Identity Dilemmas and Psychological Discourse: The Case of Psychopaths in a Secure Psychiatric Hospital

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ABSTRACT: Contemporary culture is patterned with psychological ideas and concepts. Social constructionist theory contends that these ideas constitute a regime of truth which constructs rather than describes a version of who we are. It is argued that the option of whether to reject or assimilate such concepts poses dilemmas for personal identity. This dilemma is considered through the example of a Q-methodological study of discourse about psychopathy amongst patients and staff in a secure, psychiatric hospital in England.

Introduction

This paper explores some of the dilemmas posed for the notion of personal identity by recent developments within the human sciences. Essentially these trends have been characterized by a movement away from attempting to discover what "really" exists in the world towards a concern with language and text as structures through which our world is understood and experienced. This concern is associated, *inter alia*, with the idea of the "post modern condition" (Lyotard, 1984) and social constructionism (Gergen, 1985) in which a position of primacy is afforded to language as an impersonal medium which, rather than *reflecting* external reality, *constructs* both our sense of what exists and what is going on in our lives.

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A variety of writers have explored the way in which contemporary reality is now patterned with psychological theories. Moscovici (1976), for example, has described how the penetration of psychoanalytic ideas into 20th century society has left a set of representations through which it becomes "natural" for people to construct themselves as having an unconscious, an id, ego, superego, etc. Ingleby (1983) has used the term "psychological complex" to reflect the pull of psychological language within contemporary Western culture. Rose describes how the emergence of this vocabulary has opened up the "human soul" as a target for government and rational management by providing both a language to describe subjectivity and a technology to inscribe it (1990, p. 104).

This paper considers one of the dilemmas posed by the avoidance or rejection of psychological language: on the one hand, rejecting allegiance to psychological discourse (and its implied psychic norms) may prove liberating; on the other hand, positioning oneself as an outsider to this discourse may lead to marginalization and alienation. As an example of this dilemma the study described here utilizes Q methodology to elucidate the way in which psychological language, centered around the notion of psychopathy, provides the textual material from which patients in an English maximum-security psychiatric hospital develop a form of identity. The application of Q methodology which I will offer here can be seen as an expression of the "British dialect in Q" (Stainton Rogers & Stainton Rogers, 1990) which draws upon social constructionist, postmodern and poststructuralist theorizing to deconstruct and explore in a novel way traditional psychological concepts, such as identity and the self (Kitzinger, 1986; Curt, 1993).

In this constructionist reading of Q, language patterns defined by analysis are considered as external to the sorter and are not construed as an element of a personalized subjectivity. The notion of "viewpoint" is contested as a "viewpoint" requires a "viewer," a unitary subject, a center of awareness to which the external world can be referred. In its place the constructionist understanding of Q emphasizes the pattern analysis of propositional configurations as texts which, at one and the same time, are constructed by and construct the sorter: " ... we are multiply storied as well as well as multiply storying beings: *homo narrans narratur*" (Stainton Rogers & Stainton Rogers, 1992, p. 5). Put another way, while the Q sorter acts upon the Q pack, the principle of "finite diversity" (Stainton Rogers, 1995, p. 180) assumes that s/he will be tapping into some form of existing, ordered cultural understanding that will inform how s/he makes sense of the topic of interest.

Language and Identity

These principles of construction also apply to an analysis of the self. The constructionist adaptation of Q method opposes the modernist perspective upon the self as a center of awareness and replaces it with the idea of a "decentered" self that is constructed through a multiplicity of potentially, contradictory discursive practices. While we may retain a sense of unity and personal history, this sense of self is always conveyed in language and influenced by preformed structures such as narrative, theory, and discourse. Both self and identity are deeply enmeshed in the material structure of language and this enmeshment closes off the possibility of "accessing" or "discovering" a "true" self that exists outside of language. This point is summarized in the following way by Stainton Rogers *et al* (1995, p. 45).

> The injunction to 'be yourself' is meaningless unless you have some practical understanding of what this means, and some agreement as to what counts as an instance of 'being yourself.' In other historical and cultural circumstances, different understandings prevail as to what human beings 'are' (which tend to be related to differences in the way that social life is organized) and hence different ways of 'being a person' hold sway.

The futility of attempting to "be ourselves" is illustrated by Lovlie in his discussion of the attempts of the Enlightenment philosopher, Rousseau, to give a portrait of himself "in every way true to nature" (1992, p. 127). Lovlie argues that Rousseau's efforts in *Confessions* are inevitably doomed as the quest to unearth and delineate some kind of "deep-structure" is always distorted by the pregiven structures of, for example metaphor and metonymy, that are already embedded in the text.

Constructionist theorizing, in as much that it argues against modernist notions of a pre-formed, *a priori* self, suggests that the attainment and maintenance of viable forms of identity are always problematic. These problems are intensified in the case of the users of psychiatric services where the invitation might be towards identifying the self with professional norms and categories (*e.g.*, Barrett, 1988). Further intensification of such problems occurs for those embroiled in the coercive end of psychiatry under the fragmented category of psychopathy.

The term "psychopathy" has a number of different applications but perhaps common to each is an attempt to theorize a relationship

between an "abnormal" mind, self or personality and a propensity for grossly anti-social behavior. Internationally, the confusion which has arisen in the course of attempting to make sense of this relationship, is something that has led many countries to abandon the concept of psychopathy altogether on the grounds that it is beyond definition (Bean, 1986). Within the UK, critics such as Blackburn (1988) have pointed to the fact that countless studies have failed to identify a single type of abnormal personality which is prone to chronic rule violation and have repeatedly made the error of confusing social deviance with personal deviance. Chiswick (1992, p. 108) concurs with this analysis, suggesting that failure to identify a "true" personality type allows almost any violent offender to slip into the category with diagnosis being influenced by such vagaries as to which prison the offender is remanded or by which psychiatrist s/he is interviewed.

Much of this uncertainty haunts the issue of helping or "treating" psychopaths. Collins (1991) noted the vague, nonspecific way in which psychiatrists addressed treatment issues and Black (1984) suggested that, on the basis of information available, any identified improvements in the psychopaths condition could not be related to specific inpatient treatments offered. Bailey & McCulloch (1993) showed that psychopaths were significantly more likely to offend than a mentally ill group of offenders and other commentators (*e.g.*, Faulk, 1990) have hinted at the psychopath's facility to display a level of institutional adjustment which conceals their underlying propensity for further antisocial behavior.

Despite these concerns, English, forensic, psychiatric hospitals continue to admit patients under the category of psychopathic disorder. Once admitted to these institutions, however, ambiguities about the definition and treatment of psychopathy are not left behind. Some indications of how this confusion is translated into the clinical context is provided by studies which have shown the length of stay for psychopaths in the forensic hospitals correlates with severity of offending behavior, rather than psychological functioning (Norris, 1984; Dell & Robinson, 1988). Hence the more severe the offence, the longer the treatment required—an association which hints at the merging of legal, custodial, ethical and clinical issues.

Method

In this article I will delineate the various accounts and theories shared amongst a staff/patient population within a total institution (an English

maximum-secure, Special Hospital). These accounts are considered as a series of conceptual locations, or texts, within which individuals, subject to detention by the legal category of psychopathy, can be "read." Additionally, I will offer some suggestions as to the way in which these texts are assimilated and developed in order to maintain a viable form of personal identity.

Material

I described earlier how within the UK the practical management of psychopaths appeared to conflate a number of legal and clinical themes. Sensitivity to these issues was maintained by the means through which the Q sample was derived. This was sampled from a range of diverse sources which included a review of the theoretical literature, a number of semi-structured interviews with a range of staff and patients in a Special Hospital, informal discussions with patients and colleagues and a trawl of media representations of psychopathy. On the basis of this a 61 statement Q sample was constructed (see the Appendix) which integrated statements about the cause, definition and treatment of psychopathy.

Participants

Forty participants completed the Q sort. These comprised a range of core mental health professionals (*i.e.*, nurses, psychiatrists, psychologists and social workers) working in the Special Hospital and 10 patients, all of whom were detained in the hospital under the legal category of psychopathy.

Procedure

Participants were requested to sort the Q statements along a response matrix (agree/disagree) in accordance with the following format.

Distribution Values

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
(3)	(4)	(5)	(6)	(7)	(11)	(7)	(6)	(5)	(4)	(3)

Distribution Frequencies

Results and Factor Interpretations

The responses were factor analyzed using the PCQ program for Q technique (Stricklin, 1990). This allowed a centroid factor analysis to be carried out. Factors were selected if one or more of the participants had a factor loading of 0.45 or more, and then rotated to simple structure using the varimax criterion and the propositions, constituting the emergent factors, were given an interpretative gloss.[1] On the basis of this, four unipolar and one bi-polar factors were identified. The interviews from which some of the Q statements were derived were transcribed and provided a source of data to illustrate some of the possible ways in which both staff, and more particularly, patients, deployed and worked with the identified accounts.

The six accounts represented by these four factors were interpreted as follows.

The treatable psychopath

The Q sorts of five persons, two nurses, two social workers and a patient, defined this factor which affirmed the role of adverse life experiences and environmental factors in influencing the aberrant behavior of the psychopath. It dismissed the relevance of intrinsic, biological features or fixed psychological traits and, for these reasons, seemed to offer the hope of change through the receipt of psychological treatment and the provision of a more nurturing environment.

The autonomous psychopath

A nurse and a social worker define this factor. Deviant, anti-social behavior is ascribed to volition and is not attributable to environmental factors. Psychopathy is located as a form of "lifestyle" which certain individuals have elected to adopt. In a similar way psychopaths can "will" their own recovery. Consistent with this account, one interview participant—a patient—described a critical moment in his life when he was confronted with a choice between a conventional or more anti-social life style and he chose the latter.

[1]A more complete description of the results including factor loadings and factors scores is available upon request from the author.

The victims of labeling

The Q sort of one patient achieved a significant positive loading on this bi-polar factor. In this factor psychopathy is presented as a label that is arbitrarily imposed upon particular individuals. It therefore has little scientific value but survives as a coercive legal category through which unconventional, non-conforming groups can be regulated through detention in secure institutions.

Psychopathy is an objective scientific label

Two participants, a psychiatrist and psychologist, loaded negatively on factor 3 and this has been interpreted as constituting a separate factor. The reverse reading of factor 3 presents a conventional empiricist account of psychopathy in which the category is neutrally and accurately applied to a particular group of people.

The Separate Population

The separate population factor was defined by the sorts of a nurse and psychiatrist and down-played the causal significance of life experience and the environment in the development of psychopathic disorder. The psychopath is presented almost as a separate species, with unique, idiosyncratic characteristics. This text emphasized the unchanging nature of the psychopaths core features, or inner reality, so that the possibility of therapeutic change was limited.

Appearance and Reality

Psychopaths have an appearance and a reality was defined by one nurse. This appealed to notions of the psychopath having an underlying "depth reality," which was inherently bad, evil and unchanging, and a "surface-appearance" through which superficial conformity to social and institutional norms were affected. Illustrative of this position was one interview participant who described a psychopath in a well known English psychiatric prison (Grendon Underwood) as "having a first class honors degree in Grendon language."

The accounts identified by Q analysis are interpreted as some of the more prominent accounts of psychopathy to pattern the domain of the Special Hospital and these accounts will now be considered as textual resources for the formation of identity.

Language, Power and Identity

The relationship between power, language, and the self was implied by the fact that although such accounts did not seem particularly "user friendly" to psychopaths—appearing to express a combination of cynicism and therapeutic pessimism—there was considerable evidence (provided by factor loadings and in interviews with patients) of them being readily taken up.

There are several possible reasons for this. One explanation is that the accounts identified by Q analysis can be seen as defining the boundaries within a particular conceptual universe. How we reflect upon and define ourselves is determined and constrained by the structures of knowledge available to us within that universe. As this study suggested that the above descriptions were amongst the more popular and visible, it should not be seen as surprising that they were deployed as part of "peoples" everyday attempts to make sense of themselves and the world. Additionally, as the accounts of psychopathy identified by Q analysis were likely to be amongst the more powerful or plausible ones in circulation within the institution, there were potential risks in failing to identify with them. Shotter (1993) has stated that everyday reasoning and discourse has a coercive quality to it, in as much that it is only by seeing and talking about things in a regimented or institutionalized way that we come to be recognized by other members of a community as responsible and competent.

Barrett (1988) has indicated how this process might be augmented when it operates in psychiatric settings. He suggests that through repeated assessments and interactions with professional staff, patients increasingly come to define their experiences in relation to professional norms and categories and, as such, come to be seen as competent patients. Failure to endorse discursive norms may lead either to marginalization or discreditation through identifying with more peripheral or subjugated forms of knowledge.

The coercive pull of language was illustrated by the frustration of patients who, having initially expressed their opposition to the term "psychopath," found themselves during the course of the interview incorporating the term in their description of themselves and others. Here it seemed that the institutional vocabulary was so saturated with this particular lexical item that it became difficult to avoid using it. A number of interviewees expressed antipathy to the concept but then as the interview progressed, found themselves employing the term quite readily. For example:

> I mean you can channel, or perhaps ... you can channel your psychopathy into acceptable levels. I am conscious here that I am accepting the term psychopath but although I am constantly using it I still dispute it in a sense.

Personal Identity and the Variability of Discourse

Consistent with the theoretical debate about the definition, treatment and management of psychopaths, the discursive material elucidated through Q analysis contained many contradictory patterns and practices. Some accounts were openly antagonistic (*e.g.*, *The treatable psychopath* compared to *The separate population* account). Whatever the explanation for this, I will suggest that variation must be considered highly relevant to the relationship between language and identity, providing a precondition for some resolution of the identity dilemma which I defined earlier.

Harre (1983) has argued that personal identity amounts to the assimilation, idiosyncratic transformation and publication of socially available theories and templates. While there is a coercive dimension to discourse it is also possible to envisage a patient's identification with a particular account as an attempt to create a space or position within which a particular form of identity could emerge. For example, the adoption of an objectivist account of psychopathy might indicate a patient's identification of himself in a position of scientific respectability, a labelling account with being "radical" and an appearance-reality account with being cynical or "street wise."

The suggestion made here is that, in developing and working with particular types of account, patients were engaged in a form of identity politics, attempting to negotiate a favorable identity for themselves through the deployment of a chosen text. This perspective, which emphasizes the action, rather than referential function of language, allows us to see both the fluidity and multiplicity of identity taking shape. The types of psychopathic identity which emerge do not maintain fidelity with some reified inner state but can be seen as historically constructed, shifting constructs, invoked for tactical purposes. They appear as constantly shifting, momentary positions and the sense of movement which they invoke allows us a glimpse of the self as no more than a "nexus of subjectivities" (Walkerdine, 1981) set in relation to different types of (contradictory) texts.

For those who are able to grasp this action function of discourse, and are able to reflect upon themselves as, for example, the object of a scientific discourse about psychopathy, there is the possibility of

successfully defending against marginalization or devaluation. This allows, on the one hand, the attainment of a satisfactory social identity but, on the other hand, by aligning the self too closely with a dominant social order threatens the loss of uniqueness required for personal identity. As earlier discussed, Barrett has described how psychiatric patients, through the course of repeated assessments, come to increasingly define their experiences in accordance with a professional definition of psychiatric illness (Barret, 1988, p. 286-7). As such they come to be seen by clinicians as "competent" patients whose idiosyncratic qualities are swallowed up within global psychiatric categories. The task for such people, and for the patients in this study whose social identity is constructed within the narratives described above, is to retain a sense of uniqueness through resisting the oppression of dominant narratives.

Davies and Harre (1990) have suggested that a proliferation of contradictory discourses allows for at least the possibility of notional choice by giving to the person some freedom over which particular narrative or story they might engage. It is this element of choice which allows some resolution to the identity dilemma described above. This was observed within interviews as patients moved through a variety of different discursive positions. The following extract is fairly representative of this pattern. At an early stage in the interview the participant, a patient, appears to adopt an objectivist position:

> Erm, yes. (pause) Obviously on my definitions already I've shown or said about two different types of psychopath. Er, it is where you draw the line really. It is like if you go up from the normal person to the primary psychopath, or whatever, erm (pause), there would be differences, yes.

While at a later point the arbitrariness of diagnosis and definition is emphasized:

> Erm, once again I'm gonna' come back to my personal being. I've been labelled at some stage a psychopath. Through talking to people and the relaxed atmosphere then I don't think I'm a psychopath no longer by whatever terms I was classed by in the first place.

Scientific notions of treatment are also derided:

> I was going to ask does the provision of any kind of treatment influence change and. ...

> Oh yes, it does, but once again its very hard because, once again the people in authority, if someone has committed a crime to be a psychopath and then they're locked away for it erm, first of all you've got to do your time, basically. Once you've done the certain amount of time that's been set by the courts, whatever, erm, people can be a little bit over-careful. As I say it's hard for them because they've got responsibility to release somebody and not wonder whether they're going to reoffend. So they've got to be secure in their own minds, but I find it very frustrating when I know I'm alright now and trying to put that point across to the people who have responsibility.

The patient is, therefore, accepting the dominant scientific discourse about psychopathy but then combines this with a more peripheral discourse about labelling. One interpretation of this sequence is that by drawing upon this flexible repertoire the patient/psychopath is able to both identify with the dominant social order while, at the same time, defend against becoming the "model patient," the mere cipher at the center of the role, by developing a position that is at variance with the established order.

Similar resistance was offered by patients who in interviews developed a position based upon a *Separate Population* or *Appearance and Reality* story line, *i. e.*, narratives which contradict and challenge the dominant discourses of objectivity and treatment. The positions adopted there emphasized the inherent differences of the psychopath, and hence the impossibility of coopting them into the social order. Alternatively it stressed the fact that change through treatment represents only token compliance on the part of the psychopath. Underneath the underlying personality structure remains intact and hence individuality is preserved.

Conclusion

This study utilized a social constructionist application of Q analysis to elucidate some of the key texts of identity available to patients detained in an English maximum security hospital under the category of psychopathy. The diversity of accounts elicited by analysis resonated with the varied and, often, contradictory ways in which the idea of psychopathy has been theorized and applied within the UK.

In keeping with a social constructionist agenda I avoided making the "individual" the focus of analysis and chose, instead, to examine the texts identified by Q analysis as discursive practices which contributed to the way in which the individual—"the psychopath"—is experienced

and understood. As earlier noted, this approach problematizes traditional understandings of the *a priori*, pre-formed self that is external to language and insists that language is always "more than just words." On the contrary, the necessity of working with and internalizing particular texts about psychopathy constrains and regulates the lived reality of those to whom it applies. However, as we saw, such texts can also be used creatively to resolve the dilemma of, on the one hand, needing to think of ourselves as having a sense of personal unity and history, while, on the other, enabling us to avoid allegiance to the regulatory, psychic norms.

Appendix

Q statements

1. The traits which constitute a psychopathic disorder are at the extreme end of a continuum.
2. A person with a psychopathic disorder is likely to exhibit some form of disturbance almost from birth.
3. It's possible to behave in a psychopathic manner in one situation but not, in general, to be a psychopath.
4. Psychopaths are able to use their knowledge of what they feel is socially acceptable in order to conceal their underlying problems.
5. Psychopaths are responsible for their actions whereas people who are mentally ill are not.
6. Psychopathy is like alcoholism: you're never fully cured but you can learn how to live with the problem.
7. When you first meet a psychopath they're just like anybody else but as you get to know them you begin to realize what they're really like.
8. It's always possible to know if somebody is psychopathic.
9. The more disturbed psychopaths have their problems buried well below the surface.
10. Whether a person is diagnosed as being psychopathic has a lot to do with what social class they come from.
11. There are no "objective" ways of assessing whether or not someone is a psychopath.
12. Through employing psychometric tests and sound clinical judgement it's usually possible to tell if someone suffers from a psychopathic disorder.
13. Ordinary people might well have psychopathic traits and a capacity for psychopathic behavior.
14. Discovering the extent of someone's psychopathy is more a question of intuition rather than employing objective tests and measures.
15. As a way of coping with the disappointment and sadness in their life psychopaths have distanced themselves from emotions and feelings.

16. Observing the person's behavior is the best way of determining whether or not they're still psychopathic.
17. Psychopathy is a label that enables people in authority to maintain offenders in a custodial setting for an unlimited period of time.
18. In the right context it's possible to channel psychopathic traits towards an acceptable goal.
19. Psychopaths never really accept social boundaries and norms.
20. In everyday life there are many similarities between psychopaths and ordinary people.
21. "Psychopath" is a convenient label that psychiatrists employ when they can't make their minds' up about someone.
22. It's possible to live or work with a psychopathic person and not know that they're psychopathic.
23. It's easy to see psychopathic traits when you're aware of the diagnosis but without that awareness those same traits might go unnoticed.
24. Under pressure a psychopath's "camouflage" is likely to fall apart.
25. What differentiates one psychopath from another is the extent of their anti-social behavior.
26. Psychopaths fail to realize that other people have needs and feelings as well.
27. Labels such as "psychopath" are irrelevant when it comes to working with and preventing offending behavior.
28. The characteristics of a psychopath are more extreme or exaggerated than those of the ordinary person.
29. People are diagnosed as being psychopathic because they reject and don't conform to oppressive social norms.
30. Psychopathy is a label that's used only when people can't understand why somebody has behaved in a seriously anti social way.
31. Psychopaths seem to lack many of the qualities which ordinary people have.
32. The similarities between psychopaths and so called "ordinary people" are almost too numerous to mention.
33. How psychopathy develops in a particular person will depend upon the basic defect in their personality.
34. Biological factors such as hereditary and organic damage play a big part in the causation of psychopathy.
35. Under pressure and stress many ordinary people might behave in a way that's considered psychopathic.
36. People who suffer from a psychopathic disorder seem to have lost the ability to make choices.
37. Psychopaths have either felt or experienced rejection from significant people in their life during their early years.
38. What makes people psychopathic is not necessarily what has happened to them but how they interpret what has happened to them.
39. You can't make someone psychopathic unless there already predisposed

to becoming psychopathic.

40. The features of psychopathy are things which the person has learnt during the course of their life.
41. As people grow up they have choices and people who have a psychopathic disorder have, to a degree, made choices about their particular lifestyle.
42. The quality and nature of early emotional relationships are most significant in determining whether or not somebody will become psychopathic.
43. It is inevitable that certain people will become psychopathic.
44. A person with a psychopathic disorder is motivated by a particular set of drives.
45. Certain types of early learning experience are inherently damaging and will inevitably result in a person developing a psychopathic disorder.
46. Sometimes when people behave in a psychopathic way they are almost compelled to do so by their circumstances.
47. In general people who develop a psychopathic disorder are likely to have experienced physical or sexual abuse.
48. As a result of treatment people with psychopathy are able to make drastic changes in the way that they function.
49. Treatment within an institution might affect an improvement in the way a person behaves within the institution but it doesn't guarantee they won't reoffend when they leave it.
50. As psychopathy is a major disorder of personality it's unlikely that basic personality deficits will ever improve to the point where they are no longer a problem.
51. Psychological treatment doesn't remove psychopathic traits but it does help the person to respond better in certain situations and thereby remain on an even keel.
52. With the provision of appropriate therapy most people with a psychopathic disorder can make a good recovery.
53. Institutions, such as Special Hospitals, which purport to treat psychopathy actually make it worse by mirroring the cold, abusing environments within which many psychopaths have grown up.
54. Psychopaths might change superficially but underneath they will remain the same.
55. The fact that psychopaths lack emotion means that they will never function satisfactorily with other people.
56. Psychopaths may gain insight into their behavior but their "internal attitude" will remain the same.
57. Counseling and therapy might modify psychopathic behavior but it will never get to the core of the problem.
58. The best way to "cure" psychopathy is to have a person assessed by a psychiatrist who doesn't believe in the label.
59. People who suffer from psychopathy can change for the better by living in a therapeutic community.

60. Psychopaths can learn the language of therapy but are unlikely to undergo any fundamental changes to themselves.
61. As a consequence of being in prison or hospital psychopaths learn to assimilate the norms and values of society without ever really feeling committed to them.

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