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Institutional Mental Health and Social Control: The Ravages of Epistemological Hubris

Seth Farber

Network Against Coercive Psychiatry

I argue in this essay that the phenomena we classify as "mental illness" result largely from the refusal of socially authorized "experts" to recognize – and thus to constitute – the Other (the developing person, the social deviant) as a subject. I suggest that Institutional Mental Health refuses to do this not merely because it seeks to aggrandize its own power but also because it fears to acknowledge that we are all participants in a process of historical development. It denies this because it is historically conditioned by its own moment of origin in the project of the Enlightenment. It is consequently wed to an ethos of rationalized order that does not accommodate, much less support, the unpredictable creative power of the Other (the individual) and that sustains instead the project of mastery, of domination, of discovering eternal laws that will (supposedly) enable Reason to master history and to master the Other. For this reason Institutional Mental Health and its diverse ideologies, ranging from the psychoanalytic to genetic defect models, constitute a major obstacle to the evolution of humanity.

One cannot step into the same river twice.

Heraclitus

There is a widespread misconception in society that Institutional Mental Health (this term is intended to cover psychiatrists, psychologists and other "mental health" professionals) provides valuable services to individuals in need of help and generally attempts to foster personal change or "growth." I argue in this paper that the praxis of Institutional Mental Health is based on a model that is not oriented primarily toward generating change, but toward maintaining social control. Thus, this model is problematic on ethical as well as on epistemological grounds: it *underestimates* the individual's capacity for change and it consequently *undermines* this very capacity.

Requests for reprints should be sent to Seth Farber, Ph.D., 172 West 79th Street, Apt. 2E, New York, New York 10024.

The term "medical model" will be used here in a sense general enough to subsume a number of more specifically articulated models; the two most popular in the field today are the psychoanalytic model and the "genetic defect" model. Scheff's (1966) comment on psychoanalysis succinctly points to the fundamental premise (expressed through a number of different idioms) that underlies all medical models. "The basic model upon which psychoanalysis is constructed is the disease model, in that it portrays neurotic behavior as unfolding relentlessly out of a defective psychological system contained within the body" (p. 9).

The Mental Health Worker as a Social Control Agent

The contemporary disease model in psychology has its roots in a bureaucratic, industrial society that promoted the idea of an increasingly rationalized world-order as a solution to the ills of the world. The historian Scull (1975) has noted that the hegemony of the medical model in psychology and the increasing power of psychiatry to redefine any aspect of life in medical terms is merely one important example of a general trend in modern societies. "Elites in such societies over about the past century and a half have increasingly sought to rationalize and legitimize their control of all sorts of deviant and troublesome elements by consigning them to the ministrations of experts. No longer content to rely on vague cultural definitions of, and informal responses to deviation, rational-bureaucratic western societies have delegated this task to groups of people who claim, or who are assumed to have, special competence in these areas" (p. 219).

Many of these experts call themselves "psychotherapists" but they have in fact the orientation and values of social control agents within a rationalized world-order. Haley (1980) has defined the difference between the two social roles:

> The goal of a therapist is to introduce more complexity into people's lives, in the sense that he breaks up repetitive cycles of behavior and brings about new alternatives. He does not wish to have a problem person simply conform, but wants to place in that person's hands the initiative to come up with new ideas and acts that the therapist might not even have considered. In that sense a therapist encourages unpredictability. The therapist's job is to bring about change, and therefore new, often unanticipated behavior.
>
> The social control agent has quite the opposite goal. His task is to stabilize people for the community, thus he seeks to reduce unpredictability. He wants problem people to behave in respectable ways, like others in the community so that no one is upset by them. It is not change and new behavior that he seeks, but rather stability and no complaints from citizens. (pp. 54–55)

The medical model, the model of the social control agent, exemplifies an "objectivist" approach, to borrow Gadamer's (1976) term. It is based on the

premise that patients are objects who are not influenced by the way in which they are understood and interpreted by Institutional Mental Health. Today, psychology, fueled by positivist aspirations, apes the natural sciences in a futile attempt to delineate transhistorical laws of human behavior that it imagines will allow it to achieve the ideal of total predictability. This is ultimately the project of Reason, which seeks to escape from its historical moorings by totally objectifying history – and by objectifying persons.

The hermeneutic approach provides the tools for exposing the limitations of objectivism. Hermeneutics recovers history. The observer is implicated in the act of observation, what he or she observes is not independent of this act. This is the fundamental hermeneutical insight. Objectivism obscures this reality, it pursues the illusory Enlightenment ideal of the "detached" scientist, unmindful of the historical roots of this ideal, unmindful of the social consequences of the futile attempt to realize it. Gadamer wrote, "In this objectivism the understander is seen . . . not in relationship to the hermeneutical situation and the constant operativeness of history in his own consciousness, but in such a way as to imply that his own understanding does not enter into the event" (p. 28).

Institutional Mental Health acts as if its own understanding does not enter into the event. It focuses its lenses upon the Others, the deviants, and professes to possess objective knowledge about their situation and their destinies. It fails to see how its own way of understanding the Other enters into the event. It is as if its particular way of understanding has no historical or social ramifications. It is as if psychiatrically labeled individuals are deaf to the discourse that Institutional Mental Health articulates through a variety of media, institutions, groups and individuals. Mental illness is a cultural artifact, the end result of a particular kind of highly structured dialogue between socially empowered experts and socially disenfranchised, psychiatrically stigmatized individuals.

To state that Institutional Mental Health is oriented toward social control is not to imply that its hegemony can be completely explained by economic and political motives. In the last analysis, its maintenance depends on a preference for a particular set of aesthetic values: uniformity, predictability, familiarity, orderliness. Institutional Mental Health consistently follows a particular narrative imperative: it seeks to banish history from its midst, to banish chance, *to banish the unexpected.* It secretly fears the creative autonomy of the Other which it regards as a threat to its attempt to control the process of change. It seeks to subordinate change to method and formula, to discover invariant laws, untouched by history, governing human behavior. To use a current metaphor it seeks to secure the domination of the left brain over the historical process.

This project is bound to fail. As Scheibe (1979) has written, "Because cer-

tain scholars start to view human beings as automatons or as very intelligent ants, the facts of human unpredictability do not suddenly change. . . . Full human predictability is impossible in principle" (p. 149). A willingness to accept human unpredictability, to encourage "unanticipated behavior" would spell the end of the disease model with its emphasis on diagnostic classifications and prognoses. The failure of this model (in human terms) is demonstrated by the draconian measures Institutional Mental Health has relied upon to maintain order, ostensibly to protect patients from their illnesses.

In the first half of this century the popular psychiatric "treatments" included: bleeding mental patients to the point of syncope, poisoning them with cyanide, inducing comas with insulin, performing lobotomies and freezing them into a state of nearly fatal coma by packing them in ice. Fifty thousand lobotomies were performed in America mostly during the 1940s and 1950s (Coleman, 1984). Electroconvulsive therapy was first introduced in the late 1930s and is currently being promoted by the American Psychiatric Association [APA]. The APA estimated in 1978 that 100,000 to 200,000 individuals received at least one battery of ECT a year (Coleman, 1984). (Most writers agree that the reliance on ECT is increasing. This is reflected also by the promotional campaign that APA has been leading to convince the population that ECT in its improved version is safe and harmless.) A treatment that has now become standard practice is pressuring "mental patients" to take neuroleptic drugs that are known to cause serious neurological damage when used for more than a brief period of time (Breggin, 1983); psychiatrists typically encourage long-term dependence on these drugs.

The Stability Orientation

There are two variants of the medical model that are dominant in the "mental health" field today; the neopsychoanalytic model (this term refers to the various revisions of classical psychoanalytic thought, including ego psychology and "object relations" theory) and the biochemical imbalance model. Both exemplfy what Gergen (1977) has termed the "stability orientation" which emphasizes the stability of behavior patterns over time and which implies that the individual is predictable. The neopsychoanalytic model assumes that individuals are programmed in the first few years of their lives. They will continue to reenact those early programs for the rest of their lives unless psychoanalysts intervene. As Gergen has put it, "Without massive intervention, ideally through psychoanalysis, the same psycho-behavioral patterns relentlessly repeat themselves throughout the life-cycle" (p. 141). Psychoanalysts claim to be able to change the programs of individuals who are "neurotic" through long-term psychoanalysis. A larger number of individuals are believed to be more pathological; these encompass "personality

disorders" as well as such "severely mentally ill" types as "schizophrenics" and individuals with "bipolar disorders." Most psychoanalysts feel that the most they can offer these individuals in good conscience are supportive psychotherapy and psychiatric drugs (termed medication). This form of therapy cannot significantly alter the original program or, to use a popular psychoanalytic idiom, "correct the damage done to the ego," but it can help individuals to adjust to their pathology and thus to live somewhat more comfortable lives. In many intellectual circles such psychoanalytic dogmas are accepted uncritically.

For example in an article published in the *New York Times Book Review*, Trilling (1986) criticized Gloria Steinem for giving the reader the impression in her biography of Marilyn Monroe that the actress was in psychoanalysis rather than in "psychodynamically [i.e., psychoanalytically] derived supportive treatment." Trilling claims "The distinction is important. Patients with her emotional affliction are not available to orthodox psychoanalysis. Unhappily medicine has not yet found a cure or even a confident therapy for Marilyn Monroe's personality disorder" (p. 23). Unhappily modern intellectuals are credulously willing to accept psychoanalytic lore as scientific truth.

Gergen (1977) reviewed a number of studies that belie the psychoanalytic contention that events in early childhood predetermine the individual's later development. The work of Kagan (1970, 1984) provides a decisive refutation of psychoanalytic dogma. Both Gergen (1977, 1980) and Kagan agree that behavior patterns in the first six years of life have virtually no predictive validity in relation to behavior shown during adulthood. The major variable neopsychoanalysts stress is anxiety over "object loss" in the first few years of life. As Kagan (1970) noted, "the variation in degree of anxiety over loss of access to attachment figures during the first three years of life predicted no significant behavior in adolescence or adulthood" (p. 60). Although current research supports a more optimistic interpretation of the effect of early childhood experience on later development there has not been a modification of psychoanalytic theory or practice. Nor has this research had any impact on contemporary culture which Gergen (1977) notes has "almost fully accepted the assumption that early experience is vital in shaping adult behavior" (p. 142).

Psychoanalysis accepts the premise, as do the various other medical models, that individuals can be placed in diagnostic classes that will predict their future development. But Gergen (1980) shows how the data collected by life-span development researchers indicate that development is idiosyncratic and unpredictable. "The individual seems fundamentally flexible in most aspects of personal functioning. Significant change in the life course may occur at any time. . . . An immense panoply of developmental forms seems possible; which particular form emerges may depend on a confluence of particulars, the existence of which is fundamentally unsystematic" (p. 43). As argued below,

the intractability that Institutional Mental Health finds among "the severely mentally ill" is an artifact of its own practices.

The other main example of the stability orientation is the biochemical imbalance theory. This theory now dominates the field (Cohen and Cohen, 1986); its utility lies in the fact that it provides a justification for prescribing psychiatric drugs which in turn seem to lend credibility to the theory. In furtherance of the goal of social control, the majority of psychoanalysts adhere to an amalgam of psychoanalytic theory and the biochemical imbalance theory. According to the latter view, "mentally ill" individuals suffer from "genetic defects" that will cause their biochemical metabolism to become persistently and frequently "unbalanced"; this imbalance will manifest itself in predictably irrational and unmanageable behavior. If not for neuroleptic drugs the individual would be forced to relive the same nightmare, subject to the cruel decree of fate, the eternal law of return. The drugs ostensibly keep the "illness" under control; they also reduce the risk of unanticipated behavior or genuine novelty, as noted below.

It should be noted that contrary to a common misconception, it has not been established that "genetic defects" *cause* "mental illnesses" or "biochemical imbalances." The most that has been established is that certain individuals have a genetic *predisposition* to have certain experiences (usually precipitated by a crisis) that violate particular norms and that are "diagnosed" as "severe mental illnesses" (see the critical survey by Cohen and Cohen, 1986). The outcome of the predisposition obviously depends upon a complex of social, cultural and environmental factors.

Nonetheless, adherents to the biochemical imbalance theory maintain that once the disease appears it will recur in the same fashion at regular intervals. As Polantin and Fieve (1971) write about "manic depression" – a "disease" which seems to be replacing "schizophrenia" as the "sacred symbol of psychiatry" (to borrow Szasz's [1976] apt phrase): "The patient who cannot accept the fact that he is suffering from a chronic recurrent illness, analogous to diabetes, tends to deny the threat of recurrence and therefore refuses to accept the ingestion of lithium carbonate for the rest of his life" (p. 865). Patients are invariably indoctrinated to believe that they have a "chronic recurrent illness." Their lives become oriented around defending themselves against the recurrence of the original experience that led to the diagnosis. As the above quote indicates they are told they must take lithium for the rest of their lives.

Two advocates of lithium (Dyson and Mendelson, 1968) have described its effects as follows: "It's as if (patients') 'intensity of living' dial had been turned down a few notches. Things do not seem so very important or imperative; there is greater acceptance of everyday life as it is rather than as one might want it to be; their spouses report a much more peaceful existence" (p. 545).

The social control agent is not interested in exploring the idea that such "biochemical imbalances" might have adaptive value for the evolution of society, as Laing suggested about schizophrenia 25 years ago. Rather he or she mobilizes all his or her resources to make sure "manic depressives" accept life as it is "rather than as one might want it to be."

But the fact is that a number of individuals refuse to accept the disease metaphor and are able to turn these "imbalances" to their advantage once they become familiar with these unusual states of consciousness and learn not to be overwhelmed by them. Even such strong adherents to the disease model as Polantin and Fieve (1971) describe several such cases. One woman, a writer, felt "inhibited" on lithium. She discontinued taking it "and is now finishing her next novel, which her editors state appears very favorable. She is now relaxed, comfortable, happy, and says that for the first time in a long time she is really enjoying life. She remains at present in a mild hypomanic state" (p. 865). It is a strange disease that can manifest itself in enhanced creativity and joy and it is a strange sensibility that sees such joy as a symptom ("hypomania") of an illness. As Blake wrote in his poem *The Garden of Love*, "And the Priests in black gowns were walking their rounds, and binding with briars my joys and desires" (1974, p. 111).

Interpreting the Signs

The disease model in psychology is based on the presumption that individuals who manifest particular behavioral signs can be expected to behave in accordance with Institutional Mental Health's expectations. The fact that some individuals who manifest these signs consequently act counter to expectation refutes the model. It demonstrates that Institutional Mental Health has not discovered invariant transhistorical laws that enable it to make reliable predictions. Adherents to the disease model might counter that their expectations are based, if not on laws, then at least on probabilities. What this assertion tragically neglects to notice is that the historically conditioned expectations of the disease model are a significant factor *constituting* the probabilities it claims to discover. These expectations will determine for example whether a person "diagnosed" as schizophrenic will or will not remain incapacitated for life.

Certain individuals seem to have a predisposition, particularly when experiencing developmental crises, to manifest behavior that is socially deviant. These behaviors are invariably interpreted by Institutional Mental Health as signs that these individuals are mentally defective and must learn to drastically constrict the horizon of possibilities that they might otherwise believe are open to them. We come to the crux of the issue now: the way in which Institutional Mental Health's own understanding enters into the

historical event. It does so by creating and sustaining a set of expectations that are fixed, uniform and limited. The expectations of Institutional Mental Health inevitably enter into the historical process. *These expectations constitute the covert discourse of psychology, its unexamined social text.*

In this connection the research on experimental bias is unequivocal. After reviewing the literature on this topic, Frank (1974) wrote, "To recapitulate the chief findings, an experimenter's expectations can strongly bias the performance of his subject by means of cues so subtle that neither experimenter nor subject need be aware of them." Furthermore, "A therapist cannot avoid biasing his patient's performance in accordance with his own expectations, based on his evaluation of his patient and his theory of therapy. His influence is enhanced by his role and his status, his attitude of concern, and his patient's apprehension about being evaluated" (pp. 127–128). Seen from this perspective the so-called epidemic of mental illness is a self-fulfilling prophecy created by Institutional Mental Health. It is an artifact of the set of uniform and limited expectations maintained about individuals who have been psychiatrically labeled – and an artifact of mental health workers' expectations about their own ability to genuinely help individuals who act in socially deviant ways.

A Dialectic of Domination

The dialectic that currently exists between Institutional Mental Health and individuals labeled "mentally ill" is one characterized by domination. Individuals seeking help are scoured for particular signs deemed relevant by the experts. On the basis of the presence or the imagined presence of particular signs, these individuals are placed in a particular "diagnostic" class. The class placement will determine Institutional Mental Health's expectations about these individuals' possibilities. These expectations are refracted throughout society and are encoded in a variety of social institutions.

Individuals in modern society are subjected to a constant barrage – from pop psychology books to TV talk shows to psychoanalytic journals – instructing them what behaviors ought to be interpreted as symptoms of "mental illness" or neurosis. Even in the best of cases – relatively rare – the individual seeking help will be defined as being mentally ill, as pathological or as neurotic. In these cases the expectation is that with *proper treatment* the damage can be undone or almost undone.

All individuals experience problems during the course of their lives. The claim that certain problems are signs of "mental illness" implies that persons with these problems are ontologically defective. In other words (1) their lives are lacking in authentic meaning or significance; (2) they are unworthy of being loved; and (3) they are incapable of judging what is in their own best interests (they are objects, not subjects).

The "mentally ill" are, in other words, fundamentally unworthy. One need only consult any standard psychiatric text or *The Diagnostic and Statistical Manual of Mental Disorders* (any edition) and examine the metaphors that are used to describe the psyche (the Greek word for soul) of an individual who is defined as a patient: "damaged ego," "deeply-rooted pathology," "basic fault," etc. It is useful to remember that terms such as psyche or ego do not refer to an actual corporeal body. Rather they are metaphors that attempt to convey something about the core, the essence of a person's being.

Epistemologists (Cua, 1982) have demonstrated that a scientific or philosophical theory depends on a root metaphor that provides the theory with a set of categories for classifying and interpreting diverse phenomena. Institutional Mental Health is based on the premise that a vast range of unusual or distressing human experiences can best be understood by fitting these experiences into the categories provided by the disease metaphor (Sarbin and Mancuso, 1980). From this perspective, aspiring persons, persons who are facing obstacles, are *necessarily* damaged beings (unless they have already achieved a certain social status).

Other metaphors could be used that would not lead to the conclusion that individuals seeking help are ontologically deficient. One might look at a troubled person as an artist attempting to create a life in harmony with his or her own innate sense of truth or beauty. We do not feel sorry for a painter who is struggling with his or her *oeuvre*. We might look at an individual in distress as a pioneer daring to explore uncharted territory of the psyche, as Laing suggested. Different metaphors would entail different social consequences.

An individual who "discovers" that he or she is "mentally ill" will typically go to a mental health worker who will usually prescribe a course of treatment. Should the person wish to terminate the treatment at a time that the therapist deems "premature," he or she will be told that this is a sign of his or her resistance to getting well, i.e., to remedying his or her ontological deficiency. Only the experts know if and when "mentally ill persons" are well enough to make authentic choices.

As long as people continue to grant experts the power to define them as "mentally ill," as ontologically defective, there will be perpetuated a dialectic of domination and dependency. As Szasz (1987) has argued there can be no viable democracy without faith in the individual's capacity to make his or her own choices about issues concerning his or her welfare – even if these lead to "mistakes." In short, defining individuals as mentally ill threatens the foundation of democracy.

By perpetuating the idea that certain kinds of deviant behavior are signs of ontological deficiency Institutional Mental Health perpetuates and aggrandizes its own power; it impedes the cultural evolution and democratiza-

tion of society by creating and sustaining the polarities of Mental Health and mental illness, Truth and error, the experts who possess objective scientific knowledge and their charges, "the mentally ill."

These categories are absurd unless one accepts the premise that Institutional Mental Health constitutes an absolute standard by which all else is to be judged. That is to say it implies that the society we live in is an ideal, or at least that no improvement is possible. If on the other hand, a process of cultural evolution is taking place then the standards of any generation must be regarded with skepticism. (In the last century when the standard of sexual normality was different from the present standard, masturbation was regarded as an evident symptom of psychopathology.) Institutional Mental Health denies that it is conditioned by history and that we are all involved in a process of historical development and change.

In creating these polarities Institutional Mental Health follows here in the tradition of Institutional Christianity. Pagels (1988) has documented that St. Augustine radically revised Christian thought with his innovative interpretation of the myth of the Fall. Whereas Christians before Augustine had used this myth to illustrate to their contemporaries the danger of freedom, Augustine claimed that human beings had totally lost their capacity for free will as a result of Adam's original sin. Their souls were severely damaged and they were totally dependent on external intevention for any possible hope of redemption. Augustine developed his interpretation at a time when Christianity unexpectedly attracted the "blessing" of imperial power. "By insisting that humanity, ravaged by sin, now lies helplessly in need of outside intervention, Augustine's theory could not only validate secular power but justify as well the imposition of church authority – by force if necessary – as essential for human salvation" (p. 125). The parallel with Institutional Mental Health is chilling. Whereas Institutional Christianity impressed upon individuals the sense that they were helplessly damaged as a result of original sin, Institutional Mental Health now impresses upon individuals that they are helplessly "mentally ill" as a result of "bad" child-rearing or "bad" genes.

The enormous prestige of psychoanalysis among intellectuals has almost completely prevented the intelligentsia from taking a critical stance toward the idea of mental illness. For example, Jurgen Habermas accepts the psychoanalytic dogma that as a result of early childhood trauma individuals' communications are so "pathologically distorted" that they must go to psychoanalytic experts who can teach them how to communicate in an authentic fashion (Habermas, 1980). Habermas fails to see that a dialectic of domination is perpetuated by the ascription of "pathology" to the Other and by experts' arrogation of the right to decide on the basis of their own *conventional* criteria which individuals are capable of "true" communication. Habermas' argument demonstrates that if one does not believe that the possi-

bility for *development* exists within the democratic process itself – which includes direct action and political struggle – one ends up advocating undemocratic elitist practices as a means of fostering democracy.

A New Dialectic

The fact that the behaviors that are interpreted as signs of "mental illness" in this culture do not have unequivocal meaning is demonstrated by looking at other cultures: that is to say, the same signs can be *interpreted* in radically different ways. Silverman (1967) has noted that whole societies have been known to conduct their everyday activities in such a way that from a psychiatric point of view one would have to regard them as "communities of psychotics" (p. 22). The attempt to create a cross cultural theory of "psychopathology" founders absurdly on this fact.

Two psychiatrists, (Billig and Burton, 1978) for example, recently wrote, "a belief in sorcery and ghosts may not be unusual unless it develops in an individual who never placed any trust in apparitions and if the beliefs are accompanied by a personality change, in which case they may be of pathological significance" (p. 49). One would not say that the symptoms of tuberculosis were pathological only if they occurred in an individual who had never experienced them before! The relevant lesson from anthropology teaches that adaptive and creative cultures existed (and exist) in which individuals normally exhibit the kinds of behaviors that Institutional Mental Health views a univocal signs of psychopathology when they are manifested in our culture.

Benedict's prescient remarks on this subject are as follows:

> It is clear that culture may value and make socially available even highly unstable human types. If it chooses to treat their peculiarities as the most valued variants in human behavior, the individuals in question will rise to the occasion and perform their social roles without reference to the ideas of the usual types who can make social adjustments and those who cannot. Those who function inadequately in any society are not those with certain fixed "abnormal" traits, but may well be those whose responses have received no support in the institutions of their culture. The weakness of these aberrants is in great measure illusory. It springs not from the fact that they are lacking in necessary vigor, but that they are individuals whose native responses are not reaffirmed by society. They are as Sapir phrases it, "alienated from an impossible world." (1934, p. 270)

It is typically a crisis that inaugurates the dialogue between Institutional Mental Health and psychiatrically labeled individuals. An individual in crisis goes to Institutional Mental Health for help. His or her sense of identity is in question. The psychodiagnostic procedure is the ritual in which Institutional Mental Health reaffirms its own identity and confers a new identity on the being in distress. Because the psychiatrist or psychologist making the diagnosis acts under the extraordinarily powerful authority of medicine and

science, and because the individual in crisis is in a particularly impressionable state, this ritual is an effective force in stabilizing the identity of the two parties. The person in crisis may be said to have experienced a spiritual death; one finds a death/rebirth scenario in religious conversions and in the rites and initiations of many premodern societies (Eliade, 1975; Sarbin and Adler, 1971). In this society, the nature of rebirth is less felicitous. Institutional Mental Health examines the individual in crisis – the crisis is immediately assumed to be a symptom of *some* kind of "mental illness" – interprets the signs and then rechristens the individual: "You are a schizophrenic," or "You have a bipolar disorder," or "You are severely mentally ill." The crisis is now resolved, the individual is reborn, he or she now knows who he or she really *is*. All further interactions will take place within the parameters established in the diagnostic procedure in which the roles are ascribed, and in which the identitites are clarified.

What we take as evident signs of "mental illnesses" can be interpreted in an altogether different way, which would lead to an entirely different dialogue. In a society that values smooth operations above all else, it seems natural to interpret crises as symptoms of "mental illnesses." In premodern societies, crises, i.e., breakdowns, were valorized. They were believed to be necessary to the process of spiritual development. Mircea Eliade wrote, "The true knowledge, that which is conveyed by the myths and symbols, is accessible only in the course of or following upon, the process of spiritual regeneration realized by initiatory death and resurrection. . . . The future shaman, before becoming a wise man, must first know madness and go down into darkness. . . (1975, pp. 225-226).

Indeed, Silverman (1967) argued that the initiatory crisis of the future shaman is phenomenologically and behaviorally indistinguishable from the psychotic crisis. However as Silverman notes, "One major difference is emphasized – a difference in the degree of cultural acceptance of a unique resolution of a basic life crisis. In primitive cultures in which such a unique life crisis resolution is tolerated, the abnormal experience (shamanism) is typically beneficial to the individual cognitively and affectively; the shaman is regarded as one with expanded consciousness. In a culture that does not provide referential guides for comprehending this kind of crisis experience, the individual 'schizophrenic' typically undergoes an intensification of this suffering over and above his initial anxieties" (p. 21). *What was previously interpreted as signs that one was called upon to assume a leadership position in one's culture are now interpreted as symptoms of chronic disorders.*

The Hermeneutic Approach

It is not clear what kinds of new dialogues will develop today if individuals in positions of power and authority give up the stance of social control agents,

if they relinquish the attempt to objectify the Other. But it is clear that new possibilities will be actualized.

It is beyond the scope of this essay to explore all of the epistemological implications of the hermeneutical insight. Nonetheless in conclusion I want to note that psychology must choose between two different epistemological approaches, reflective of two different modes of being in the world. By continuing to pursue the ideal of the objective scientist who can stand outside of history and subject humanity to methodical control, psychology is only succeeding in tightening the "mind-forged manacles" that prevent human beings from realizing their innate potential. This idolatry of scientific method represents the most tragic kind of epistemological hubris. Its claim to validity is belied by the findings of experimenter bias.

The alternative epistemology has been explored by Heidegger and by Gadamer (1976). It is exemplified by the therapist Haley, who – as the quote near the beginning of this essay reveals – "encourages unpredictability," evokes the creative autonomy of his clients. In this epistemology there is a continually renewed appreciation of the value of love and chance. The knower or the therapist participates in history, and in the midst of flux, of what he or she accepts as unpredictable events, is guided by his or her imagination and intuition. Certainly the therapist will use methods that have worked in the past but he or she also appreciates the value of experimentation. The process of change inevitably involves crises, mistakes, relapses. This approach does not seek to banish history, to achieve full predictability. On the contrary it is based on the realization that human creativity – freedom – manifests itself through the mysterious phenomenon we term chance. If this is so then it must be because the universe is "friendly," as Einstein once remarked. If we fail to find this the case then that is because *we* have alienated ourselves from the universe, by our efforts to dominate it rather than to dwell within it.

Gadamer believed that the project of understanding is undertaken as a means of overcoming our alienation as modern men and women, and finding our way back home. The attempt to banish the unpredictable – chance – precludes the completion of this project. The universe is so constituted that frequently we "come across," happen upon, the path that leads home, as Einstein happened upon the theory of special relativity. We can intuitively recognize this path when we discover it because we are accessible to truths that elude methodical prediction and control. We are not machines in a mechanical universe but artists in a wonder-land where God (i.e., meaning) is continually assuming unexpected guises, startling us with unpredictable revelations and opportunities.

If we forget to remember that we dwell in a universe that is continually changing, we will probably overlook the unexpected path that leads home. If we remember, we can remain ever present to new possibilities. As psycho-

therapists, as researchers, as scientists, as persons, our maps will prove of no avail unless we are also willing to discern the unpredictable signs of opportunity (of God?) as they reveal themselves in the nuances of a universe that is continually evolving.

Conclusion

The findings in experimenter bias, though published decades ago, have radical implications that have not yet been appreciated – there is not and cannot be a detached observer. If we *expect* individuals to fail we will increase the chances that they *will* fail. The fact that most therapists proceed as usual and ignore these findings is testimony to the ignorance and moral depravity of which human beings are capable.

To describe a person as "mentally ill," "schizophrenic," "manic-depressive," etc., means operationally that therapists hold low expectations for these individuals. We cannot help human beings to solve their developmental crises if we insist on defining these crises as symptoms of chronic mental illnesses. If we verbally encourage human beings to succeed while expecting them to fail, our encouragement is facile.

Haley (1980) described the attitude of one of his own teachers. "He believed that there was nothing wrong with a person diagnosed as schizophrenic. It was inspiring to watch him work with a mad offspring who was an expert at failing. I recall one who would not speak. She would sit pulling at her hair like an idiot. Yet Jackson treated her as if she was perfectly capable of normality, given a change in her family and treatment situation. The family was forced to accept her normality, partly because of Jackson's certainty" (p. 22).

The question arises: On what should therapists base their expectations of success? Since these expectations are *constitutive* they must not be based on the presence or absence of specific behaviors. Either the expectation is a gratuitous act of love or it is based on faith in the creative power of the human spirit. This power is manifesting itself today in the pioneering efforts of a growing number of individuals who have succeeded in responding adaptively to the challenges of life, in spite of the efforts of Institutional Mental Health to consign them to the ranks of the doomed, i.e., the severely mentally ill. To these individuals humankind owes a debt of gratitude.

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