned out, it seems I have been at it, out of necessity evidently, making up a life for myself, ever since. Yet now I find myself thinking about science, a science of *experience*, about what such a thing could be. And the answer I have come to: it could well be *literature*.

It should be no surprise then that I would like to speak from within the *cone-of-experience*. From this position, I do not, I cannot, talk about illness. From this position there isn't one. No one, I believe, actually *experiences* mental *illness*. What people experience is the *diagnosis*. Experienced too of course are the consequences of a diagnosis. In fact, as we know, whole careers begin with diagnosis.

As it has come to be experienced, diagnosis is a kind of detective work. A certain attitude is required. This attitude can be described as the Sherlock Holmes view of human character: there are no mysteries, everything that needs to be known can be known, one has only to know what to look for, and how to look for it.

This is how Holmes goes about solving mysteries:- Step one: he puts himself in the position of the other and imagines what, in the same circumstances, being that other kind of person, *he* would have done, or thought or felt or believed.

Step two: he reconstructs the chain of circumstances which he is imagining himself into the midst of, being that *other* kind of person of course, he would never have got *himself* into such a mess; he ties himself up in the very knot he wants to unravel.

This reconstruction is accomplished by starting right now, right here, in the present moment, faced with the body, the crime so to speak; or the suspect. We are fortunate indeed; perhaps indeed we are fortunate, for we, unlike Holmes, always begin with a suspect. What is in doubt is the crime. We are not yet sure

whether a crime has occurred, but we already have the suspect.

From the present moment then, travelling back, far into the past, to reconstruct, from its very beginning, in someone else's history, the sequence of events that led up to the present moment, correctly accounting for every significant event, and passing on, without pause, beyond the present, into the future, not too far into the future though, a few minutes at most, we wouldn't want to lose our grip, to the inevitable denouement waiting just up ahead, the inevitable denouement is always waiting just up ahead, the revelation of who did it, the guilty party; or the dirty deed itself, the presence of a mental illness. We complete the *story*. For story it is. Apply to it the full stop of fact. Of certainty. Of the certainty that in order to have done what the other has done, or thought or believed, we would have had to be mad. Case closed.

This is what I like to call the *whodunnit,* perhaps more aptly the *whatdunnit* approach to diagnosis. And it is where we remain today, stuck fast, despite our marching under the glittering, star-studded banner of person-led recovery, because we fail to recognise the aspect of storytelling inherent in the process. Of course there is more to it than simply spinning a good yarn; but the power and persuasiveness of skilled storytelling, and the insights it offers, cannot be ignored.

A bit of literary theory will I think be helpful here; the difference between story and plot, according to the Russian formalists at least.

The *story* is the list of events in chronological order; that is, as they happened.

The *plot* is the list of events in order of presentation; that is, as they are told.

The story consists of the facts of the matter, the events under consideration. They are gathered by observation; by attentive reading, or by interrogation, astute questioning; anyone who does this will, we say, or should, get the same results. Of course there is a prior selection process, decisions already taken about what will count as the relevant events in a person's life; the incidents that arouse suspicion; the bona fide facts of the matter.

The storyteller is the diagnosing clinician, and not the person undergoing assessment, this is the root of the problem, right here: the person undergoing assessment is not granted, must not be allowed, the *authority* of their own story.

The diagnosing clinician simply applies rules that determine what events to look out for; events that will, when discovered and placed in the real-time order of their occurring, make up a story.

Having laid out the events, the storyteller next *reassembles* them, and this is the crucial step, the reassembly is essentially a process of *plot-making.*

Yes indeed, someone is plotting! And it isn't me. The story is mine; that much I grant you; but what is this, could someone be plotting against me?

A plot is a calculated ordering and juxtapositioning of the events deemed significant; an interpretation; the imaginative reconstruction of a state of affairs, a representation of someone caught in the act of being that someone in particular; and a judgement upon that act, upon the performance of being that someone in particular. And all encoded, invisibly sewn into the plot.

The business of the plot is to reconstruct the story; to give it meaning, significance. This process employs some of the tools of literature. But in so doing it must leave life and *become* literature. To reconstruct reality is to construct literature. To create it.

Shall we say then that diagnosis is a random act of literature?

If the story is of someone undergoing assessment for a mental illness, the judgement will be of the presence or absence of that illness. And the plot will lead inexorably to that judgement.

The events that make up the story can usually, if not always, be plotted in any number of different ways. And their final order, the precise arrangement of events, will significantly influence our perceptions of each event and determine what meaning the whole is given.

Think of Russia again, of Eisensteinian montage. Change the order of the parts, sometimes of only two words, or images, and the meaning of the whole changes; or collapses altogether. Different meanings can thus be derived from the same set of events. Plot is the creator and carrier of meaning. And meaning is in the mind.

But in whose, in whose mind are we now? In whose mind does meaning dwell? In whose mind does someone in particular's meaning dwell? Where, for example, is mine? Meaning, that is. Or mind.

It is fashionable nowadays to downplay diagnosis. Yet it remains the necessary condition for being treated; being *formulated* so to speak, *managed*. If there were no diagnosis of mental illness, or no indication of the likelihood of mental illness, no presence even of a posturing lookalike, there could be no justification for any kind of clinical intervention.

But storytelling does not end with diagnosis.

There is a line that connects the process of initial assessment with its culminating moment of diagnosis and which then fans out into the many branch lines of formulation before focusing again and zeroing in on what will be its final destination, the promised land of the management or recovery plan. Management or recovery, recovery or management, as if they were interchangeable!

This line has great difficulty coming to an end; it tends, if left to its own devices, to go on ruthlessly spinning out a never-ending story, a career for someone. Recovery speaks of journeys without destinations. The light at the end

of the tunnel shines on the end of the tunnel, futilely, and not where it would be of most use, right here! To see exactly what shit our feet are stuck in.

The line is a narrative line; if it has been well-crafted, for that is what is going on, crafting, it will obey the principles of narrative structure. Everything that happens along it will be storytelling. Plotting.

How the world brims over with plots! Fifty-seven varieties! A dangerous and contested place indeed.

Especially so for someone undergoing assessment for a possible mental illness. The diagnosing clinician searches for signs of illness. The person undergoing assessment, on the other hand, reacts to the assessment, *to being assessed*, and *not* to the possibility of illness.

There isn't time now for the whole story, of the experience of the person undergoing assessment. A few words though. One doesn't so much walk the line as stumble along it. Everyday relationships are suspended, according to the rules, and the established, putatively scientific discourse of mental health, or illness, or psychiatry now prevails; a discourse within which the diagnosing clinician can confidently move about. The same cannot be said for the person undergoing assessment. There is this proviso: the first move has already been made; the rules of the game have been set; someone has blown the whistle. Thrown the first punch. The person undergoing assessment is under suspicion and in the dark, forever faltering one step behind. Not knowing what the diagnosing clinician is looking for; wondering if, nevertheless, they can get to it first.

Here we have a *differend.* Which is where the *"common way of understanding"* appealed to by an earlier speaker comes in. A *differend* exists precisely where there is *no* common way of understanding, no one rule that will be agreeable to all parties; which is more often than not the case during assessment.

When the diagnosis is duly declared - it seems inevitable now doesn't it - the reaction will be to the *verdict* of illness and not to the illness itself. The declaration does the job. Obviously, but not so obviously, the diagnosis precedes the illness; the diagnosis is the necessary condition for there being an illness at all.

Perhaps the *gnosis* in diagnosis refers to the secret or forbidden knowledge that the diagnosis *creates* the illness, literalises it, brings it into being; that the judgement is a kind of performative utterance; and, perish all rational thought, there isn't anything else. Not for science anyway. The rest is ethics. What Freud said is mental health, Spinoza saw as simply a free mind, a mind *freed-up*; which, for him, is an *ethical* state. What it is to be human is not, and cannot be, a medical question. Surely being human, ordinarily, laboriously, from day to

day, is not a mental illness.

But if it turns out after all that it is, then at least it will be the norm, a dullness afflicting every one of us, the default position, and therefore no longer an illness, but simply a reflection of the ordinary frailties of human being, unfitness not so much for purpose as for dreams of purpose; unless of course we sign up to those newly fashionable yet far-fetched notions of perfectibility.

Is this *gnosis*, that there is no mental illness, the long searched-for insight --or the much-maligned lack of it? The Holy Grail of Recovery - or the subversion of it?

Back to diagnosis. Acceptance of, or identification with, or dependence upon, or colonisation by, or resistance to, or release from, is never to or from the illness; the relation is always to the diagnosis. The imperatives of diagnosis are not so easily thrown off. Whatever happens to the illness, it comes and goes, the diagnosis sticks.

Seen from within the cone of experience diagnosis, formulation and the subsequent plan, management or recovery, recovery or management, are all artefacts, created things, hence their possession of an inherent defining subjectivity; a subjectivity with which formulation, unsurprisingly, has often been charged. After all, the articulation of character is what novelists do (and sometimes, of course, detectives!); and creation, well, whose province is creation?

But we should not be afraid of subjectivity. We should not shun its sly seductions. The way forward will be, and can only be, through the creation of an inter-subjective space in which the diagnosing clinician and the person undergoing assessment can come each to approach the other. It is a necessary *inter-dependence*, a *mutuality-of-interest* that must be vigorously entered into, unequivocally endorsed, resolutely defended. And not denied in the name of a mythical disinterestedness --if, that is, there is to be any true depth of clinical insight. We must, I believe, return to the kind of *implicating* relationships that characterise the day-to-day of our lives, the barely manageable mess and muddle; the very kind of relationships that in the name of a Rigorous Science we have sought to remove ourselves from. And hidden within such relationships we will surely find a science of experience waiting.

Diagnosis, we are often told, is difficult; uncertain, inconclusive, disputable, demeaning, vulnerable; and therefore, in the end, unhelpful. Though it is never any less emphatically diagnosis, and no less decisively imposed.

Whatever it is or isn't, diagnosis is always contingent; because it is a product of the inter-subjective space out of which it emerges. A different relationship will more often produce a different story; a different diagnosis, formulation and plan: management or recovery, recovery or management. It doesn't have much

to do with DSM.

So what should we ask for?

The abandonment of diagnosis altogether?

The fixed and false concern of open-ended assessment, which slips all too easily into a state of surveillance?

A retreat into the banalities of those new and brightly costumed, brashly commercialised versions of wellbeing?

The diagnosis, if there is to be a diagnosis, will be most useful when it is less of a diagnosis; when the formulation is believable, lifelike, a closer match with the person's own experience; when the plan is grounded in Planet Earth, the very shit our feet are stuck in, and thus at least worth a shot: when the assessment line comes to an end in a point of understanding, if understanding is possible, insofar as it is possible then, if it is not possible then to an *appreciation of the person's own understanding, of themselves*, understanding only perhaps that an understanding has been reached, by someone else, and making no other grand claim; an understanding which amounts to an *appreciation* that someone in particular is making sense of themselves, however thinly that sense must be stretched to cover the vast gulfs of the dire and the inexplicable, however liable it is to snap at the slightest touch.

And this assessment will be useful, is that really the best we can say, when the person comes to *recognise themselves*; when the person undergoing assessment, and not the diagnosing clinician, is the one who understands; understands only what, at the time, it is possible to understand.

That is all there can ever be to go on.

So we begin at last to move forward again, suitably plotted out, beyond the menacing singularity of diagnosis and into, we tell ourselves, brave new worlds of formulation.

Alas, it seems we are moving in a circular motion, as if the line was somehow bending back in on itself. And whom should we meet travelling towards us but our old friend Sherlock Holmes; as if, all along, he knew we'd be back!