



REVIEW ARTICLE

THE POLITICS AND POSTMODERN REINTERPRETATIONS OF CLINICAL PRAXIS: ESPOUSING LOCAL UNDERSTANDINGS OF DISTRESS

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ABSTRACT

In this paper, inspired by a postmodern reconceptualization of truth and the deconstruction of objectivity, I critique the notion of western-inspired psychotherapy as neutral, universal, apolitical, and normative for all cultures and groups. This value-free idea of clinical praxis, I argue, would advantageously give way to understandings that re-vision the therapeutic encounter as a deeply political context – subject to the vulnerabilities of normal social interactions. Consequently, in view of increasingly credible ideas about the embeddedness of human experience, the subjectivity that must attend ‘scientific’ work, and the deconstruction of hegemonies as givens, I frame the crises currently facing orthodox psychotherapeutic praxis, and challenge its assumed superiority over local espousals of mental distress. This is done in the hope that a new space for more pluralistic forms of therapy might evolve unconstrained.

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INTRODUCTION

Mainstream psychotherapy, a largely western phenomenon (Samuels, 2005; Ryde, 2005), is popularly conceived and practiced in terms of unilinear clinician-client dyadic encounters. In the psychotherapy room, identities endemic to the therapeutic alliance are often assumed: the psychotherapist becomes the expert-healer who must use her special knowledge to alleviate the problems of her client; the individual client becomes the passive recipient of the psychotherapist’s expertise, and must submit to her interpretations and perspectives.

The focus of therapy is on helping the individual make rational decisions, and achieve a state of maturity and independence (Ryde, 2005). Therapy is often deemed successful when the individual faithfully follows the instructions of the therapist, and adheres to the contractual agreements unique to the alliance. In other words, ‘*the self needs fixing*’, and the traditionally western-inspired clinician-client therapeutic configuration provides a supposedly politically-neutral, value-free, scientific space to enact healing irrespective of the context in which it is practiced. At least in practice, this *neutrality* and professional isolation from the volatility of politics and power is often assumed (Totton, 2005). This western expertise, with its

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attendant interpretations, standards, discourses and models, are then taken as a universally accurate picture of mental healthcare. Not lightly motivated by postmodern critiques of truth and objectivity, as well as the social constructionist insights into the political/cultural/social/historical embeddedness of human experience, different understandings of clinical praxis are gaining compelling audiences.

The issues of concern that have enlivened discourse about clinical praxis border on the suitability of western conceptions of mental health and illness for all other cultures, the belief that we are actually *healing* our clients – that is, the validity of expertise and, not least important, the idea that we can attain to any objective conceptualization of human experience in much the same ways that have arguably proved beneficial to scientists who deal with the physical world. Current trends, such as terminated clinical appointments and an observed unwillingness of certain minorities (such as African Americans) to participate in western configurations of therapy (Yeh, Hunter, Madan-Bahel, Chiang and Arora, 2004), are also influential in contributing to the present critical moment. For the purposes of rigour, these issues, presented above, might be reframed (if it might be said without levity that there are palpable tensions of opinion brewing in the therapeutic franchise) as the crisis of centrality, the crisis of neutrality, and the crisis of objectivity respectively. What might be called the ‘politics of psychotherapy’ is one of the central themes of this paper – alongside postmodern / social constructionist reinterpretations (and the messy complexities introduced) of this *very* human institution. Psychotherapy is not politically neutral or free from stubborn power issues as previously supposed. Sands (2003; in Totton, 2005) states: Psychotherapy is the only profession where the practitioner can be insensitive, evasive, patronising, arrogant, discourteous, self-righteous or just plain wrong and where clients’ observations of this can be taken to be an expression of their problems, evidence that what they really need is more of the same therapy.

Consequently, there is a growing realization among practitioners that the practice of psychotherapy is just as vulnerable to the abuse of

power as other forms of social encounters. Far from being a positivistic science that neatly demarcates (as chemists would attempt to isolate the chemical properties of a liquid) and objectifies mental illness and health, therapy is situated within the hermeneutic nexuses of powerful interests and conventional discourses on what counts as distress and normality. Paradigms determine, constrain, and contain thinking patterns; if psychotherapists are situated within these paradigms, then it is not difficult to see how fragile the supposedly invulnerable praxis of therapy really is. Further still, the concerns discussed herein may have more to do with the *very idea* of psychotherapy and its concomitant configurations than with the psychotherapists themselves. This paper explores these issues, and problematizes – alongside other notions – the assumptions of neutrality and universal expertise, the assumptions that a particular conceptualization of mental illness is, on the strength of its being labelled ‘scientific’ and ‘global’, superior to local understandings of distress, as well as the assumptions that therapy is apolitical, value-free, neutral, and not often the imbalanced power relations context many are beginning to perceive it as.

The Paradigmatic Discourses of Psychotherapy

To begin, this section explores, albeit summarily, the historical antecedents and the dynamic currents of theories and perspectives that have given rise to western psychotherapy and its closely affiliated profession, psychiatry. The focus is placed on the epistemological foundations of the professions. As such, some deeply philosophical issues are discussed. At first this recourse into ‘philosophy’ might seem uncalled for in today’s scientific circles, it is anything but. As Ingleby (1981) asserts, researchers have often sidestepped conceptual clarity for greater experimental sophistication. The present paradoxes and chaos that clinical psychology and the specialized profession of psychotherapy is faced with would demand that practitioners explore how they have constructed the discipline over time. Thus, to think about how clinical psychology has operated historically, it is important to recognise the underlying influence of paradigms, which may be roughly construed as mentalities or systems of

thought with a set of assumptions that constrain and predispose adherents to perceive 'objects' in particular ways. Paradigms are 'whole systems of prejudice about what constitutes useful and respectable data, what form theories should take, what sort of language scientists should use, how they should go about their business, and so on' (Ingleby, 1981). Kuhn (1970) popularized the notion of paradigms and their influence on the business of science. Contrary to hitherto held understandings about the nature of scientific change and progress, Kuhn posited that scientific activity of any sort is deeply embedded in socio-political systems with preferences and power interests. His 'close examination of the history of science showed that the grounds on which one paradigm is preferred to another are not exclusively scientific ones: the determinants of that choice lie to a large extent *outside* science, in social and psychological factors' (Ingleby, 1981).

A term I prefer, which is closely allied with the notion of a 'paradigm', is 'discourse'. The term, 'discourse', in keeping with the social constructivist tradition, captures the linguistically constructed nature of these frameworks (Botella, 1997). That is, according to social constructivist accounts of 'reality', objects do not precede, and are not independent of, discourse; objects have no extralinguistic referent, but are co-created in the very act of discourse. In this sense, as Botella (1997) states, we can no longer ask the question, 'what is a human being', which is an essentialist enquiry. Instead it seems more appropriate to ask 'what kind of human being is constructed by our theoretical discourse?' It is possible, then, to distinguish between a discourse of objectivism and a discourse of constructivism (Botella, 1997) in clinical psychology and psychotherapy.

The former, variously referred to as positivism, is characterized by the assumption that reality exists beyond, and is independent of, the observer. There is the observer and the observed, and the distance that must be traversed between them is a neutral set of procedures and expertise best encapsulated in what we now term 'the scientific method'. Accordingly, accessing 'objective' and universal knowledge of reality is possible; all that is required is the correct application of certain

protocol to contain the subjectivity of the observer. Thus, according to Kerlinger (1979; in Smith & Deemer, 2000), 'the procedures of science are objective – not the scientists. Scientists, like all men and women are opinionated, dogmatic, ideological...that is the very reason for insisting on procedural objectivity; to get the whole business outside of ourselves'. The discourse of objectivism/positivism posits a singular external referent – the knowledge of and access to which is available to those who have mastered this 'procedural objectivity'. Every knowledge claim that falls beyond the predetermined operational and conceptual boundaries of this 'procedure' is not considered knowledge, but merely belief – which ultimately falls short of truth (Kirk, 1999). Consequently, the concept of truth as correspondence with reality and the notion of expertise stems from this paradigm. From the positivist perspective, truth is the accurate representation or an internalized form of external reality, and expertise is procedural proficiency or the set of skills needed to effectively translate and apply internalized reality (or truth) in meaningful ways. As Botella (1997) affirms, 'when applied to clinical psychology and psychotherapy, this discourse carries not only epistemological implications, but also methodological, technical, and ethical ones.'

Though the alternative, the discourse of constructivism, represents a kaleidoscopic array of perspectives (that have been variously referred to as constructionist, interpretive, narrative, postmodern, post-colonial, dialogical, discursive), some 'core' assumptions of the many strands are a disavowal of any notion of objective truth and its attendant ideas of procedural/empirical objectivity, and the assertion that truth is not an external referent to which humans may relate to gain epistemic privileges and, consequently, expertise. Additionally, practitioners within this paradigm believe that knowledge is a social construction, co-created and situated within local moral orders; that is, knowledge is framework dependent (Smith & Deemer, 2000). What humans affectionately refer to as reality is not 'out there' in the sense of having an existence independent of our perception of it; reality is a dialogic 'product', the dynamic evolution of our situated linguistic heritages and

potentials. In a very vital sense, we speak ‘reality’ to being; hence, the notion of objectivity is itself a *myth* and a social construction that is embodied and embedded in politically dense, culturally biased, historically situated spaces. The consequence is obvious: there are no value-free observations; the quest for objective truth is defeated from the outset—for if observation is ‘tainted’ by the observer (that is, if all observation is theory-laden, framework dependent, and political), then access to ‘raw data’ or the empirical referent is undermined.

The very act of experiencing is *not* to be neutral, is to be implicated, is to be involved (thus, empirical neutrality is impossible). The only way to obtain ‘objective truth’, so it seems, is to somehow step out of one’s experience, and yet act in experience. Exploring the practical implications of this paradigm for clinical psychology and psychotherapy are beyond the objectives of this paper. However, it is important to note that the implications/consequences are ‘real’ – not merely philosophical and, as some researchers might be led to believe, impotent.

The practice of psychotherapy and its close affiliate, psychiatry, are largely in a state of crisis today. Questions that continue to express concerns about the future of the professions reflect the evolving volatility of the field. As mentioned in the preceding pages, there are deep and troubling contentions that have to do with defining/conceptualizing mental illness in the first instance (or even demonstrating its existence), deciding what methods or methodology is appropriate for research, and judging the efficacy of treatment. The emergent field of anti-psychiatry, partly motivated by Thomas Szasz’s critique of the mental health professions (Szasz, 2001), takes up issue with the predominant bio-medical model that informs much of clinical practice – stating that its emphasis on the diagnosis and treatment of ‘mental illness’ is undue and ill-founded. Szasz (2001) calls mental illness the ‘phlogiston’ of psychiatry, positing that ‘in [the] act of medicalization lies the root error of psychiatry’. Ingleby (1981) however believes that the real issue to grapple is the positivist orientation of the profession. The real problem of clinical psychology is its uncritical alliance with Auguste Comte’s brainchild,

positivism. He suggests that early psychologists and psychiatrists, in a historical milieu that celebrated the perceived successes and progress of the physical sciences, would have been pressured to ‘conform’. These early researchers ‘could not afford to isolate themselves from [the model of the natural sciences] by challenging its positivist assumptions’. Hence, psychotherapists and mental health researchers today have inherited a paradigm that is largely positivist in configuration. But is this a problem, and why? Are there reasons to believe these paradigmatic controversies have led the affiliated fields of psychotherapy and psychiatry to critical moments where a paradigm shift is desirable? Is psychotherapy in a state of crisis due to its positivist backdrop? How can we correct the anomalies in clinical praxis?

The Crisis of Objectivity

Positivism assumes the ‘givenness’ of an accessible reality. This empirical referent is universal, global and, through the use of reason (conceptualized as ‘the scientific method’), can become knowledge to the observer. Every other knowledge claim that does not satisfy the empirical standards of the scientific method is not considered knowledge, but mere belief.

In a broad sense, positivism is the philosophical expression of scientism, the view that empirical science is the primary cultural institution, the only one that produces clear, objective, reliable knowledge claims about nature and society that accumulate over time and thereby the only enterprise that escapes the contingencies of history. For positivists, that reliability is proportional to the proximity of claims to observed facts—the empirical basis of knowledge. Every substantive claim not tested by experience is sheer human fabrication (Nickles, 2005).

Mainstream psychology today is largely informed by such positivist assumptions. Zayed (2008) states that positivism ‘presupposes the neutrality of observation, the “givenness” of experience, the independence of empirical data from theoretical frameworks, and the ideal of a univocal language. As such, it clearly demarcates the scientific enterprise from qualitative and

interpretive disciplines, and implies that its view is the privileged one regarding knowledge.' Translated into the therapeutic context, these 'pretensions to objectivity' (Ingleby, 1981) manifest as a certain professional aloofness and 'removed-ness', a contrived distancing of the self from the entanglements of sentiments and subjectivity. Mainstream psychotherapists often work with the idea that their diagnoses and prescriptions for health are derived from 'objective' and unbiased assessments. Nothing could be farther from what actually obtains. The postmodern critique of 'procedural objectivity' enunciates the impossibility of assuming a 'God's eye point of view' or a 'view from nowhere'. The modernist postulations about the objective realm naively leave out that experience is necessarily situated and embodied. Every observer is a by-product of dynamic influences within a locality – hence, there is no possibility for an 'objective' viewpoint. Observation is an exercise in bias. It might be instructive to trace the notions of an objective realm to Cartesian (in the Enlightenment era) dualism (Guba and Lincoln, 2000). Polkinghorne (1989; in Guba and Lincoln, 2000) comments:

The idea that the objective realm is independent of the knower's subjective experiences of it can be found in Descartes's dual substance theory, with its distinction between the objective and subjective realms....In the splitting of reality into subject and object realms, what can be known 'objectively' is only the objective realm. True knowledge is limited to the objects and the relationships between them that exist in realm of space and time.

Rene Descartes, arguably the father of modern philosophy, had a machine-like view of reality. Everything operated mechanically in complex cause and effect relationships. The soul, alone, was removed from this billiard-ball scenario. Cartesian dualism split 'reality' into two – the knower and the known, effectively creating a wide gulf between the two substantive realms. The problem his intellectual descendants were faced with was how to reconnect the two realms. In other words, how is 'true' knowledge of the 'objective' realm possible? Today, truth and knowledge are now seen 'as the end product of rational processes, as

the result of experiential sensing, as the result of empirical observations, and others' (Guba & Lincoln, 2000). However, this construction of truth and knowledge as access to a so-called objective realm has been shown to be naive and elitist. A theoretical objective realm would require less (or more) than humans to access it. This is because humans operate from within traditions, and are storied beings. The notion of truth and its assumed imperviousness must give way to a more realistic view, one which affirms the highly politicized, local, and acculturated notion of 'truth'. Indeed the notion of truth has fallen on hard times in a sceptical postmodern age, 'when honouring multiple perspectives and diverse points of view has gained ascendancy in reaction to the oppressive authoritarianism and dogmatism that seemed so often to accompany claims of having found Truth' (Patton, 2002).

Social constructivists, in an attempt to free up space for this multiplicity of perspectives and narratives, view 'truth' as consensus. Of course, the question might be asked: how do we judge the quality of praxis and perspectives since it seems constructivism avows the equal merit of all perspectives? For the researcher situated in the discourse of objectivism, the concepts of validity and reliability are important. The critical moment these paradigmatic controversies help practitioners realize is the assortment of criteria available to us: we need not ascribe to the demands of validity and reliability as 'objective criteria', for there are no such things. Criterion-setting is just as well a social construction; local groups must decide what is important to their interests, and make judgments appropriately.

The crisis of objectivity in mainstream clinical praxis is the realization that there are no objective criteria for making judgments and, much more importantly, there is no empirical reference point from which the psychotherapist supposedly draws insight about his clients' situations. The diagnosis of psychopathology, the aetiology of distress, and nosology of 'diseases' are social devices that have evolved from political, historical and social constraints. In a sense, mainstream psychotherapy is an exercise reflecting one of many perspectives about the human person, what mental illness is, and

how to get rid of it. It is by no means the default configuration for enacting healing contexts.

The Crisis of Neutrality

Following the considerations about the non-absoluteness of 'truth' (and the consequences of this 'liberation' in terms of the polyvocality of perspectives and praxis that suddenly come to bear) is the need to deconstruct the notion of expertise, which draws its plausibility from the defunct modernist/positivist epistemological project.

The expert is a person skilled in a particular discipline, possesses procedural proficiency, and may be relied on – more or less – as an authority in his/her field of discourse. There is a certain grounding that is believed to elevate the expert (in this case, the psychotherapist), giving her the upper hand and privilege over the non-expert (the client seeking help). In conventional clinical praxis, one of the major tools that grants a psychotherapist expertise and legitimizes the therapeutic context is the DSM IV nosology. Proficiency with the DSM IV grants the context a certain sort of predictability and confidence (Gergen, 1996). This is because diagnosis and prognosis are, arguably, the psychotherapeutic expert's most critical tasks. From a modernist perspective, this is all very much in order; a diagnosis presumes the stability of forms, objects of inquiry and methods of inquiry. A diagnosis assumes that language is representational, and can accurately depict 'reality'. The clinical expert is so called because of his access to this pathological referent in reality; he, the expert, uses his knowledge to help the non-expert. Consequently, the expert actively (and hopefully) communicates a 'true' diagnosis to a largely passive recipient of this expertise. Herein is where the danger lies.

From a social constructionist perspective, there are no 'true' diagnoses, in terms of an accurate representation of an objective pathological condition in time/space. Reality is dialogic, discursive and interpretive. Diagnoses 'are socially constructed meanings put forth by the dominant professional culture. A diagnosis is an agreement to make sense of some behaviour or event in a particular way' (Gergen, 1996). Hence, the

'diagnostic reality' is not an empirical fact but a linguistic-relational co-creation. The emphasis then is not on how 'true' a diagnosis is, since there are no objective referents by which that qualitative judgment may be made; the focus is on the mutuality and the participatory space dialogue frees up. Gergen (1996) comments:

Social constructionism invites alternative questions: What is the intent of a diagnosis? What questions are believed to be answered by diagnosis? What information is thought to be gained? What does one want a diagnosis to communicate and to whom? If there are many ways to think about, to describe what may be thought of as the same thing (i.e., behaviors, feeling), how can we respect and work within all realities? Should we consider the possibility of multiple diagnoses? How can we bring the client into the process? How can, and is it possible, for a diagnosis to be meaningful for all involved? How can it be collaborative, tailored to the individual, useful? What other words can we use? If we reject diagnostic terms, should we try to persuade the helping system to change its nosology? How do we develop a way in which multiverses can co-exist? If one views life as dynamic, unstable, and unpredictable then inquiry about it must be ever active. If one views knowledge as socially created and knowledge and knowers as interdependent, then it makes sense to include the client in the diagnostic process. This moves diagnosis from the realm of a private discourse to a shared inquiry in which diagnosis becomes a mutual discovery process.

The absence of an absolute realm of knowable objects deals a deadly blow to the notion of clinical expertise. Without an absolute diagnostic referent, we are compelled to focus on relationships formed instead. Certainty and predictability are obviously compromised in a constructionist paradigm; however, if life is viewed as unstable, volatile and dynamic, the predictability offered by the modernist view becomes problematic. The dichotomization of expert/non-expert, which the DSM IV requires and assumes, also introduces other complexities, which may be collectively referred to as the 'politics of psychotherapy'. When conceived in terms of its relational dynamics,

conventional psychotherapy could be conceptualized as a very oppressive context indeed. The imbalance of power, the privileging of epistemic forms over another, the silencing of client narratives and perspectives, the forced medicalization of mental illness, the institutionalized passiveness of healthcare recipients, and the instances of sexual exploitation reported in clinical contexts are recurrent features of traditional praxis. Many researchers have begun to draw attention to the 'structural problems of the therapy relationship' (Ryde, 2005), some of which are psychotherapy's undue focus on the 'individual' in sharp contrast to society (bolstered by the western *myth* of individuality), the unspoken imbalance of power in the therapy relationship, and the suppression of the perspectives of clients. Foucault (1980, in Totton, 2005) argued that mainstream healing professions are social normalizing devices that exert power over forms of behaviour that do not fit cultural appraisals of 'normality'. There are power interests at stake in the western psychotherapy session that transcend the economic aspirations of drug manufacturing firms; worldviews are at stake. In a very real sense then, western psychotherapy is a political process within a larger culture that prescribes what normality should look like. 'In other words, there is no political neutrality, since politics permeates our social experience' (Totton, 2005).

A deconstructed view of expertise must situate it within its local bailiwick of relevance; the proficiency implied in expertise has nothing to do with an external world of diagnostic significance – for such a world is merely a social construction with its attendant power dynamics. The western-type clinician has no privileged or advantage over other forms of healing configurations. Moreover, the rigid distinction between expert and non-expert, in the post-structuralist moment, becomes fuzzy and blurry. To conclude this section, we (practitioners, clinicians, researchers and the public) must recognize that 'there is no absolute truth, that truth is not singular but plural and contingent, and, therefore, subject to negotiation. This is perhaps the greatest realization of modernity and of immeasurable political importance' (Totton, 2005). What might this realization augur for the profession?

The Crisis of Centrality

If mainstream (western) therapy has no epistemic or procedural privileges over other forms of therapy, and the 'expert' and his tool (the DSM IV) is just one of many ways a therapeutic interaction can be built (itself having no privileged access to an objective diagnostic referent), it seems the next obvious action is to ask the question: where are the many other ways of enacting healing?

The postmodern moment affords us practitioners a practical opportunity to critique the suitability of western therapy for all cultures. Hitherto, some kind of lip-service has been paid to the growing cross-cultural sensitivity within therapy discourse. The assumptions about the default nature of western psychotherapy however remained; the modernist presuppositions about western access to an objective aetiological referent were constant. What is needed today is more than a mere addition to the default (Ingleby, 1981); what is needed is a decentering of therapeutic discourse. We (in reference to practitioners and the concerned public) can no longer continue to pretend that mainstream therapy meets the needs of all people – for if 'psychotherapy' loosely defined is intersubjective activity, made possible by dialogue and discourse, then it is necessarily an exercise in narratives and story-telling. The consequent realization is that we, Africans, must tell our own stories, and enact our own healing contexts. The need is evidenced by growing reports about the refusal of people of heterogeneous cultures to engage in mainstream therapy and an increasingly influential call for culturally-sensitive therapy (Akinsete, 2002, in Totton, 2005). What is needed today is the re-enactment of indigenous knowledge systems, hitherto silenced by the monolithic predominance of western paradigms.

It's a Local Thing: Promoting Indigenous Knowledge Systems

The crises of objectivity, neutrality and centrality, brought to the fore by the deconstructive prowess of the postmodern moment affords a new moment for the decentralization of therapy discourse and the emergence of pluralistic conceptions of truth, human experience, distress, healing and human

flourishing. The realization is deafening: wellbeing is a local thing. Suddenly, the 'native' forms of healing do not seem trivial and embryonic anymore. Indeed, in place of the singular dyadic configuration comes potentially infinite spaces for healing that are contingent upon the local moral orders and worldviews, and are significant to local adherents.

There is a real need to address the silence in African contexts. The discourse of constructivism affords us a new thrilling ethos to engage the narratives and worlds of indigenous people, facilitating discourse, and then evolving locally sensitive non-western 'therapy'. The 'sudden' diversity of perspectives that potentially replace the monolith of western therapy may be unsettling – but it is a thrilling source of creative expression that is more in keeping with our emergent understandings of human experience (Maree, Ebersohn, & Molepo, 2006). Different researchers are exploring the indigenization of therapy – opening up new pathways to different, more holistic, more sacred/spiritual conceptions of wellbeing not available in the modernist moment (Ebigbo, 1997 is a case in point). We must continue to do this – so long as the academic institutions are willing to accommodate creative new forms of inquiry and research. The possibilities are endless.

Conclusion

I have argued that mainstream therapy does not possess, as once assumed, a privileged link to an objective world of diagnostic / psychopathological referents. This is simply because no such world exists. In place of a politically neutral, value-free, objective praxis, we realize that conventional praxis is theory-laden, embodied, politically driven, and, to our modernist dismay, one of many possible social constructions possible in a dialogic reality. Observation always involves interpretation, and theories are never completely dictated by the 'facts' (Ingleby, 1981). The empirical project, now defunct, must inspire new ways of doing therapy. The need today is for academics to re-examine their practice in relation to the needs of the public they serve. The realization of the now obvious politicization of psychotherapy (thanks to

postmodern insight) does not mean that we should do away with western psychotherapy; however, it does mean we must do away with it being the default, the central discourse, or the praxis of reference. African practitioners must critically assess their allegiance to western therapy, and strive to connect with their communities and their indigenous knowledge paradigms in order to develop culture-sensitive approaches to wellbeing. The proverbial cat was never in the bag; there has never been an objective referent to which we may aspire to in order to gain competence, and there never will be. We are left with the uncertainty, vulnerability, chaos, relativism, and unpredictability that modernism eschewed. And, in a very queer way, this does not appear disturbing after all.

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