Can the Clinical Subject Speak?: Some Thoughts on Subaltern Psychology

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Can the Clinical Subject Speak?

Some Thoughts on Subaltern Psychology

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ABSTRACT. This paper is concerned with the extent to which the clinical subject, in postcolonial clinical encounters, is able to speak, and be heard, through and beyond the structures of clinical theory and practice. The paper aligns itself theoretically with the project of *Subaltern Studies*, and particularly the work of Spivak, in her quest 'to learn to speak to (rather than listen to or speak for) the historically muted subject of the subaltern woman'. It is concerned specifically with the complexity of learning to speak to the muted clinical subject of postcolonial Africa. It argues that this task is bedevilled by representations of Otherness (black, woman, illiterate, poor, rural) in clinical theory that speak for, but seldom engage in dialogue with, the clinical subject. Multivocal texts available in narrative therapy projects present an interesting challenge to conventional authorial ownership. More broadly, subaltern psychology, as a theoretical direction, offers an opportunity to understand ways in which muting occurs, and to work actively against professional deafness.

KEY WORDS: clinical records, colonialism, subaltern psychology, voice and silencing

In 1892, a woman called Dorothy was admitted to Valkenberg Asylum in the Cape Colony. A case record survives, spanning the years 1892 to 1944, when she died (S. Swartz, 1999a). The record tells us that she was born in London in the early 1860s, and immigrated to South Africa with her family when she was approximately 3 years old. We know nothing of her childhood, except that she lived in Cape Town, and had smallpox, had subsequently become depressed, and thought herself 'disfigured'. She then 'took to wandering'. When she was admitted to Valkenberg, she was said to have been ill since 1884. She was admitted as a paying patient, evidence that her family had money. The medical certificates state that she was emaciated, haggard, maniacal, excitable, with erotic delusions. She believed her food was being poisoned, and that it was prepared in the kitchen by the same knife used to commit murder. She had attempted suicide by drowning. On admission, Dorothy claimed that her father had a mistress and three

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illegitimate children. One medical certificate also states: 'She thought herself ill-used at home.' She elaborated on this once in the asylum, expressing 'foolish delusions' that her father had raped her. There is no evidence in the record that anyone followed up on the possibility that she had been sexually abused.

There are five pages of clinical notes, covering the period from 1914 to 1944. The notes are repetitive, describing over and over the symptoms of her insanity. Over a period of many years, she was described as spending many hours sitting with her hands folded tightly in her lap, or 'messing about in the W.C.', washing, or using toilet paper, for a purpose unspecified. She was also described as having dirty habits, abusing herself, and being cheeky and impertinent. She became a 'demented dementia praecox', and remained in this condition until she died, senile, in 1944.

Money left to her in her father's will was administered by the Colonial Orphan Chamber and Trust Company, and this allowed her to be provided with a diet a little more luxurious than that given to non-paying patients. The Orphan Chamber also provided a basic wardrobe consisting of a few dresses, underclothing, slippers, shoes and stockings. In 1935, the Orphan Chamber forwarded to Valkenberg an enquiry from 'a relative' about Dorothy's health. The only other mention of her family is a letter dated 1901, from the Orphan Chamber. It appears to be a reply to a suggestion that her sister Eliza, similarly afflicted with mental illness, and living in Grahamstown Asylum, be moved to Valkenberg. The suggestion was vetoed on the grounds that Eliza appeared happily settled in Grahamstown, and there was no certainty that the sisters would get on with each other. When Dorothy died, her worldly goods amounted to six vests, two bloomers and three petticoats. She had received no visitors for years. Attempts were made to contact relatives when it was clear that she was dying, but none were found.

This is all that we know of Dorothy from a lifetime's case record. We learn how doctors managed and wrote about a case, and as a case it differs only in detail from those of hundreds of other men and women, incarcerated during the same period. The records have a striking uniformity across all groups of patients, regardless of racial classification, gender, class and form of insanity (S. Swartz, 1995). Dorothy herself has no voice at all. Her experience of her illness, a life-time of days behind locked doors, friendships, desires—all are entirely lost. What remains of her life is appropriated into the discourses of psychiatry and hospital management, on the one hand, and a spider's web of delicate counter-readings, on the other, readings which appropriate the silences themselves as evidence of, *inter alia*, the dehumanizing effect of asylum life, the erasure of sexual abuse by patriarchal systems of knowledge and power, and a persistent refusal to embed the so-called 'psychotic' voices in those contexts that might render them meaningful. From neither appropriation does Dorothy herself speak. Both are political

and strategic, serving interests of their own. As Spivak (1993) trenchantly remarks: 'The subaltern', by whom she means the silenced subject of history, products of 'imperialist subject-construction' and 'epistemic violence', all those systematically excluded from the powerful systems of representation, 'cannot speak. There is no virtue in global laundry lists with "woman" as a pious item' (p. 104). Indeed, Dorothy's laundry list has no virtue beyond a moment of pathos, and the pathos itself is a construction of an elite consciousness woven of material possessions and guarded with the right to privacy.

This paper is concerned with subaltern voices, and with the enticing possibilities of a subaltern psychology. As an avenue of thought it emerged from engagement with historical case records and documents, through which the reader learns a great deal about doctors and their systems of self-representation, and almost nothing of the patients of whom they wrote. Counter-readings often seem flimsy, or else banal: sometimes shrill and political annexing of silences, or else laundry lists, signifiers strangely detached from a signified. But the struggle does not stop with history. As clinicians we write case histories all the time: what will their readers 'know' of their patient subjects—beyond the knowledges through which their voices are filtered? And beyond that, in writing, in the historical record, in histories, in conversation with our patients, are we not able to allow subaltern voices to speak? How much do we listen for very specific constellations of meaning, and then speak for, rather than speak to? And yet beyond that, what of the subalternhood created and perpetuated by white (imperialist) psychology, struggling with the task of speaking to sometimes-colonized black patients. White middle-class Western knowledge systems of training in African contexts also spawn subaltern voices, and the deafness with which we meet them (Bennett, 1997).

The concern of this paper parallels that of the subaltern historians. However, it goes beyond the concerns of the relationship between the historical record and the lived experience appropriated by history. It begins with the 'epistemic violence' of deleted clinical subjects in the case histories of psychiatry and psychotherapy (Spivak, 1993, p. 104). It broadens the parameters of the subaltern quest to include the interrogation of everyday activity of clinicians making historical subjects of their clients in case records, sewing them into a patchwork of clinical theories and techniques. Beyond the inscription of the clinical subject in writing is the elusive (therapeutic?) encounter. The paper will argue that even here there is a subjugation of the client's voice to the louder resonances of theories and trainings. Clinicians hear what their training enables them to hear. A subaltern psychology maps both deafness and silence, and explores ways in which the subaltern might privilege us with her speech.

Unlike many psychologies of oppression, such as those identified with Thomas Szasz (1972), R.D. Laing (1965) and in postcolonial Africa with

Frantz Fanon (1967a, 1967b), subaltern psychology does not assume a unitary subject constructed in the dialectics of power. Programmes of resistance to power, and opposition to clinical hegemonies, construct a clinical subject that is a coherent inversion of dominant meanings—madness (so-called) 'read' as sanity. Rather, subaltern psychology argues that the clinical subject exists forever in an 'unknowable region' (Bollas, 1987, p. 200). A transformational agenda ruptures the binaries of powerful/powerless, oppressor/victim, mad/sane, and builds into the clinical encounter an expectation of being surprised. The paper suggests that there is no clinical subject to speak, only a series of constructions of subjectivity, co-created encounter by encounter. The truly liberatory position to be taken by the clinician is to allow herself to be 'cumulatively coerced' into a shared in-language moment (Bollas, 1987, p. 200). To unlearn clinical privilege is not simply to replace one theory with another, but to move into the realm of negotiating subjectivity itself.

This is a large project, part historical, part archival, part experiential, and the purpose of this paper is to do no more than flag the footpaths. It will venture into three realms of clinical practice. One is uncovering hitherto silent narratives of the historical record, particularly as it relates to colonialism. One is the written record of clinical work, and the discovery of forms of training and writing that amplify the traces of the subaltern record. The final one is the clinical encounter and the possibilities of constructing spaces in which speech and hearing are not taken for granted, but are a salient goal in a struggle with language and history. The paper also explores speaking with the 'unconscious' subject, and the implications of such a process in African contexts.

Subaltern Studies

To rehearse a familiar history, the first in the series of *Subaltern Studies*, a collection of essays in the area of South Asian studies, appeared in 1994. The editor, Ranajit Guha (1994), defined 'subaltern' as 'a name for the general attribute of subordination in South Asian society, whether this is expressed in terms of class, caste, age, gender and office or in any other way' (p. vii). The term 'subaltern', as used by *Subaltern Studies*, is drawn from its usage as a rank given to an officer in the British army, below the rank of Captain. The *Oxford English Dictionary* quotes a reference to the 'long subalternhood' of Indian officers in the British army dating from 1857, no doubt a comment on the inferior status of Indians in the colonizing forces. The *OED* also captures (in passing, by chance and perfectly) the whole quest of *Subaltern Studies* in an 1859 reference: 'Have you any ears

left for small items of private intelligence from insignificant subaltern officers?'

The series is an extended attempt to engage critically, and to reshape a historiography dominated by colonial and bourgeois nationalist elitism, and determined by elitist access to institutionalized forms of representation. In a compelling essay entitled 'The Small Voice of History' (1996), Guha deconstructs the phrase 'historic events and historic deeds', asking the question,

> But who is it that nominates these for history in the first place? For some discrimination is quite clearly at work here—some unspecified values and unstated criteria—to decide why any particular event or deed should be regarded as historic and not others. (p. 1)

Subaltern historians then set themselves the task of listening to the small voice of history. Their problem was how to find it in an archive dominated by the voices of the elite. There is a double task—to create ears with the capacity to hear 'small items of private intelligence' from subaltern voices, but also to construct, from the tension between the blaring voice on record and the silences caused by the erasure of the ordinary, inferior, subordinate subjects of history, a less partial narrative. Around this central problematic, a paradoxical historiography was formed, one that reads the presence of the subaltern voice through elitist (or what Guha calls 'statist') opposition to it. Thus insurgency is read from counter-insurgency, the position of peasant women from men's positioning of them, and so on—a reading of history with little 'hard' evidence, beyond silence, contradiction, irony.

One cannot read far in subaltern historiography without coming across the figure of the Hindu widow, burning herself on the funeral pyre of her dead husband (see, e.g., Rajan, 1993). The practice of *sati* was outlawed by the British in 1829, an act described by Spivak (1993) as 'white men . . . saving brown women from brown men' (p. 92). As she points out, this sentence discursively entails another, the Indian nativist argument, 'The women actually wanted to die.' She argues that in neither representation does the figure of the widow herself speak. The reason for this is that both discourses are invested in particular narratives that disallow the speech of the widows themselves, in all their heterogeneity.

Perhaps the most powerful contribution of *Subaltern Studies* to post-colonial historiography lies not in its attempt to reconstruct the small voice of history, but rather in the prominence it gives to the question of who speaks (or writes), when, to whom, and in what system of representation. Voice, the capacity to speak, and to command an audience, and the possibility of inventing a language that will rupture the steady appropriation of experience into hegemonic meanings, has a central place in postcolonial studies. Linguistic imperialism in particular, the process through which

indigenous languages are replaced by the language of colonizers, is implicated in the silencing of the subaltern. The subaltern's experience of his or her own life in translation, caught forever between the disenfranchised mother tongue and the public voice of law and authority, reconstructs consciousness itself (Fanon, 1967a). Clawing back a relationship to subaltern experience constitutes a wrestle with language, therefore; an 'abrogation' of imperial culture through 'appropriation', shaping colonizing languages, using them to burst through dominant fixed meanings into layers of lived experience beyond (Ashcroft, Griffiths, & Tiffin, 1989, p. 38).

Indigenous languages uncontaminated by imperialist rewritings of history do not necessarily solve the problem of finding the subaltern voice. The rifts and erasures of patriarchal and class relations always and forever create silent subjects. Reading subalternist historiography 'against the grain', Spivak comes to the conclusion that, despite its best intentions, such an enterprise eventually fails. Her reasons lie in her critique of postcolonial discourse, 'that renders the place of the investigator transparent' (Spivak, 1993, p. 91). Her concern is that subaltern histories 'cohere with the work of imperialist subject-constitution'. Simply put, the subaltern voice is a fiction constructed through a series of oppositional readings of dominant texts. For Spivak (1993),

> . . . in seeking to learn to speak to (rather than listen to or speak for) the historically muted subject of the subaltern woman, the postcolonial intellectual *systematically* 'unlearns' female privilege. This systematic unlearning involves learning to critique postcolonial discourse with the best tools it can provide and not simply substituting the lost figure of the colonized. (p. 91)

The concern, then, is to 'make language stammer' (Deleuze & Guattari, 1987, p. 98), not to create from 'stammered dialogue' (Foucault, 1971, p. 274) a second fiction, as replete with silence as the first. Bearing the burden of hearing the stammering voice is the task of the newly found ears; creating fluency is not.

The Historical Record

To turn to a very specific analysis of what subaltern studies, and Spivak's work in particular, have to offer clinical psychology, this discussion starts with an assertion: that the clinical patient, and sometimes the clinical trainee, is the subaltern. This assertion positions the clinical patient, by virtue of her relationship to the clinician-elite, as bereft of speech in certain critical respects. As every aspect of clinical work orients itself ostensibly at least to the activity of listening to the stories of patients, this position is clearly

contentious. In what follows, the paper will begin to justify the claim, starting with its least problematic and uncontroversial space, that of archival research on case records, and the compelling but ambiguous figure of the patient within them.

As with the case of *sati*, two strong readings quickly emerge, and are framed in these two sentences. The first: 'Lunatics are dirty, irrational, incoherent, potentially violent and out-of-control children in need of humane care from doctors.' The second: 'So-called "lunatics" are misunderstood rebels against imperialist/patriarchal society, and expressing their pain through intrinsically meaningful symptoms.' The first reading takes its place in the rich genealogy of mainstream psychiatry; the second in that of anti-psychiatry, arguing that illness lies not in the patient, but in society.

To illustrate. Dorothy, our subaltern, emerges from her case record as written by the doctor-elite as a deluded and eventually dementing woman, her diseased mind and body falling prey to dirty habits, a burden on the state. The counter-reading of Dorothy, as victim of sexual abuse ('ill-used by her father') and excluded from taking up a position as woman in white middle-class colonial society by the disfiguring marks of smallpox, does not provide us with Dorothy's voice—although she did speak, she cannot, now, speak to us. In our imaginings of what she might have said, and then what her words might have meant, we inevitably draw on theory, our own experience, a landscape that is utterly our own. What remains of Dorothy's own words are used to lend fictional authenticity to the canvas. A photograph of Dorothy in her patient folder, of the WC next to which she sat, are dangerous imitations of intimacy because they are seductive. Our eyes drink in the fine porcelain of the toilet bowl, and we believe we are there, in Dorothy's asylum, living beside her.

Another example. The Valkenberg records from the 1920s contain the stories of two black women, both of whom were given a diagnosis of 'psychopathic personality', here used as an equivalent to current conceptions of 'personality disorder' (S. Swartz & Ismail, 2001). Both were domestic workers who killed their new-born infants in the homes of their employers. Gertie R., who gave birth in her bedroom, alone, had been told that she was to be dismissed when her baby was due. Annie J. also gave birth alone, in the outside toilet of her employer's house, left the baby in the lavatory pan, and walked, haemorrhaging, down the street. She had one previous conviction for having left her place of employment without giving notice, and was presumably concerned about the consequences of giving birth. Neither woman showed signs of psychosis, and there is no record of any psychiatric symptoms, other than the fact that they conceived of the inconceivable—they chose to kill their own babies. One reading of this is that both are therefore ill, and need to be saved from themselves by protective custody. The counter-reading positions them as colonial subjects, exploited and

abused by their white (female) employees, who appear to have had little knowledge and less sympathy for the economic plight of their servants, and took no responsibility for the desperate acts to which these young women were driven. Both explanations deprive the women in question of agency. In relation to both cases the writer is Foucault, without the confession of Pierre Rivière.

Deafness in the moment silenced the subaltern patient: we have no idea whether Annie or Gertie was desperate or callous, driven by rage or expediency or shame or cruelty. Beyond the rare cases in which patients themselves write—a letter pleading with a doctor, an appeal to the Colonial Secretary for release—we have no access to individual subjectivities. The occasional records in which the subaltern voice is dimly apparent are highly significant for subaltern psychologists. Doctors themselves on rare occasions recorded, it seems in spite of themselves, the subaltern voice. James S., for example, after thirty years in Valkenberg, downed tools, and when asked why, he said that 'he does not work, because he is not a bloody fool'. He said he had been sent to Valkenberg because he was 'mad'. The doctor asked if he was now well, to which he replied, 'Don't be silly, once mad, always mad.' He made clear in this conversation that he would not be pulled into a conversation, the purpose of which was to 'prove' his madness. Simultaneously, he deconstructed the discourse of 'cure' or 'recovery' on which the asylum's reputation for humane care rested (S. Swartz, 1995).

Following the subalternists, there is an argument to be made for reading the dominant discourses of the records with a view to noting their resistances, repetitions and silences, even though this might do no more than map the perimeters of an empty space. So, for example, it is important to note that there is no record that anyone ever asked Dorothy if she had been sexually abused by her father. There is no record of either Gertie or Annie having been asked why they killed their babies. Were they asked? If they were, why were their responses not recorded? Why do 'dirty habits' and ability to do ward work figure so prominently in the records, and why are friendships between patients are mentioned only when they involve sexual contact?—and so on. The narrative to be constructed from these counter-readings grows in significance, the more embedded they are in the documented history of multiple social contexts—of the institution, of psychiatric knowledge, of the raced and gendered social and economic history of the Cape. It is only within a matrix of collusive and opposed discourses that the edges of our own deafness will become apparent. This, however, is not to be confused with hearing the subaltern voice; it simply begins to map the relationships between race, class, gender, and institutions in ways that are suggestive of what might have been silenced or spoken. This tracery of structures, historically, sharpens our hearing, and attunes us to new perspectives on current practice.

The Clinical Record

I have argued at some length elsewhere that clinical case records are noisily informative about the doctors, psychologists, psychiatrists and other professionals who write them, about institutional practices, and the professional knowledges sustaining those institutions (S. Swartz, 1996, 1999a, 1999b). As Barrett and others have also pointed out, the stories told to clinicians by patients are certainly heard (as in listened to), but the process of hearing is filtered through diagnostic and therapeutic monoculars, and tailored for the record to fit pre-existing identities—that of 'schizophrenic' or 'narcissist' or 'borderline', to name a few (Barrett, 1998; Hak, 1992; Luske, 1990). Histories have become longer and more detailed over the past century, without changing substantially an empty signifier at the heart of the case record enterprise, one indissolubly linked to the signifieds of professional discourse. As Prakash (1990) says of the Orientalist construction of India as an object of knowledge:

> Because the government viewed knowledge contained in official documents as a representation of reality, or in one official's words in 1860, as a 'photograph of the actual state of the community', it was always possible to argue that the photograph did not represent the external reality adequately, thus requiring more adequate representations. (p. 387)

So the histories gather detail, but fundamentally the terms of representation do not change: we continue to listen to in order to speak for, about—and fail to speak to.

The theoretical architecture of case histories is very seldom made explicit, and this encourages the illusion that they represent a verbal photograph of the patient and the patient's life. Longer and more detailed histories are simply the Imax version of this naïve realism. Add-on questions about economic, cultural, religious or political values, experiences or beliefs seldom challenge the deep-structure assumptions, which remain wedded to a universalist and liberal humanist middle-class, Northern-hemisphere notion of mental health. Just as with case records from a century ago, the patient's voice is hard to detect, and hearing her places the reader in the business of working with ellipsis, silence, contradiction.

Case records shed what is extraneous or irrelevant to a central narrative. Most frequently that narrative is of an illness episode. Moreover, in the search for a diagnosis and explanation of it, clinicians are trained to listen for specific constellations of events, given salience by naturalized theories of what constitutes 'healthy' development and family life. To mention a few, ideological links to the heterosexual nuclear family drive a set of enquiries about bonding in early infancy, separations from caregivers, and hence difficulties in later life with patterns of relationships. The ghost of various psychoanalytic positions underlie our questions about breast-feeding and toilet-training, transitional objects and the meaning of certain kinds of play.

A very different example can be found in our questions about work histories. To have a history of many short-term periods of employment is often read as a marker of instability, or rather inability to sustain a set of life-goals, ambition and interest despite competition, criticism or temporary adversity. Such a notion positions an unbroken career path as a marker of mental health, and is derivative of an economically stable middle-class ideology that values individual material success as a primary life goal. In societies in which limited access to education, poverty and unemployment are more the rule than the exception, stable work histories have dubious value as a marker of anything except privilege or luck.

Psychoanalytic case histories have a particular claim to representing 'the real' (Lacan), 'the true self' (Winnicott), the 'I' before the structuring and alienation of self from need/desire through the intervention of language. Such case histories, then, might take centre-stage in our search for the voice of the clinical subject. Bollas and Sundelson (1995, p. 94) talk of the musing notes representing the reverie of the psychoanalyst recording his/her relationship to an analysis, fragments of many hours of listening. For many contemporary psychoanalysts, in such reverie the unconscious of the analyst would be regarded as an essential and active presence, functionally inseparable from the unconscious of the analysand (see, e.g., Aron, 1996; Bollas, 1992; Ogden, 1997). Traces 'direct' from the analysand are heard in accounts of dreams, in skeletal bodies and in cuts on arms. In other words the symptoms speak, but the case record is an appropriation of the symptoms into a theory that explains it, an interpretation, at best a merger of two subjectivities. It could be argued that the symptom speaks for itself only outside of treatment and in relation to a primary witnessing of pain (Bennett, 1997).

Bollas and Sundelson (1995) and Aron (2000) discuss increasing pressure on psychoanalytic psychotherapists to be accountable to law-enforcing agencies, and to report confidential material in situations of sexual abuse or threats of violence, for example. The possibility of clinical records being used in court certainly has the effect of creating a circumspect writer at a slant to his/her own voice, let alone the free-associating voice of the analysand. In 1905 Freud raised the issue of disguising clinical material in the written construction of case material (Freud, 1905/1977), and a century of debate on the ethics of publishing case histories has changed very little in practice. Disguise of identifying data and under certain circumstances 'informed consent' from the analysand appear to be standard (Aron, 2000; Casement, 1985). There can be little doubt, however, that protection of clinical privilege in case records at best narrows and controls the channels through which the voice of the clinical subject is transmitted. At worst, disguise leads to fundamental distortion.

The implications of this for the subaltern psychologist are clear. As with the historical record, we must not expect to discern the voice of the clinical

subject from clinical records, especially in settings in which the threat of litigation presses upon the practitioner. Clinical documents serve as a memory for the clinician, and as a regulatory device within and between institutions. They place the clinical subject forever under construction for various purposes, none of which allow her to speak for herself. The possibility of allowing patients to contribute to their own case notes appears to offer the possibility of hearing a subaltern voice. However, for as long as such records are interpellated into the power structures of institutions with the capacity to incarcerate, and to determine the material limits of care, the authenticity of the voice will always be in question. To speak and to hear requires freedom from these restraints.

There are many accounts of various states of internal suffering or conflict recorded by sufferers themselves. These provoke the question: can we read the poems of Sylvia Plath or Anne Sexton, both of whom explored the depths of their mental anguish at length, as, for once, the clinical subject speaking? Neither of them would have constituted themselves in this way, except occasionally, and to read them as giving voice to 'clinical' subjectivity would again constitute an act of deafness. By contrast, the account given by Martha Manning (1994), psychotherapist, of her episodes of manic-depressive illness creates an intrasubjective dialogue between psychiatrist-self and patient-self in which each is heard. The liberation here is unstable, power shifting between selves, but the experience remains multivocal throughout.

The Spoken Encounter

But what of all the talk that happens between clinicians and patients, and is never recorded? Arguably, this is a freer space, one in which the experience of 'feeling heard' is a pivotal dimension of therapeutic change. Spoken encounters between patients and clinicians take a number of forms, and their relationship to the possibility of hearing subaltern voices is complex.

For example, the form of the interview is critical in determining the extent to which submerged narratives, those outside of hegemonic meanings, might be given space. Structured interview schemata do more than constrain the written record; they also constrain the talk that produces the record. For example, psychiatric history formats begin by telling the clinician to let the patient tell the story of the illness 'in his or her own way'—but this pre-empts any number of narratives not about illness. Early in their training, psychologists and psychiatrists are taught to gather a structured 'history' and to do a mental state examination within a single session. 'Rambling' histories (often those in which the patient or family is allowed to talk freely, about their pressing concerns) do not result in prompt diagnoses and management plans, both essential for managed health care. 'Good' histories

gather 'relevant' information succinctly, a performance which places strict limits on the amount of spontaneous talk that is allowed to happen. Again, this has implications for our capacity to access, let alone hear, the subaltern voice, and changing this situation means unlearning the privilege given to us by our armoury of knowledge.

Of course, structured interviews are fair game for those on the hunt for the conversational mechanisms through which patients' perspectives are deleted. Many kinds of therapy encounter seem to encourage patients to talk about whatever comes to mind. Client-centred psychotherapy installs listening as the foremost skill to be learned by the psychotherapist. The first rule of psychoanalysis is free association. However, it would be naïve to assume that these encounters are without rules, and not productive of very specific kinds of talk. The insistence, in Rogerian approaches, on the here-and-now empathic encounter does not necessarily offer the clinical subject unfettered space within which to speak. Such freedom is available only to those inhabiting subjectivities not divided from the listener by historical contestations around gender, race and class. Even when dialogue is constituted between clinical pairs evenly matched on social variables, the act of constituting oneself as professional listener to—for example—tales of woe simultaneously structures the speaker as 'woeful' prior to her act of uttering a word. Paradoxically, it is precisely client-centred therapy's claim to the possibility of both speech and hearing that constitutes its greatest weakness. Rogers refused to complicate his theory with notions of Otherness, inaccessibility and history, a stance that certainly informed his visit to a deeply divided South Africa 1986, when he insisted that speech and understanding between black and white people was possible (L. Swartz 1986). His optimism was admirable, but his assumption that he could access voices beyond the well-rehearsed traumatic and highly politicized ones with which we all spoke in the 1980s was naïve.

More pessimistic models of therapeutic interaction make much more cautious claims, even going as far as to suggest that confronting the dragon of Otherness, and experiencing together the impossibility of scaling its spiny flanks, is enough to mobilize change (Benjamin, 1990; Kohut, 1971).

In relation to psychoanalysis, Parker (1997) points out that different forms of unconscious material are elicited by the theory of the psychoanalyst. Not only that, the patient's talk is then heard in particular ways, according to the clinician's theoretical stance. Sometimes even the possibility of rebellion against the rules—by arguing, being silent, mocking, denying, avoiding—is assimilated into the theory through such notions as resistance, and the resistance itself is re-positioned not as resistance to the recalcitrant mishearing of the clinician, but a resistance to anxiety-provoking inner conflict.

It is ironic that narrative therapies, while explicitly privileging the subaltern voice by placing the stories patients tell in the centre of clinical interventions, also make clear that narratives are not like photographs of

lives—they are discourses, the deconstruction of which will enable new narratives to be formulated. Narrative therapy is underwritten by the postmodern assumption that self, identity and history are discursively constructed (White & Epston, 1990). It is therefore in the moment of giving up on 'truth' and simultaneously on clinical privilege that the subaltern begins her aria. The notation is delicate, particularly after the spoken encounter when a written account is offered. Authorship of these moments is displaced into an intersubjective space constructed of witness, speaker and (academic) audience. Narrative therapists frequently succumb, in writing, to the temptation of claiming authorship, regardless of disclaimers, and acknowledgements to speaking subjects. Exceptions find themselves dividing their attention between giving space to the subaltern voice and deconstructing their own privilege, a tortured but necessary process (Abrahams, 2002; Bennett & Friedman, 1997; Swan, 1998).

All this raises a set of issues about the way we use, and are used by, technologies of psychotherapy in clinical practice. The search for the voice of the clinical subject requires both theoretical vigilance and a willingness to embrace a wide set of new theoretical allies. The clinical subaltern is always the product of very specific historical circumstances. To discern the small voice means coming to terms with the history that silenced it.

In South Africa, for example, many psychologists have accepted the challenge of grappling with the consequences of a long history of institutionalized racism. Clinicians are less adept at ceding the power derived from cultural imperialism, and the racisms this entails. As Said (1994) points out, 19th- and early 20th- century European imperialism 'still casts a considerable shadow over our times' (p. 5). He is referring to the processes through which a 'dominating metropolitan centre' continues to rule distant territory by force of 'impressive ideological formations' (p. 9). In South Africa, psychotherapy is practised by both psychiatrists and psychologists, and there are strong ties in both disciplines to British and American theories and techniques, often assumed to have universal applicability, with minor adaptations to local contexts. To see the historical forces shaping the production of systems of knowledge that now present themselves as ahistorical, even atheoretical, and universally applicable is a first step towards undoing a debilitating relationship of subordination to the metropolitan centre, in which even 'colonial' practitioners become subalterns, subordinating themselves to the authority of knowledge developed in quite different social and cultural circumstances.

Apart from historicizing our work, we also need to be self-conscious about, and to actively theorize, what can be said to whom, and how. This takes us into the heart of the postcolonial discourse analytic enterprise, as we grapple with the formation of multiple subjectivities through race, class and gender positions. The theoretical tools available to us need to become interior to our psychological theorizing and affect our practice in practical

ways. An important place to begin this work is with our own gendered, raced and classed positions as clinicians; to proceed otherwise puts us in immediate danger of Othering the 'alien' subaltern subjectivities (S. Swartz, 2000).

Difference and Othering

In a recent controversy erupting over the display of photographs of gay black men at a conference on sexuality, Nokuthula Skhosana, a delegate, made the following trenchant remarks: 'Why is it that at every conference one attends, white "experts" present on black lives? Whites continue to present us, talk on our behalf and exploit us in the process' (*Mail and Guardian*, 2003). She was referring to a tension and a silencing that continues to dog South African professional circles, a decade post-apartheid.

Subaltern Studies emerged from a concern with the perception that difference creates silence. Othering is a term that describes the inscription of hierarchy within difference, and clinical privilege creates such a hierarchy. Conversations between clinicians and patients separated from each other by racial designation, class, gender, religion and sexual orientation compound the challenges to being heard. In these situations, the possibility of and need for hearing the subaltern voice are foregrounded and explicit. Multi-cultural counselling, community psychology and cultural psychiatry as genres dedicate themselves to exploring difference in subjectivities (for recent examples, see Drennan, 2001; Gibson, 2002). This literature has been influential both in raising awareness and in insisting that practitioners take account of lives lived very differently from their own (see, e.g., Dawes, 1999; Seedat, Duncan, & Lazarus, 2001; L. Swartz, 1998; L. Swartz, Gibson, & Gelman, 2002). There can be no doubt that insofar as this work has destabilized hegemonic meanings, by questioning the universal applicability of Western diagnostic systems, and by drawing attention to the embeddedness of cultural difference in consciousness and social interaction, it has made an important contribution to clinical practice.

However, inequalities of access to knowledge, to writing, to publication and to clinical training install hierarchy in these discussions of cultural difference, and this makes Othering inevitable. The rhetoric of empowerment for underprivileged communities that fuelled community psychology in South Africa in the last decade of apartheid has given way to sophisticated analyses of shared power and professional expertise (see, e.g., Tomlinson & Swartz, 2002). Neither ameliorates the silencing effect of class or clinical privilege, an effect deepened by frequent failure to allow black clinical subjects to speak for themselves, either as patients or as clinicians, unless they speak of difference, and in so doing Other

themselves (see, e.g., Christian, Mokutu and Rankoe's [2002] description of their experiences as black students in a predominantly white clinical training). Clinical writing about black or gay or working-class experience from positions of privilege in terms of class or cultural dominance sometimes give the unfortunate impression that the people so classified cannot describe their own experience.

Judith Butler (1997) argues that to be named by another 'is traumatic: it is an act that precedes my will' (p. 38). However, this 'founding subordination' becomes 'the occasion for something we might still call agency, the repetition of an originary subordination for another purpose, one whose future is partially open' (p. 38). The appropriation of 'difference' in the writing of those with clinical privilege might then be the beginning of a dialogue, made possible because the naming, however traumatic, has been done.

In South Africa, the work of the Truth and Reconciliation Commission (TRC) has been premised on the belief that to speak openly about our traumatic history, and to hear the narratives of both perpetrators and victims, will bring about the possibility of healing. Often the idea of forgiveness is woven into the tapestry (Gobodo-Madikizela, 2003). In many ways, the TRC was a therapeutic encounter on a massive scale, designed specifically to allow subaltern voices of the apartheid past to speak. An extraordinary moment, acknowledged world-wide, but not unfettered by pre-designed roles (perpetrator, victim, political affiliation). Moreover, the intersubjective complications of forgiveness implicate privilege. The act of forgiving in a conversation between perpetrator and victim issues from a position of power, however momentarily it is held. This unsettles the free flow of dialogue, invokes uncomfortable notions of who after all is 'innocent', and never allows the sentence 'I forgive you for being my victim', thereby creating another layers of subalterns, 'the forgiven', ironically shackled in the very moment of release.

To let clinical subjects talk for themselves in ways that acknowledge difference but do not create alienation might require revision to the structure of writing itself. The work of Jonathan Morgan and colleagues reporting on encounters with South African men, women and children living with HIV/AIDS in poverty-stricken communities finds a balance between narrative space given to their subjects and reported verbatim, and commentary (often autobiographical or intersubjective) beside it. The 'authors' of these pieces position themselves not as *authoritative*, expert or professional, but simply as some among many voices. The written product is multi-textual, with visual variation in the presentation of voices from a range of experiences forming a barrier against the interpellation of one by the other. Some text is in boxes, some in italics; there are emails, and photographs and body-maps: the multivocal effect is powerful (Morgan 2003; Morgan & the Bambanani

Women's Group, 2003; Morgan & the Great Spider Writers, 1999; Payi, Kete, Morgan, & Thomas 2002).

Training

Finally, another version of subaltern consciousness exists in the relationship of the clinical trainee during the process of induction into the profession. Clinicians in training talk, informally, of encounters with patients that are never taken to supervision, because it is assumed that they fall outside of approved practice. Awareness of surveillance, and the censorship which automatically takes place in relation to it, has a significant impact on what supervisors are allowed to see and hear. This layer of subaltern voice is important as potentially a rich site for the hearing of multiple voices. The challenge is to enable experimentation that encourages the expression of patients' voices within a programme that also offers a set of rules for professional behaviour. Training readily becomes prescriptive about the rights and wrongs of clinical practice. However, early in their training some clinical trainees are admirably placed to hear voices that older, more experienced clinicians have long since ceased to register.

What Silence?

The argument outlined in this paper suggests that the clinical subject is effectively silenced by the way in which clinical privilege has appropriated her representation in language. There are honourable exceptions.

The argument also assumes that she has voice and that we might train ourselves to hear it, if we are prepared to offer access to sites of privilege. It is important not to conflate erasure and professional deafness with failure to speak. Just as the subjects of *Subaltern Studies* spoke, but were erased from historical accounts, so too do clinical subjects speak, but under erasure. In cyberspace, patients talk to each other about their treatment, their symptoms, their therapies, finding kinship outside of professional relationships. Accounts of therapies written by patients (Dinnage, 1989; Masson, 1992) make uncomfortable reading for therapists. Advocacy groups are increasingly a presence at professional conferences and are vigilant about patients' rights. However, just as the mobs of history are recorded as a disturbance to be contained, so too is the critical patient a force to be contained, neutralized, to be shaped into forms that harmonize with hegemonic meanings. Counter-readings of clinical practice are discursively positioned in a fixed relationship to dominant readings; privilege (access to knowledge, to representation) determines dominance. So, for example, angry anti-psychiatry voices at a large psychiatric conference might be appropriated by practitioners through

being ignored, being treated as a controversial sideline, through being used as emblematic of the very disorders psychiatrists treat, even as evidence of psychiatry's increasing open-mindedness and egalitarian philosophy. Freedom to speak comes not from the syntagmatic chain in which subjects and objects change position, but from unrelated sentences, from the voices that speak not from within the profession or against the profession, but for themselves and in relation to self-expression, like a dream, like an aria. Bollas (1995) describes reaching a state in which the analyst is able to 'dream the analysand during the hour' (p. 12). The dream is shared, intersubjective, anarchic, allowing 'news from within himself' about the unconscious communications of the client (Bollas, 1987, p. 55). With Bollas's notion of the analyst allowing him/herself to become 'situationally ill' (1987, p. 204), disturbed, stirred up by the client's communications, comes the idea of a shared and unstable clinical subjectivity—not 'subject'—shared between two speakers.

Can the Clinical Subject Speak? Unlearning Clinical Privilege

To conclude: in this paper, I have mapped out some of the difficulties that stand in the way of hearing the clinical subject speak. I have suggested some of the conditions that might enable us to hear her better. And because those conditions are laborious to obtain, because colonizing systems of knowledge deafen us day after day, because training is an expensive and time-limited exercise, and because people's mental anguish calls on us to act with urgency, whether we hear clearly or not, we will continue to do what we can, muteness notwithstanding. Clinical subjectivities do communicate, under particular circumstances, and to particular people, even if the voice of the clinical subject is difficult to discern. What we need is to ready ourselves to be available to hear.

What does it mean, to unlearn clinical privilege? I am African, born in Africa, but unsure of what to call myself, with my colonizer's skin. I have privilege—class, clinical. Where are the innocent ears that will allow me to listen? The answers stammer through wrestles with structures of language, themselves saturated with history, and binding us all into an associative matrix not of our making. Accountability to our own history and the ways in which that positions us (our privilege, our perpetrator status), bearing the burden of our own memory and desire, is helpful.

No state of hearing is permanent. Every moment of speaking and hearing is won through a recognition of difference and deafness, and a commitment not necessarily to creating space for the clinical subject to speak, but to creating an intersubjective space in which the subjectivities of neither clinician nor client dominate. In this quest, clinical work has eventually

shrunk to a simple pair of tasks: speaking for oneself, and struggling to hear.

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