©1990 The Institute of Mind and Behavior, Inc.
The Journal of Mind and Behavior
Summer and Autumn 1990, Volume 11, Numbers 3 and 4
Pages 353 [107] - 368 [122]
ISSN 0271-0137
ISBN 0-930195-05-1

Therapeutic Professions and the Diffusion of Deficit

Kenneth J. Gergen
Swarthmore College

The mental health professions operate largely so as to objectify a language of mental deficit. In spite of their humane intentions, by constructing a reality of mental deficit the professions contribute to hierarchies of privilege, reduce natural interdependencies within the culture, and lend themselves to self-enfeeblement. This infirming of the culture is progressive, such that when common actions are translated into a professionalized language of mental deficit, and this language is disseminated, the culture comes to construct itself in these terms. This leads to an enhanced dependency on the professions and these are forced, in turn, to invent additional terms of mental deficit. Thus, concepts of infirmity have spiraled across the century, and virtually all remaining patterns of action stand vulnerable to deficit translation. Required within the professions are new linguistic formulations that create a reality of relationships without evaluative fulcrum.

How may I fault thee? Let me count the ways. . .

Impulsive personality
Malingering
Reactive depression
Anorexia
Hysteria
Mania
Psychopathia
Peter Pan syndrome
External control orientation
Anti-social personality
Exhibitionism
Seasonal affective disorder. . .

Low self-esteem
Narcissism
Bulimia
Neurasthenia
Hypochondriasis
Dependent personality
Frigidity
Voyeurism
Authoritarianism
Transvestism
Agoraphobia

My central concern in this paper is with the effects of the mental health professions on the quality of cultural life. Judging from my many colleagues,

Requests for reprints should be sent to Kenneth J. Gergen, Ph.D., Department of Psychology, Swarthmore College, Swarthmore, Pennsylvania 19081.

students and friends engaged in therapeutic practices, I believe there is a strong and genuine commitment to a vision of human betterment. Further, although research results are interminably equivocal, I am convinced that at least from the standpoint of many who seek help, the therapeutic community plays a vital and humane role in cultural life. Yet, my concern in the present offering is with the paradoxical consequences of the prevailing vision of human betterment, and the pervasive dependency of people on these professions for improving their lot. For, there is reason to believe that in the very efforts to furnish effective means of alleviating human suffering, there are important respects in which mental health professionals simultaneously generate a network of increasing entanglements for the culture at large. Such entanglements are not only self-serving for the professions, but add exponentially to the existing sense of deficit. After exploring this progressive infirming of the culture, its causes and proliferating effects, I shall open discussion on possible alternatives to the existing condition.

Mental Language: Reified or Relational

In order to appreciate the nature and magnitude of the problems at stake, a prelude is required. In particular, a distinction must be drawn between existing views of the vocabulary of mind. We commonly employ such terms as "thinking," "feeling," "hoping," "fearing," and the like referentially. That is, we use such terms as if they depicted or reflected actual occurrences. The statement, "I am angry," is intended, by common convention, to describe a state of mind, differing from other states such as joy, embarrassment or ecstasy. The vast majority of therapeutic specialists proceed in much the same manner. Therapists listen for hours to people's accounts in an attempt to ascertain the quality and character of their "inner life" – their cognition, emotions, unarticulated fears, conflicts, illogicalities, blind spots, repressions, "the world as they experience it," and so on. As it is typically presumed, the individual's language provides a vehicle for "inner access" – revealing or setting forth to the professional the character of the not-directly-observed. And, as it is further reasoned, this task is essential to the therapeutic outcome – whether for reasons of furnishing the therapist with information about the problem domain (thus leading to remedial actions on the therapist's part), or for the client-provoking self-insight and clarification, enhancing the sense of autonomy or self-control, instigating a process of catharsis, reducing guilt and so on.

Whether in the therapeutic context or daily life, the presumption that the language of the mind reflects, depicts or refers to actual states may be termed *reificationist.* That is, such an orientation treats as real (as ontological existants) that to which the language seems to refer. As otherwise put, it is to engage

in the *fallacy of misplaced concreteness*, treating as concrete the putative object rather than the sign. Certain readers will protest at this juncture at the demotion of what they believe to be a referential language (referring to actual states) to the status of reifying device. They may argue that, "It simply is the case that I have mental states, and when I say I am angry I do so because my state of mind is different from when I am sad or sexy. I speak of anger to reflect real states of anger." However, lest such resistance render the reader insensitive to all that follows, it is useful to make a rapid tour through the groves of intractable problems generated by a realist view of psychological language:

1. How can consciousness turn in upon itself to identify its own states? How can experience become an object to itself? Can a mirror reflect its own image?

2. What are the characteristics of mental states by which we can identify them? By what criteria do we distinguish, let us say, among states of anger, fear and love? What is their color, size, shape, or weight? Why do none of these attributes seem quite applicable? Because our observations of the states prove to us that they are not?

3. How can be we certain when we identify such states correctly? Could other processes (e.g., repression, defense) not prevent accurate self-appraisal? (Perhaps anger is eros after all.)

4. By what criterion could we judge that what we experience as "certain recognition" of a mental state is indeed certain recognition? Would not this recognition require yet another round of self-assessments, the results of which would require additional processes of internal identification, and so on in an infinite regress?

5. Although we may all agree in our use of mental terms (that we experience fear, ecstasy, or joy, for example, on particular occasions) how do we know that our subjective experiences resemble each other? By what process could we possibly determine whether my "fear" is equivalent to yours? How then do I know I possess what everyone else calls "fear"?

6. How are we to account for the disappearance from the culture of many mental terms popular in previous centuries, along with the passing fashions in mental terminology of the present century? (Whatever happened to melancholy, sublimity, neuralgia, the inferiority complex, and the adolescent identity crisis?) Have the words disappeared because such processes no longer exist in mortal minds?

7. How are we to account for the substantial differences in psychological vocabulary from one culture to another? Did we once have the same mental events as the primitive tribesman, for example, the emotion of *fago*, described by Lutz (1988) in her studies of the Ifaluk? Have we lost the capacity to experience this emotion? Is it lurking there within the core of our being, buried beneath layers of Westernized, industrialized acculturation?

Mental realists have yet to furnish viable and compelling answers to any of these perennial conundrums. Thus, although we need not go so far as to doubt that "something is going on" when we report a mental state, to treat the reports as descriptions, pictures or maps of identifiable events is essentially to reify the existing language practices.

Let us contrast the reificationist orientation to mental language with yet another. Following Wittgenstein (1963) in this case, let us abandon the view of mental language as a referential picture of inner states, and consider such language as a constituent feature of social relationships. That is, we may venture that psychological language obtains its meaning and significance from the way in which it is used in human interaction. Thus, when I say "I am unhappy" about a given state of affairs, the term "unhappy" is not rendered meaningful or appropriate according to its relationship to the state of my neurons or my phenomenological field. Rather, the report plays a significant social function. It may be used, for example, to call an end to a set of deteriorating conditions, enlist support and/or encouragement, or to invite futher opinion. Both the conditions under which the report can be used and the functions it can serve are also circumscribed by social convention. The phrase, "I am deeply sad" can be satisfactorily reported at the death of a close relative but not the demise of a spring moth. A report of depression can secure others' concern and support; however it cannot easily function as a farewell, an invitation to laughter, or a commendation. In this sense mental language is more like having a nine iron when shooting from a sandtrap than possessing a mirror of the interior, more like a strong grip between trapeze artists than a map of inner conditions. We shall call this orientation to mental language *relational*, in its emphasis on the use of mental language within ongoing relationships.

(It should be noted that the relational view of mental discourse does not commit one to a "skin deep" view of such language. Rather, mental terms are only constituent parts of full blown action patterns – patterns that may engage one fully. To "do anger" properly, for example, may require an enormous recruitment of bodily resources – with mental language playing but a minor part in the performance. For a more extended account, see Gergen and Gergen, 1988.)

Invitations to Infirmity

The pervasive stance toward psychological language in Western culture is decidedly reificationist. We generally accept persons' accounts of their subjective stats as valid (at least for them). If sophisticated, we may wonder if they are fully aware of their feelings, or have been misled in an attempt to protect themselves from what is "really" there. And, if scientific in bent, we

may wish to know the distribution of various mental states (e.g., loneliness, depression) in the society more generally, the conditions under which they occur (e.g., stress, burnout), and the means for their alleviation (e.g., the comparative efficacy of differing therapies). However, we are unlikely to question the existence of the reality to which such terms seem to refer; and because the prevailing ontology of mental life remains generally unchallenged, we seldom inquire into the utility or desirability of such terms in daily life. If the language exists because the mental states exist, there is little reason to ask about preferences. To do so would be tantamount to asking whether we approve the roundness of the world.

Yet, if we view psychological discourse from a relational perspective, the language of the mind loses its rhetorical capacity as "truth bearing." One cannot claim rights to language use on grounds that existing terms "name what there is." Rather, significant questions are invited concerning the functions of existing terminologies in maintaining or changing the patterns of cultural life. What are the effects on human relationships of the prevailing vocabularies of the mind? Given our goals for human betterment, do these vocabularies facilitate or obstruct? And, most important for present purposes, what kinds of social patterns are facilitated (or prevented) by the existing vocabulary of psychological deficit? How do the terms of mental health professions, terms such as "neurosis," "cognitive dysfunction," "depression," "post-traumatic stress disorder," "character disorder," "repression," "narcissism" and so on, function within the culture more generally? Do such terms lend themselves to desirable forms of human relationship, should the vocabulary be expanded, are there more promising alternatives? There are no simple answers to such questions; however, neither is there at present a prevailing dialogue concerning such issues. My purpose here is not so much to develop a final answer as to generate a forum for continuing discussion.

Grounds for such discussion have been laid in several relevant arenas. In a range of pointed volumes Thomas Szasz (1961, 1963, 1987) has demonstrated that concepts of mental illness are not demanded by observation. Rather, he proposes they function much as social myths, and are used (or misused, from his perspective) largely as means of social control. Sarbin and Mancuso (1980) echo these arguments in their focus on the concept of schizophrenia as a social construction. Similarly, Ingelby (1980) has demonstrated the ways in which categories of mental illness are socially negotiated so as to serve the values or ideological investments of the profession. Kovel (1980) proposes that the mental health professions are essentially forms of industry that operate largely in the service of existing economic structures. Feminist thinkers have also explored the ways in which nosologies of illness, diagnosis and treatment have all been biased in favor a patriarchal system (Brodsky and Hare-Mustin, 1980; Hare-Mustin and Marecek, 1988).

Let us extend the implications of such discussions to consider the functioning of mental deficit language in social life. Again, there is much to be said on this matter, and not all of it is critical. On the positive side, for example, the vocabulary of the mental health professions does serve to render the alien familiar, and thus less fearsome. Rather than viewing non-normative activities as "the work of the devil" or "frighteningly strange," for example, they are given professional labels, signifying that indeed, they are perfectly reasonable by scientific standards. At the same time, this professional transformation of the unusual invites one to replace repugnance with more humane reactions – sympathetic reactions of the kind displayed toward the physically ill. Further, because the mental health professions are allied with science, and science appears to be a progressive or problem solving activity, such labels also invite a hopeful attitude toward the future. One need not labor under the belief that today's strangeness is forever.

For most of us these represent improvements of the present vocabulary of mental deficit over predecessors of yore. Yet, optimism on such matters is hardly merited. For there is a substantial "down side" to existing intelligibilities, and as I shall hope to demonstrate later in this paper, these problems are of continuously increasing magnitude. As an opening to the problem, we must consider the functioning of mental deficit vocabularies in engendering and facilitating each of the following processes.

Social Hierarchy

Although attempting to occupy a position of scientific neutrality, it has long been recognized that the helping professions are premised on certain assumptions of the cultural good (Hartmann, 1960; Masserman, 1960). Professional visions of "healthy functioning" are suffused with cultural ideals of personhood (London, 1986; Margolis, 1966). In this context we find, then, that mental deficit terms operate as evaluative devices, demarking the position of individuals along culturally implicit dimensions of good and bad. We may often feel a degree of sympathy for the person who complains of being incapacitated by depression, anxiety, or a Type A personality. However, such sympathies may often be tinged with a sense of self-satisfaction, for the complaint simultaneously casts us into a position of superiority. In each case the other reveals a failure – insufficient buoyancy, levelheadedness, calm, control – and thereby defines others as superior in these regards. While such results may seem inevitable, even desirable as a means of sustaining cultural values, it is vital to realize that (1) the existence of the terms invites such rituals of degradation (Goffman, 1961), and (2) other vocabularies could carry out the same descriptive work without such perjorative effects.

This is to say, that the existence of a vocabulary of deficit is akin to the

availability of weapons; their very presence invites certain patterns of action, in this case the creation of implicit hierarchies. The greater the number of criteria for mental well-being, the greater number of ways in which one can be rendered superior (or inferior) in comparison to others. Further, the same events can be indexed in other ways, with far different outcomes. Through skilled language use one might reconstruct depression as "psychic incubation," anxiety as "heightened sensitivity," and Type A freneticism as "Protestant work ethic." Such use of language would either reverse or erase the existing hierarchies.

Reduced Interdependency

Because mental deficit terms imply the existence of "problems in need of attention," and the mental health professions are accorded a certain degree of expertise on such matters, the use of the vocabulary contributes to the institutionalization of treatment. In the same way that attributing teenage criminality to economic deprivation, deteriorated family conditions, or lack of recreational outlets would each have different behavioral or policy implications, attributing non-normative actions to mental deficits suggests that professional help is required. Yet, when such help is sought, the discussion of "the problem" is removed from its generating context and reestablished within the professional sphere. Or, in other terms, the mental health professions appropriate the process of realignment that would naturally occur in the non-professional context. One may venture that processes of natural realignment are often slow, anguished, brutal, or befuddled, and that life is too short and too precious to "wait and see." However, the result nevertheless is that problems otherwise requiring concerted participation of organically related persons are removed from their ecological niche. Marriage partners carry out more intimate communication with their therapists than with each other, even saving significant insights for revelation in the therapeutic hour. Parents discuss their children's problems with specialists, or send problem children to treatment centers, and thereby reduce the possibility for authentic (unself-conscious) communication with their offspring. Organizations placing alcoholic executives in treatment programs thereby reduce the kind of self-reflexive discussions that would elucidate their contribution to the problem. In each case, tissues of organic interdependency are injured or atrophy.

Self-Enfeeblement

Because of their reifying capacities, mental deficit terms are essentialist in character. That is, they operate so as to establish the essential nature of the person being described. They designate a characteristic of the individual per-

during across time and situation, and which must be confronted if the person's actions are to be properly understood. The result of deploying mental deficit terms is thus to inform the recipient that "the problem" is not circumscribed, limited in time and space to a particular domain of his/her life, but that it is fully general. He or she carries the deficit, like a cancer, from one situation to another, and like a birthmark or a fingerprint, as the textbooks say, the deficit will inevitably manifest itself. In effect, once people understand their actions in terms of mental deficits, they are sensitized to the problematic potential in all their activities, the ways in which they are infected or diminished. The weight of "the problem" now expands manyfold; it is as inescapable as their own shadow. The sense of enfeeblement becomes complete.

There are other lamentable repercussions of mental deficit language. As existentialist theorists argue, because such language is embedded in a deterministic worldview, in which persons' actions are caused by their essences, people cease to experience their actions as voluntary (Bugenthal, 1965). They feel their actions to be outside the realm of choice, inevitable and unchangeable, unless they place themselves – dependently – in professional hands. Further, as Sparks (1989) has proposed, by conceptually placing problems within the personality structure of the individual, professionals suggest to people that their problems are virtually intractable.

The Process of Progressive Infirmity

It is a central contention of the present paper that problems of the preceding variety are not simply pervasive in modern culture; rather, they are expanding exponentially within the present century. This process of progressive infirmity now requires attention. The concept of neurosis did not originate until the mid-18th century. (Had such problems simply escaped general notice for so many centuries?) In 1769 William Cullen, a Scottish physician, elucidated the four major classes of *morbi nervini*. These included *Comota* (reduced voluntary movements, with drowsiness or loss of consciousness), the *Adynamiae* (diminished involuntary movements), *Spasmi* (abnormal movement of the muscles), and *Vesaniae* (altered judgment without coma) [see Lopez-Pinero's 1983 account]. Yet, even in 1840, with the first official attempt in the United States to tabulate mental disorder, categorization was crude. It proved satisfactory, indeed to use only a single category, in which idiotic and insane persons were grouped together (Spitzer and Williams, 1985). At present, the American Psychiatric Association's 1987 *Diagnostic and Statistical Manual of Mental Disorders*, third edition, revised [DSM-III-R] lists some 200 categories of mental disorder. Many additional "problematic behaviors" (e.g., stress, burnout, erotomania, etc.) are discussed and treated within the profession

more generally. As the language of psychological deficit has expanded, so have we increased the culture's hierarchies of discrimination, damaged the naturalized patterns of interdependence, and expanded the arena of self-deprecation. In effect, as the language of deficit has proliferated, so has the culture become progressively infirmed.

On the optimistic side, one might propose that the increase in the language of deficit reflects an incremental sharpening of our capacities to distinguish among the existing array of psychological states and conditions. However, such a proposal grows from the same reificationist soil that proved so barren in our initial proceedings. There is little sense to be made of the supposition that the enormous proliferation in the language of psychological deficit represents a refinement in linkages between discourse and the mental world as it really is. How then are we to account for the proliferation of such language and the consequent infirming of the culture? Here again the relational view of language becomes useful, for as we consider the functions of discourse in human relationships it is possible to discern a pattern of formidable consequence. In particular, we may locate a cyclical process which, once activated, operates to expand the domain of deficit discourse in ever increasing degrees. We are not dealing, then, with an accidental surge in such discourse, but with a systematic process that feeds upon itself to engender an exponentially increasing infirmity.

For analytic purposes the cycle of progressive infirmity may be broken into four major stages. In actual practice, events in each of these stages may be confounded, with temporal ordering seldom smooth, and with exceptions at every turn. However for purposes of clarity, the cycle of progressive infirmity may be outlined as follows:

Deficit Translation

Let us view the situation of mental health professionals in the following way: they confront a client group whose lives are managed in terms of a common or everyday discourse. Because life management seems impossible in terms of everyday understandings individuals in the client group seek professional help. Or, in effect, they seek advanced (more objective, discerning, etc.) forms of understanding. In this sense it is incumbent upon the professional to (1) furnish an alternative discourse (theoretical framwork, nosology, etc.), and (2) translate the problem as presented in the daily language into the uncommon language of the profession. In terms of the preceding this means that problems understood in the profane or marketplace language of the culture must be translated into the sacred or professional language of mental deficit. A person whose habits of cleanliness are excessive by common standards becomes an "obsessive compulsive," one who rests the morning in bed becomes

"depressive," one who feels he is not liked is redefined as "paranoid," and so on. (An extended treatment of the way in which the client's childhood memories are reformulated by the psychoanalyst in terms of Freudian theory of psychosexual development is furnished by Spence, 1982.) For the client such translations may be essential, for not only do they assure that the professional is doing a proper job, but that the problem is well recognized or understood within the profession.

Cultural Dissemination

The mental health professional generally follows a scientific mode of analysis in which the attempt is to establish systematic ontologies or inclusive categories for all that exists within a given domain (e.g., animal or plant species, tables of chemical elements). The DSM-III-R is perhaps the most apt exemplar within the field of mental health, in its attempt to reduce all existing problems to a systematic and finite array of categories. The result of this mode of procedure, however, is to universalize existing problems. It is to inform the client that his/her problem is but an isolated instance of a larger class. Other instances in the class may thus be presumed. It is partly for this reason that pressures are created for a broad dissemination of mental deficit language. In the same way that signs of breast cancer, diabetes or venereal disease should become common knowledge within the culture, so should citizens be able to recognize symptoms of stress, alcoholism, and depression. Thus, mental deficit information is featured in undergraduate curricula, popular magazines, television programming, newspaper features, and the like. (Because of the exotic and self-relevant character of such information, there is also a broad audience for such materials.) The result is, however, a continuous insinuation of the professional language into the sphere of daily relationships.

Cultural Construction

As intelligibilities of deficit are disseminated into the culture at large, they become absorbed into the common language. They become part of "what everybody knows" about human behavior. In this sense, terms such as neurosis, stress, alcoholism and depression are no longer "professional property." They have been "given away" by the profession to the public. Terms such as split personality, identity crisis, PMS (pre-menstrual syndrome) and mid-life crisis also enjoy a certain degree of popularity. And, as such terms make their way into the cultural vernacular, they become available for the construction of everyday reality. Shirley is not simply "too fat"; she has "obese eating habits"; Fred doesn't simply "hate gays," but is "homophobic"; and so on.

Nor is such construction limited to the redefinition of problems already

recognized. That is, as deficit terms become increasingly available for making the social world intelligible, that world becomes increasingly populated by deficit. Events which passed unnoticed become candidates for interpretation; events once viewed as "good and proper" can now be reconceptualized as problematic, and in the extreme case recognized symptoms come to serve as cultural models. (Consider the spread of "bulimia" once it was recognized as a "common problem.") Once such terms as "stress" and "occupational burn-out" enter the commonsense vernacular, they become lenses through which any working professional can reexamine his/her life and find it wanting. What was valued as "active ambition" can now be reconstructed as "workaholic"; the "smart dresser" can be redefined as "narcissistic"; and the "autonomous and self-directed man" becomes "defended against his emotions." Furnish the population with hammers of mental deficit, and the whole world needs pounding.

Vocabulary Expansion

As individual actions are increasingly identified in terms of mental deficit terminology, so does the culture generate a new wave of candidates for professional help. Counseling, weekend self-enrichment programs, and programs of personality refurbishment may represent a first line of dependence; all allow people to escape the uneasy sense that they are "not all they should be." Others may seek more direct means of help for their "eating disorders," "incest victimization," or "post traumatic stress disorders." At this point, however, the stage is set for the final revolution in the cycle of progressive infirmity. For as the layperson approaches the profession with a now-appropriated professional discourse, the role of the professional is threatened. If the client has already identified the problem accurately, and knows (as in many cases) what is commonly to be done at the professional level, then the window of professional expertise is increasingly closed. (The worst case scenario would be that people learn to diagnose and treat themselves within their family and friendship circles, thus rendering the professional redundant.) In this way there is a constant pressure placed upon the professional to "advance" understanding, to spawn "more sophisticated" terminology, and to generate new insights and forms of therapy. It is not that the shift in emphasis from classic psychoanalysis to neo-analysis to object relations, for example, is required by an increasingly sensitive understanding of mental dynamics. Indeed, each wave sets the stage for its own recession and replacement; as therapeutic vocabularies become common sense the therapist is propelled into new modes of departure. The ever-shifting sea of therapeutic fads and fashions is no mere defect in the profession; rapid change is virtually demanded by a public whose discourse is increasingly "psychologized."

Progressive Infirmity: No Exit?

A recent circular invited participation in a San Diego conference on theory, research and treatment of addiction. As the circular announced, "Addictive behavior is arguably the number one health and social problem facing our country today." Among the "addictions" to be discussed were exercise, religion, eating, work, and sex. New domains of behavior now enter the ledger of deficit, subject to broad concern and professional treatment. The construction of infirmity expands again, and there is no principled means of termination. When the culture is furnished a language of mental deficit, and persons are increasingly understood in these ways, an increasing population of "patients" is created. This population, in turn, forces the profession to expand its vocabulary and thus the array of mental deficit terms available for cultural use. More problems are constructed, more help sought, and the array of deficit terms again presses forward. Again, one can scarcely view this cycle as smooth and undisrupted. Some schools of therapy remain committed to a single vocabulary; others have little interest in dissemination; some professionals attempt to speak with clients only in the "common language," and many popular concepts within the culture lose currency over time. Rather, we are speaking here of a general drift, an historical tendency of the kind, for example, that enables American psychiatric discourse to move from the restricted domain of a single journal (The *American Journal of Insanity*) in the mid-1800s to a three volume handbook – with over 50 chapters – a century later that has made therapeutic training an essential part of pastoral preparation, and that has made clinical psychology one of the fastest growing professions of the century.

I am in no way attempting to allocate blame for this trajectory. For the most part it is a necessary byproduct of the earnest and humane attempt to enhance the culture's life quality. With certain variations in the logic of the cycle, it is not unlike the trajectories spawned by both the medical and legal professions – toward increased medical needs on the one hand and the increased forms of litigation on the other. However, to the extent that the mental health professions are concerned with cultural life quality, discussion of progressive infirmity should become focal. Are there important limitations on the above arguments; are there signs of a leveling effect; are there means of reducing the proliferation of an enfeebling discourse?

I have no ready remedy in hand for the termination of the cycle. However, I do feel that the same logic that enables such a cycle to be articulated does invite a dialogue from which solutions might be derived. For, as we have seen, progressive infirmity is favored by the reificationist assumption of mental language. It is when we believe that the words for mental deficit stand in a referential relationship to processes or mechanisms in the head that the

problem begins. It is when we believe that people actually possess mental processes such as repression, for example, that we can comfortably characterize them as repressed. At the outset, then, some form of generalized reeducation in the functions of language might be favored.

Of course it is absurdly optimistic to believe that either the formal or informal educational processes could significantly alter the picture theory of language, and the companionate assumption of mind-body dualism, both so central to Western tradition. More promising is the development of alternative vocabularies within the mental health profession, vocabularies that (1) do not trace problematic behavior to psychological sources within single individuals, and (2) ultimately erase the concept of "problem behavior" itself. I am speaking here first of the development of a vocabulary of relatedness that would come to equal the rhetorical power of individualized language in making the social world intelligible. We have innumerable terms for characterizing individuals; and when confronting the social world we rapidly and securely fall back on this vocabulary. For example, we see an individual acting in a particular way, and we can scarcely avoid characterizing these actions as outward signs of inner states of depression, fear, anxiety and the like. The individualized form of accounting is ready at hand. It is far more difficult, however, to view such behavior as indicative of processes of relatedness, signs of particular forms of interaction. Such conclusions are not conceptually impossible; we simply have little vocabulary at hand for making the world intelligible in this way. While we have a highly nuanced vocabulary of individual players we are virtually inarticulate regarding the games in which they are embedded. With an adequate vocabulary in hand, we might reconstruct depression as a constituent part of a relational form. In the same way that a serve is essential for the game of tennis, and the consumption of a wafer for Catholic mass, so are "depressed actions" essential constituents of certain kinds of interaction sequences (see Gergen and Gergen, 1988). The same kind of translation could be undertaken with the full body of psychological terminology available for common use.

The impetus toward relational intelligibilities is already manifest in the mental health professions. Harry Stack Sullivan's emphasis on the embeddedness of symptoms in interpersonal relations represented an important beginning. In varying degrees the work of theorists in family systems, second order cybernetics, social ecology, stragetic therapy, contextual therapy, and therapeutic communication processes (see Hoffman's 1981 summary) all extend and elaborate a relational perspective. For many social practitioners the language of mental deficit also stands inadequate, and means are sought to generate understandings of individuals-in-relationship (Kirk, Siporin, and Kutchins, 1989). And too, these ventures share much with present theorizing in social constructionism, discourse processes, parent-child interaction, conversational

management, ethnomethodology, and organizational management. With cooperative efforts across these otherwise isolated endeavors, the possibilities for new and significant forms of intelligibility seem enormous.

With the development of relational intelligibilities may ultimately come the demise of the category "problem behavior" itself. As we come to see human actions as embedded within larger units, parts of wholes, such actions cease to be "of themselves." There are no problem behaviors independent of arrangements of social interdependency. However, we need not capitulate to the presently alluring move of shifting blame from individual to group. (The concept of "dysfunctional family" or "perverse triangle," for example, simply sets the stage for a new cycle of impairment.) For, it is also clear from a relational standpoint that the language of evaluation, blame, and thus problematics is born of relatedness; such language functions so as to coordinate the activities of individuals around ends they signify as valuable. Thus, the labeling of actions as in some way "problematic" is itself an outcome of relational process. In this way we see that there are no intrinsic or essential "goods" or goals to which individuals or groups should necessarily strive. There are only goods and goals (and concomitant failures) within particular systems of understanding. The professional need not be concerned, then, with "improvement" as a real-world challenge. (Depressive activity, for example, is not inherently problematic, and may serve an important function in maintaining the well-being of a group from its standpoint.) Rather, the emphasis may appropriately shift to enhancing consciousness of the larger system of interdependencies in which such evaluations are generated, and the capacity of relationships for coordinated integration into the larger network.

References

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (third edition, revised). Washington, D.C.: Author.

Brodsky, A.M., and Hare-Mustin, R.T. (1980). *Women and psychotherapy: An assessment of research and practice.* New York: Guilford.

Bugenthal, J.F.T. *The search for authenticity.* New York: Hold, Rinehart & Winston.

Gergen, K.J., and Gergen, M.M. (1988). Narrative and the self as relationship. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (pp. 17–56). New York: Academic Press.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates.* Garden City, New Jersey: Doubleday.

Hare-Mustin, R., and Marecek, J. (1988). The meaning of difference: Gender theory, postmodernism and psychology. *American Psychologist, 43,* 455–464.

Hartmann, H. (1960). *Psychoanalysis and moral values.* New York: International Universities Press.

Hoffman, L. (1981). *Foundations of family therapy.* New York: Basic.

Ingleby, D. (1980). Understanding mental illness. In D. Ingleby (Ed.), *Critical psychiatry: The politics of mental health* (pp. 23–71). New York: Pantheon.

Kirk, S., Siporin, M., and Kutchins, H. (1989). The prognosis for social work diagnosis. *Social Casework: The Journal of Contemporary Social Work, 70,* 295–304.

Kovel, J. (1980). The American mental health industry. In D. Ingleby (Ed.), *Critical psychiatry: The politics of mental health* (pp. 72–101). New York: Pantheon.

London, P. (1986). *The modes and morals of psychotherapy.* New York: Hemisphere Publishing.
Lopez-Pinero, J.M. (1983). *Historical origins of the concept of neurosis* [D. Berrios, Translator]. Cambridge: Cambridge University Press.
Lutz, C. (1988). *Unnatural emotions.* Chicago: University of Chicago Press.
Margolis, J. (1966). *Psychotherapy and morality.* New York: Random House.
Masserman, J. (1960). *Psychoanalysis and human values.* New York: Grune and Stratton.
Rose, N. (1985). *The psychological complex.* London: Routledge & Kegan Paul.
Sarbin, T.R., and Mancuso, J.C. (1980). *Schizophrenia: Medical diagnosis or moral verdict?* Elmsford, New York: Pergamon.
Sparks, P. (1989). *Causal attributions of personality.* Unpublished doctoral dissertation, Oxford University.
Spence, D. (1982). *Narrative truth and historical truth.* New York: Norton.
Spitzer, R.L., and Williams, J.B. (1985). Classification of mental disorders. In H.L. Kaplan and B.J. Sadock (Eds.), *Comprehensive textbook of psychiatry* (pp. 580–602). Baltimore: Williams & Wilkins.
Szasz, T.S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct.* New York: Hoeber-Harper.
Szasz, T.S. (1963). *Law, liberty and psychiatry: An inquiry into the social uses of mental health practices.* New York: Macmillan.
Szasz, T.S. (1987). *Insanity: The idea and its consequences.* New York: John Wiley.
Wittgenstein, L. (1963). *Philosophical investigations* [G. Anscombe, Translator]. New York: Macmillan.