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The Social Construction of Mental Illness and its Implications for the Recovery Model

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About the Author
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Abstract

The mental health profession has somehow missed out on the evolution of the postmodern perspective and linguistic paradigm prevalent now in philosophy, history, the social sciences, literature, and art – the exception to this being postmodern consultation (formerly known as postmodern psychotherapies). From the linguistic paradigm and postmodern perspective we see how language *creates* realities as opposed to "discovering" them. What this means for the mental health profession is that "mental illness", diagnoses, and associated concepts are social constructions. This paper will illustrate how this is so and will also explore the consequences of not recognizing this fact. Additionally, the implications of this knowledge for the recovery model will be explored. Recently in California with the passage of the Mental Health Services Act (Nov, 2004) implementation of the recovery model has become a priority for most community mental health agencies. The recovery model is a great advance in the movement towards client self-determination, empowerment, and independence. Another purpose of this paper is to bring to light how the medical and psychological models are alive and well in recovery programs in the way in which they are still thought of and spoken as essential truths - despite programs and relationships that are structured around client self-determination.

Introduction

> *Words, like the chisel of the carver, can create what never existed before rather than simply describe what already exists. As a man speaks, not only is the thing which he is declaring coming into existence, but also the man himself.* **- Martin Heidegger**

The metal restraining chains are gone – now it is time for those "invisible chains" to go: WORDS. The vocabularies of the medical and psychological models with their disease terminology and deficit-focus have got to go. It is about time that the mental health profession enters into the light of the broader historical and philosophical revolution of postmodernism and its consequent linguistic paradigm. In this light we will finally recognize that words are much more powerful when used as "tools" to facilitate change and connection as opposed to when used to try to describe some "objective reality" (such as a psychiatric diagnosis). The purpose of this paper is to help free participants on both sides of the helping relationship from the socially constructed and socially destructive illusions created by the current medical-psychological-pathologizing and deficit-based languaging.

This goal will be accomplished from several different points of view: the history of philosophy, linguistics, power, cognitive science, and an examination of consequences. We will conclude with the implications this knowledge will have for the recovery model.

History of Philosophy

Philosophy since Plato has been about the search for absolute Truth through the use of reason. Science and the scientific method were a natural extension of this. Since the Enlightenment, science had been trying to "discover" a "reality" that our senses and scientific instruments only detect shadows of. Comte's philosophy of Positivism (about 1853) held that everything could be understood in terms of science – in opposition to a historical reliance on metaphysical, and theological explanations. The scientific method sought to explain phenomena by analysis, i.e. by reducing them to constituent interacting parts. Science soon found application in medicine and psychiatry, which continue this tradition of "discovering" and labeling parts of the whole. This reductionism taken together with the medical-disease focus has produced the familiar clinical terms of diagnosis and treatment in the mental health profession.

Another product of the Enlightenment that has been foundational in the mental health profession is Newton's laws of motion and mechanistic view of the universe. The universe was seen as operating like a giant clock set into motion by God. Soon everything was seen as a machine, including human beings. From this perspective human beings can be diagnosed and treated just like computers and automobiles can be fixed. This mechanistic view of human beings is foundational in mental health despite all the contradictory evidence.

Along came Ludwig Wittgenstein (1889-1951). Prior to Wittgenstein philosophy involved the use of reason to arrive at absolute truth – a search similar to that of science. Having taken philosophy to its limit, Wittgenstein decided to inquire into the nature of language, that taken for granted substrate of philosophy and science. Wittgenstein concluded that the typical problems of philosophy (the nature of reality, mind, etc.) were unsolvable and he focused instead on the role of language in everyday social activities. Furthermore, he asserted that communication was better seen as "language games" that influenced human action as opposed to exchanges of representations of "reality." Wittgenstein later became one of the founding fathers of postmodernism.

Postmodernism asserts that there are no absolute truths, and, instead, there are only different interpretations formed in language. Pragmatism later adds the requirement of utility to the mix. Postmodernism acknowledges how human relationships and communication create vocabularies that interpret our experience – that is, our "realities" are socially constructed. This is also referred to as the linguistic paradigm.

To illustrate how realities are socially constructed let's look at a thought experiment from Berger & Luckmann's (1966) *The Social Construction of*

Reality (from *Narrative Therapy*, Jill Freedman and Gene Combs, 1996):

> "Imagine two survivors of some ecological disaster coming together to start a new society. Imagine that they are a man and a woman who come from very different cultures. Even if they share no language, no religion, and no presuppositions about how labor is to be divided, or what place work, play, communal ritual, and private contemplation have in a good society, if culture of any sort is to continue, they must begin to coordinate their activities. As they do this, some agreed-upon habits and distinctions will emerge: certain substances will be treated as food, certain places found or erected to serve as shelter, each will begin to assume certain routine daily tasks, and they will almost certainly develop a shared language.
>
> Between the two founding members of the emerging society, the habits and distinctions that arise will remain 'tenuous, easily changeable, almost playful, even while they attain a measure of objectivity by the mere fact of their formation' (Berger & Luckmann, 1966, p. 58). They will always be able to remember, 'This is how we decided to do this,' or 'It works better if I assume this role.' They will carry some awareness that other possibilities exist. However, even in their generation, institutions such as "childcare," "farming," and "building" will have begun to emerge.
>
> For the children of the founding generation, 'This is how we decided …' will be more like 'This is how it's done.' Mothers and farmers and builders will be treated as always-having-existing types of people. The rough-and-ready procedures for building houses or planting crops that our original two survivors pieced together will be more-or-less codified as the rules for how to build a house or plant corn. In all likelihood laws will have been written about where, when, and how buildings may be built or crops may be planted. It is hard not to imagine that customs governing the proper rites for starting a family or harvesting a crop will have come to be, and that certain individuals will be identified as the proper people to perform those rites. Institutions like women's societies and masons' guilds will have begun to emerge.
>
> By the fourth generation of our imaginary society, 'This is how it is done' will have become 'This is the way the world is; this is reality.' As Berger and Luckmann (1966, p. 60) put it, 'An institutional world… is experienced as an objective reality.'"

This is true not only from the perspective of the evolution of civilization and culture – it is also true in terms of the development and institutionalization

of professions. If we replace the original two survivors with the original thinkers and arbiters of psychology and psychiatry we have development of the mental health profession together with its vocabulary (meaning words, concepts, and practices). Like the children in the thought experiment, everyone receiving a formal education in mental health receive the words and concepts as "reality." This process is called reification. Reification, according to Berger and Luckmann (1966, p. 89), is

> "… the apprehension of the products of human activity as if they were something else than human products – such as facts of nature, results of cosmic laws, or manifestations of divine will. Reification implies that man [sic] is capable of forgetting his own authorship of the human world. (emphasis in original)"

So what does this all mean in terms of the mental health profession? The vocabularies of the medical and psychological models, indeed the idea of "mental illness" itself, are social constructions – THEY'RE MADE UP. Furthermore, they are vocabularies that describe disease and deficit. They view a human being as something that can be "assessed", "diagnosed", and "treated" much like a machine – hence comes the obsession with "compliance." These models make distinctions between "normal" and "pathological." They position practitioner as expert and client as more or less passive recipient of "treatment." The focus of "treatment" is on the elimination of "symptoms." As will be discussed later, the recovery model is a state of partial transformation: it is truly client-centered; however, it is contextually "weighed down" by the vestigial and anachronistic use of the medical and psychological vocabularies. These vocabularies invisibly and insidiously support the old paternalistic roles.

From a postmodern perspective these medical and psychological vocabularies are not representing reality, but, in fact, creating a "reality" or perspective. The fact is that words simply "carve up" our undifferentiated sensory experience leading to many possible interpretations of the human condition. The question then becomes "What is the best 'reality' or perspective with which to help people reach their goals?" John Walter and Jane Peller (2000), both prominent leaders in postmodern consultation, describe this shift from *belief* to *utility*:

> "From our reading of postmodern philosophy and pragmatism, we decided to abandon the debates over epistemology and the debates over the foundation of knowledge. Taking his cue from Nietzsche and William James, the contemporary author of the new pragmatism, Richard Rorty, suggested: 'Instead of saying that the discovery of vocabularies could bring hidden secrets to light, [the pragmatists] said that new ways of speaking could help us get what we want' (1982, p.150). So, instead of asking, 'How do we know what is real about the

client?' we have decided the more relevant question is 'What do our clients want and what new ways of speaking or conversing might help?'" (p. 32)

Yet the power and importance of language goes beyond even this. Like "water is to the fish," language and its implications are very difficult for human beings to discern. When we create words and concepts describing aspects of ourselves or of our environment (also know as *making distinctions*) they appear as "truths" and, consequently, they dictate our actions. Martin Heidegger (1971), widely regarded as one of the most original and important philosophers of the 20th-century, put it this way: "we do not use language"; rather, "language uses us".

Linguistics

From the perspective of linguistics we see that the reified categories (e.g. mental illness, schizophrenia, bipolar disorder) are abstractions defined by clusters of what we call "symptoms." Schizophrenia is defined as the presence of audio hallucinations (or other "thought disorders") in the absence of a "mood disorder." You can even throw in other correlates like "negative symptoms", PET scans, response to medications, etc. The issue of the DSM's poor reliability and validity aside (Caplan, 1995; Sparks, Duncan, & Miller, 2005), the term "schizophrenia" is a word used to communicate the presence of these "symptoms." The various human manifestations of thought, feeling, and behavior (aka "symptoms") exist like the chair you are sitting on as you read this exists. But the next level of abstraction, the word "schizophrenia", and the next, "mental illness", only exist through consensus and only persist by convention. Even if the correlations of defining symptoms was perfect (which it is far from), in light of the linguistic paradigm we have to ask ourselves whether using a pathologizing, deficit-based vocabulary is useful in helping people improve the quality of their lives.

One of the traditional rationales for diagnosing is to have a shorthand way of communicating with other professionals, presumably for the purposes of "treatment." One thing that gets communicated is a cluster of "symptoms" under the heading of the "diagnosis." Unfortunately, what also gets communicated is the hierarchical role relationship as well as the pathologizing and deficit-focused context.

Often so called "mental illness" is described as similar to physical illnesses, such as diabetes, where the patient needs to manage it the rest of his or her life with medications. This comparison is used to explain how medications

work as well as to make the diagnosis and treatment more palatable to the client – as if to imply that their "mental illness" is something they "have." This analogy completely breaks down for the following reason. When we are talking about a person's thoughts and feelings we are essentially talking about their identity (which includes values, beliefs, memories, fears, and desires). This is not like something physically wrong with part of their body. A "disorder" of thought or feeling is a labeling of a person's identity. The labeling of subjective experience feeds on itself and perpetuates itself. Paula Caplan (1995), former consultant to the creators of the DSM, writes:

> "The professionals most concerned with labeling claim that they assign people to categories of mental illness so that they will know how to help them. If such assignments to categories really did help very much, that would indeed be encouraging, but treatment of emotional problems and conflicts is very different from medical or surgical treatment. If I broke a limb, I would want to be properly diagnosed as having a broken arm so that the surgeon would not mistakenly set and put a cast on my leg. But diagnosing individuals as mentally ill has not been shown to do much to alleviate their anguish and indeed often makes it worse." (p. 12).

Remember that the rest of the postmodern-enlightened world understands that words associated together comprise PERSPECTIVES and not descriptors of some discovered "objective reality." Another way to look at this is that symptom clusters are like stars comprising a constellation. The constellation (say the "big dipper") only "exists" from our point of view on earth. From another point of view far from our solar system the abstraction "big dipper" no longer exists. We have to get beyond our entrenched perspective.

Psychology, like psychiatry, has found ways of linguistically contorting, convoluting, and confusing lived experience with essential "truths" of its own. Bill O'Hanlon, a preeminent postmodern consultant and author, uses his holiday cookie making experience to communicate what happens in the therapy room (O'Hanlon and Wiener-Davis, 1989). A client's problem that s/he brings to therapy is like cookie dough. The experience of it is vague and malleable. Once the "blob" of cookie dough is forced through the cookie press (a tube, funnel, and mold pressed against a baking pan) it becomes a Christmas tree, star, or Santa Claus. Similarly, when a client exposes his or her problem to a therapist it gets "molded" or interpreted in the language of the therapist. So a client attending a psychodynamic therapy session would leave having unresolved childhood conflicts. The same client leaving a behaviorist's office would walk away with problem behavior shaped by reward and punishment. An interaction with a Jungian therapist would result in the need to deal with the various archetypes that apply to him or her. Talking with a diagnostically (and thereby

pathologically) minded clinician will leave one with the idea that they "have" "bipolar disorder", "depression", "obsessive compulsive disorder", a "mental illness" – along with all the stories that go with them ("chemical imbalances", life-long duration, the need to "comply" with a treatment regimen, etc.). Like cookies, continued exposure to the "heat" of the theoretical lens causes these interpretations to "harden" or "reify" (to make real). O'Hanlon concludes that if our languaging creates "the problem" then why not leverage the use of language and create a problem that is easiest to solve. Harlene Anderson (1997), author of *Conversation, Language, and Possibilities*, adds:

> "What seems to be an identifiable objective reality – a problem – is only a product of descriptions, the product of social construction. (p. 73)"

From a linguistic point of view, the recovery model is still saddled with the baggage of pathological and deficit-based vocabularies. Let's take a look at the recovery model concept of hope. Hope, an integral component of recovery, is constantly being weighed down by the languaging of diagnoses, "treatment", neurochemical correlation to "disease", psychiatric history taking, predictions of life long "illness", and on and on. In contrast, postmodern consultation (therapies) use language to maximize strengths and optimism. For example, presuppositional questions such as "What <u>will</u> you be doing differently when the current difficulties are resolved?" have a built-in supposition that the client *will* resolve the current difficulties. Simply by answering the question the client affirms the presupposition that they *will* resolve their current difficulty. Is there any proof that a client will resolve a current difficulty? Of course not. But if you speak as if they will, they become empowered – and, empowerment is the point.

This is one of the many ways in which language is used to empower people as opposed to coming from the scientific paradigm where reason and rationality are mistakenly applied to human beings in order to reductively nail down "objective" truths about them. Such misapplication of reason is an example of what is referred to as *scientism*: the attempt to use scientific method in domains where it does not belong (Barzun, 2000).

The power of language and positive expectations has long been observed in the forms of placebo effects and self-fulfilling prophecies (Miller, et. al, 1997). Common sense has had an insurmountable problem penetrating the theoretical lenses of mental health professionals. And, as if common sense wasn't enough, cognitive scientists have discovered that the human brain operates according to complexity theory (as opposed to mechanistic theory described above) and, as such, it conforms to role expectations and resists overt or covert means of control or manipulation (McCrone, 1999).

Power

The mental health profession's isolation from other disciplines such as history and philosophy, as a whole, has left it with only a superficial understanding of the power of language. In the best cases, experienced practitioners view diagnosing as a "necessary evil" and do it with caution or, in the case of the recovery model, clients are seen as "having" a diagnosis rather than *being* a diagnosis. In addition to the understanding of language above, language is involved in setting and maintaining power relations in society. In postmodern circles this is referred to as the *political* aspect of language.

The mental health consumer movement has long recognized its struggle as similar to that of other marginalized (to use another postmodern term) groups such as women, gay men and lesbians, African Americans, and other minority groups. How this relates to language is as follows.

The vocabulary of the medical and psychological models inherently positions the clinician as expert interpreter of the client's experience. Seemingly benign words like "clinical", "treatment plan", "case", etc. also bring with them a context in which the client is seen as "abnormal" or having a "pathology" while the clinician has the role of performing "interventions" or other activities (such as wellness centers) to help the client overcome their "pathology." The power of definition is in the hands of the clinician. Once labeled "abnormal" (aka "mentally ill") you've been pushed to the edges of society – where your views and concerns are considered not important.

Humanitarian, political, and financial pressures have given birth to the recovery model. Being outcome-driven, recovery programs have had to bend to the truth of what works. This includes being client-centered, being passionate about helping clients get what they want and find meaningful roles in life, having a vocational and community integration focus, and really meeting clients where they're at. However, the discourse of the medical and psychological models still lives in the language spoken in recovery programs.

So you can have the best recovery program in the world and still be linguistically casting clients in roles in which they are in fundamental ways different from the rest of humanity. The discourse, the spoken language, creates the distinction "mentally ill" versus "not mentally ill."

Let's switch gears and take another look at the where the rest of the world has been heading. Michael Foucault, the very influential French philosopher and social critic, around the mid 20th century began to inquire into the relations between language and power. In short, he revealed that

part of the way the powerful stay in power is through a monopoly on "truth" or "knowledge." With the emergence of democracy, politicians understood the need to manipulate public opinion. In developed countries corporations, through marketing, *create* need. The mental health profession says what's "normal" and what's "pathological." Furthermore, the vocabularies of the medical and psychological models together with the professional titles become something that seemingly elevates the professional from the persons subject to the labels (and, in many instances, from all non-professionals).

The designation "being insane" or "having a mental illness" originally implied the need for incarceration in mental hospitals. Through political and humanitarian pressure "treatment" became the alternative. The distinction "mental illness" became differentiated into all the diagnoses we have today. The point being that, though we have more humane treatment and more sophisticated designations, our languaging is still defining people as "abnormal" and subject to "treatment" where, despite more empowering structuring of roles (as in current recovery models), the center of power and definition lies in the clinician. Then it follows that these power relations, maintained in the vocabulary, powerfully undermine efforts at community integration and self-determination.

Though recovery-oriented programs are more client-centered, the double-bind communications of days of old are still alive and well. The content of our conversations with clients can be about their goals, their quality of life, accountability, community integration, high expectations, self-determination, independence, self reliance, etc.; but the context of our communication is "you have a pathology that makes you different from the rest of society" and "we have the expertise to help you overcome this pathology in order to live meaningfully like normal people do." Don Jackson (1965) drawing on Gregory Bateson's work on systems theory, asserted:

> "Every message (communication bit) has both a content (report) and a relationship (command) aspect; the former conveys information about facts, feelings, experiences, etc., and the latter defines the nature of the relationship between the communicants." (p.8)

The "command" or role relationship aspect of the communication, brought forth in the vocabulary, creates and privileges clinician knowledge and marginalizes the client's knowledge and skills. This will be the case no matter how much the client accomplishes. This is true no matter how many wonderful recovery-based systems you have in place as long the medical and psychological vocabularies are still being used. The result: many so-called "mentally ill" people have skills and resourcefulness that go unnoticed and therefore uncapitalized on. The skills of negotiating the public transit system, living off welfare (in California about $250 dollars plus food stamps

per month), adapting to often dangerous and unhealthful living conditions, negotiating the bewildering and often unfair social service and child protective agencies, coping with the "mental illness" stigma and ostracization, dealing with being "infantilized" (treated as a child or infant) by others, struggling with being pathologized by helping professionals, coping with being manipulated and taken advantage of by family members, and developing a whole array of "street smarts" – are all barely noticed behind the "mountain" of pathology "heaped" upon them from the medical and psychological perspectives. [1] Often their quite understandable reactions to so many of these challenges get thrown into the "symptom list" which adds support to "the diagnosis," which implies an inherent and internal "pathology" – all of which contributes to feelings of shame, humiliation, and self-blame. The "iron-grip" of these pathologizing discourses causes us to rarely sufficiently consider a client's life circumstances when the pathologizing labels are applied.

This brings to mind the fact that the Euro-centric version of "intelligence" and skill is but of one kind. Anthropologists were among the first to discover how the human brain does amazing feats regardless of the environment in which it finds itself – that is, regardless of such conditions as time period, geography, or degree of technological or economic development (Pinker, 2002). Individuals in primitive societies used to be viewed as having undeveloped brains (e.g. lacking intelligence). Their lack of technology (among other factors) prejudiced researchers (who are predominantly immersed in the dominant western Anglo culture) from seeing the amazing ways in which their genius and creativity manifested themselves. The most obvious example of this is the ancient Egyptians. The contributions of non-dominant cultures and those of other marginalized groups such as the so-called "mentally ill" are often devalued in a similar way. Real acknowledgement of these knowledges and skills in some fundamental way puts all of us humans on an equal footing: it's not about being better or worse, just different.

Our clients often are talented poets, artists, and musicians – traditionally vocations for those on the fringe of society. The long list of accomplished people with so-called "bipolar disorder" includes: Ted Turner, Jimmy Hendrix, Sting, Francis Ford Coppolla, and Jane Pauley. The link between "mental disorders" and creativity has been well established (Rothenberg, 1990). How many potential future Van Gogh's, Schumann's, Tolstoy's, Beethoven's, Hemmingway's, etc. have been prevented from enriching our society because their talent has been disabled and hidden by these vocabularies. The wealth of creativity and genius lost is incalculable.

Non-dominant cultures have had to liberate themselves from the pathologizing "lens" of mental health professionals as well. The "gays" in the 70's got themselves out of the DSM. Since the 80's cultural pluralism and

cultural competency have been emphasized to keep the arbiters of what's "normal" and "healthy" away. Now it's time for the rest of us!

The point being that the powerful in society promote a dominant discourse (ideas and practices) that often pathologizes and devalues practices of non-dominant cultures and marginalized groups. The mental health profession acts as an agent of society in this way. Harlene Anderson (1997) asserts:

> "The dominant voice, the culturally designated professional voice, usually speaks and decides for marginal populations – gender, economic, ethnic, religious, political, and racial minorities – whether therapy is indicated and, if so, which therapy and toward what purpose. Sometimes unwittingly, sometimes knowingly, therapists subjugate or sacrifice a client to the influences of this broader context, which is primarily patriarchal, authoritarian, and hierarchical." (p. 71).

The very words and concepts used create a perspective in which clients and their talents are subjugated to the professional knowledges. To review, because of the way language works this happens despite all the rhetoric and programs promoting client self-determination, client strengths, client empowerment, etc.

The movement to put an end to the use of the medical and psychological models and vocabularies has every element of a social-political movement – with something like emancipation, liberation, or inclusion being the objective.

Cognitive Science

What about the old favorite "chemical imbalance" – the often called-upon "proof" of the "disease model" or the "reality" of "mental illness?" Once again we look outside of the profession of mental health in order to get perspective. During the last half of the 20th century there has been a strange and wonderful confluence of scientific disciplines – including evolutionary psychology, sociobiology, genetics, cognitive science, and anthropology – that have dramatically changed our view of the human condition. Steven Pinker, Richard Dawkins, Robert Wright, Daniel Dennett, E.O. Wilson, and Noam Chomsky are among the contributors. While keeping in mind this inter-disciplinarity, for the purposes of this article we will focus on cognitive science.

Perhaps due to the hegemony of psychiatry and perhaps due to power of the pharmaceutical industry (another powerful interest group that promotes the medical vocabulary) the mental health profession has been shamefully unaware of what's been happening in non-disease-model-presupposed brain research: cognitive science. What does cognitive science or its cousin, neurobiology, have to say about the notion of "chemical imbalance" and its

relation to people's various mental conditions?

The distinction "chemical imbalance" is employed among other reasons to give credence to the "illness" interpretation and to justify the use of medications. The argument is made that a biological basis means it is a disease like other physical diseases.[2] The causality is assumed in the direction from biology to mind and behavior. Much current research, however, is revealing that mind and behavior (e.g. that which happens with psychotherapy) equally influence brain chemistry. Harrop, et. al. (1996) states:

> "[It] is possible for physiological differences associated with the condition [schizophrenia] to be the result of the condition and not the cause. . . . [The] relationship between the psychological problems and the physiology should be viewed not as a simple cause-and effect relationship, but more as a reciprocal and iterative relationship where psychological effects can affect the physiology that can in turn affect the psychology." (p. 641)

Since Harrop's research in 1996, the effect of psychotherapy on brain chemistry has been well documented (Teasdale, J., et. al., 2000; Shapiro, F., 2000; Schwartz, J., 2002; Goldapple, et. al, 2004; Etkin, et. al., 2005; Otto, et. al., 2005). Researchers now use the terms and "bottom-up" and "top-down" to characterize the effects of psychotropic medications and psychotherapy respectively. Medications are thought to change brain chemistry in "lower" or emotional regions of the brain (i.e. limbic system) which, in turn, effects the "higher" or thinking regions (i.e. the cortex). Psychotherapy (most researchers used cognitive-behavioral or mindfulness approaches), on the other hand, works from the "top-down." Better thinking results in changed brain chemistry. The term "biological basis" needs to be replaced with "biological correlate" where there is correlation and bi-directional causation.

Like diagnoses, the concept of "chemical imbalance" is an abstraction used mistakenly with universal application – despite similar validity and reliability problems (Sparks, Duncan, & Miller, 2005). Both the concepts of "mental illness" and "chemical imbalance" comprise some of the arsenal used to try to break down the "denial" and persuade (or coerce) clients into treatment. The question of "chemical imbalances" becomes moot when we look at all the negative consequences.

An equally important finding of cognitive science to the mental health profession is that of *neuroplasticity*. The old functional mapping of the brain has been discarded in favor of neuroplasticity. In his groundbreaking book *The Mind and The Brain: Neuroplasticity and the Power of Mental Force* (2002), Jeffrey Schwartz chronicles the discovery of neuroplasticity by

Edward Taub during the famous Silver Springs Monkeys experiments. In short, monkeys were used to show that in response to environmental demand and repetitive effort the brain will recruit healthy neuronal networks to perform the function of damaged ones. These findings have subsequently formed the basis for treatment of stroke victims and people with dyslexia.

Similar to the situation in California, where the Mental Health Services Act has provided the financial incentive to removing other entrenched-paradigms in favor of the recovery model, Schwartz points out how it was the potential for profit in the treatment of dyslexia that finally broke the grip of the old brain paradigm. Schwartz:

> "When Ed Taub once expressed frustration about how slow the rehabilitation community was to embrace constraint-induced movement therapy for stroke, Merzenich responded that only the profit motive was strong enough to overcome entrenched professional interests and the prejudice that the brain has lost plasticity after infancy." (p.234).

Merzenich's company, Scientific Learning, was so successful in treating dyslexia – having a 90% success rate – that in July 1999 it announced its initial public offering.

Schwartz took it a step further. In trying to help people diagnosed with "obsessive-compulsive disorder (OCD)" he recognized that traditional cognitive behavior therapy didn't work because knowledge of the irrationality of their cognitions made little difference to "OCD" clients. Instead, he *redescribed* the obsessive thoughts as products of "brain lock" (using PET scans showing lockstep functioning of the orbital frontal cortex, anterior cingulated gyrus, caudate, and thalamus), impressed upon them the idea that "thoughts were not facts" and that "they were not their thoughts", and devised alternative behaviors to replace the compulsive ones. He essentially divested the thoughts of their reality status thus making mindful awareness possible.

The results were astounding. The mindfulness training proved better than all other psychotherapies used with "OCD" and, more importantly, they produced the same neuronal changes seen on PET images after treatment with powerful psychotropic medications (Schwartz, 2002). Similar mindfulness-neuroplasticity mediated changes have been reported in the process of EMDR (Shapiro, 2001) and in the "treatment of depression" (Teasdale, et. al., 2000). Mindfulness continues to be a pioneering modality among many that live and thrive outside of the confines of the medical and psychological models (Bennett-Goleman, 2001; Shapiro, 2001, Hayes, 1999).

I am not trying to disqualify the use of chemicals (aka medications) to help people improve the quality of their lives. I am saying that psychiatry will have to recognize that it is an art to be applied in a highly individualistic, non-pathologizing, collaborative way – perhaps something akin to how the East practices herbal medicine. [The book to read is A Road to Recovery by Mark Ragins, MD]. We have to view chemicals as "crutches" in order to reduce the all-to-prevalent dependency and to position clients as responsible for taking many other actions that support their personal and spiritual growth. The chemicals sometimes are a helpful and temporary "tool" – it is the "story" that goes along with them that carries with it the iatrogenic problems (problems caused by the attempted solution).

These findings all point to the need to replace the paradigm of "chemical imbalance" with that of "neuroplasticity" – replacing determinism with possibility, medication dependence with better linguistic tools. So much industry attention on "bottom-up" change using pharmaceuticals has made clinicians "dependent on medications" in the sense that clinicians have not paid enough serious attention to developing their empowerment skills – making "biochemical determinism" a self-fulfilling prophesy. No doubt the neuroplasticity paradigm will result in practitioners with much greater empowerment skills; hence, greatly reducing the need for medications. Mindfulness is one of the perspectives and practices that will eventually replace the old medicalization of experience (see Implications for the Recovery Model section).

In light of neuroplasticity, rigid abstractions such as "chemical imbalance", "mental illness" and psychiatric diagnoses, such as "borderline personality disorder", are linguistic "balls and chains" when it comes to helping people become self-determining.

Examination of Consequences

Ignorance of the linguistic paradigm has resulted in profound iatrogenic problems (commonly referred to as iatrogenic illness): problems caused by the attempt at helping. Mental health professionals may be *creating* much (being conservative) of that which they are trying to cure.

When we speak as if someone has a diagnosis or has a "mental illness" we are unwittingly *creating* a reality – a reality in which human beings are transformed into the "mentally ill". When we use words such as "mental illness", "schizophrenia", "symptoms", "tangential speech", "clinical this or that", "treatment plan", "assessment" – we are unwittingly bringing forth the entire context, the hierarchical and paternalistic role relationship together with the sticky morass of pathological and deficit-based perspectives. Jill Freedman and Gene Combs (1996) write:

> "Speaking isn't neutral or passive. Every time we speak, we bring forth a reality. Each time we share words we give legitimacy to the distinctions that those words bring forth." (p. 29)

Words, abstractions, theories, and beliefs focus our attention. Heinz von Foerster (1984), the famous cybernetician and constructivist, concluded: "Believing is seeing." We "see" those behaviors that confirm the diagnosis and hardly notice those behaviors that don't. Because those are the behaviors noticed and responded to, the client experiences herself defined as such, and, by way of self-fulfilling prophecy, feels a strong "relational pull" to behave accordingly. It doesn't take an advanced knowledge of systems theory or cybernetics to see how we amplify the "symptoms" and reify (make real) the "labels" by the use of the pathologizing language. The irony and tragedy is profound.

We know not what we do. By seeing the medical and psychological vocabularies as truths (as opposed to perspectives) we cannot see the profoundly destructive consequences of them. These vocabularies comprise closed conceptual systems in which everything can be explained within them (not unlike a so-called "delusional" system). Martin Heidegger called these often impenetrable, closed interpretive systems *hermeneutic circles*. For example, a client who doesn't fit into the Procrustean bed [3] of "treatment" is seen as resistant, not ready to change, irresponsible, employing "defensive mechanisms", at the effect of "transference", manipulative, etc. The therapist's actions (frustration, resignation, avoidance, etc.) are in perfect accord with this cadre of pessimistic terms and, of course, have their complementary responses in the client (further lack of desire to participate with the therapist, increased pessimism about their own prospects, more inaction) – thus confirming the initial interpretation. Ironically, such "client blaming" keeps the professional from taking responsibility for doing something different that might produce a better outcome. Equally disturbing is the fact that this "hermeneutically sealed" conceptual system keeps us from hearing and taking seriously the emerging "voice" of the people we are trying to help (e.g. the Mental Health Consumer Movement).

The emerging client-centered recovery model acts as a counterbalance to this. Recovery programs look to make client goals (as well as removing barriers to these goals) and strengths the focus. In this way recovery programs go a long way towards ameliorating much of the negative effects of the medical and psychological vocabularies in which they are immersed.

Without a recovery focus pathologizing runs rampant: A client can't be angry without being accused of "not taking their medications". A client can't be persistent in getting his needs met without being written off as being "manipulative." A productive day becomes hypomania. A tired day

means signs of depression. A client asserting themselves with their clinician is defensive or resistant. And, of course, the "spin" put on client's behavior confirms the clinician's expectations. Despite the gains of the recovery focus the disabling conceptual reality continues to "live" in the minds and "breath" in the speaking of these recovery programs. Paula Caplan (1995) writes on some of these effects:

> "When terms like abnormal or mentally ill are spoken, what kinds of images come to mind? Usually, images of difference and alienation, suggesting that 'they' are not as competent, human, or safe to be around as the rest of 'us.' And often, 'abnormal' and 'mentally ill' are equated with 'crazy,' a label that calls forth images of someone who is out of control, out of touch with 'reality,' incapable of forming a good relationship, untrustworthy, quite possibly dangerous, and probably not worth one's attention, time, or energy. If such labeling had some positive effects, it might be worth risking the negative consequences for those who are labeled abnormal."

Furthermore, recovery's focus on community integration is continually sabotaged by the medical and psychological vocabularies. The normal ups and downs of working or being in relationship quickly get pathologized. Remember, it's about focus and language; recovery programs are currently only addressing focus. A problem with managing work tasks or a pang of jealousy in a relationship is quickly referenced back to a "mental illness." Shery Mead and Cheryl MacNeil (2004) in their paper titled Peer Support: What Makes it Unique? poignantly illustrate this problem:

> "Recovery in mental health has most often been defined as a process by which people labeled with mental illness regain a sense of hope and move towards a life of their own choosing (President's Freedom Commission Report, 2003). While this definition on the surface seems obvious, what remains hidden is the extent to which people have gotten stuck in a medical interpretation of their experiences. With this stuckness comes a worldview in which one is constantly trying to deal with their perception of what's wrong with them instead of what's wrong with the situation. In other words, even if I have hope of moving into a better life, I have been taught to pay a lot of attention to my 'symptoms.' This interpretation of my experiences leaves me constantly on guard for what might happen to me should I start to get 'sick.' Even with recovery skills (learning to monitor my own symptoms), I find myself creating a life that is ultimately guided by something inherently wrong with me. With this understanding, I may continue to see myself as more fragile than most, and different than 'normal' people. I then continue to live in a community as an outsider, no matter what goals I achieve." (p. 7).

Mead and MacNeil advocate client peer support that is free from the vocabulary of the medical model – I am advocating this for the profession as a whole.

Another devastating consequence of the medical and psychological vocabularies is their effect on our ability to recognize and capitalize on client's strengths. There are several ways in which client strengths are wasted. First, the hierarchical role relationship wherein the clinician is the expert and the client is the passive recipient of "treatment" puts the focus on the clinician and her expert knowledge. Secondly, the expert knowledge that both clinician and client are relying on focuses on current deficits (e.g. symptoms) and historical failure & tragedy (aka psychiatric history). Thirdly, the vocabulary hides, minimizes, and explains away strengths as "flights into health", superficial in comparison with "the illness", or even manifestations of "the illness" (e.g. hypomania, manipulation). Fourthly, the medical and psychological vocabularies comprise "normative perspectives" where clients are implicitly compared to what is "normal" in society; hence, making their strengths, accomplishments, and incremental change seem insignificant (or not given nearly enough attention, admiration, wonder, and analysis). Finally, even if the professional wants to build on client strengths, there is no vocabulary and associated practices in these models with which to do it. Let's get a taste of such empowering perspectives and practices by taking a look at an example from postmodern consultation.

Postmodern consultation leverages the power of language and focus. For example, in solution-focused therapy (a postmodern modality) we start by building on "exceptions": times when the problem is less intense or less frequent. For example, with a client whose goal is social skill, we might ask, "What is different about those times when you're a little more socially skilled?." Often clients say that they are more socially skilled in one-on-one situations where they are talking about common interests. Exceptions are always occurring, even BEFORE any contact with the helping person. After engaging in them in a collaborative inquiry into the *interpretive structure* that made this exception possible, I ask them to do more of this and keep track of what else they do that works. Therapy quickly becomes about reporting all the new distinctions (ways of viewing situations) and strategies that are working. This process immediately makes client's feel more confident. Moreover, all the life-enhancing strategies, derived from exceptions, are tailor-made to the client's temperament and circumstances. By focusing on pathological constructs exceptions are hardly noticed, ignored, minimized, or explained away. The very building blocks of change are ignored! Instead, "symptom management" and skill building programs start from scratch, assuming everything must be taught to the client – which also communicates to the client that what they already know is of little or no use.

The roles taken and words used by mental health professionals prevent an existential "I-Thou" (Buber, 1958) connection with clients. There is a maddening kind of inauthenticity and duplicity that comes with interactions with today's mental health professionals – not unlike the patronizing experienced by many minority groups. A kind of gulf between their personhood and professional role makes real human connection impossible. This disconnect manifests in barriers to effectively listening, accurate empathy, limit setting, etc. For example, labeling people as having "borderline personality disorders" has historically retarded clinician's interpersonal skill development (such as being able to compassionately set limits). The label creates the problem in the client as opposed to between two people – effectively relieving the professional from the responsibility for maintaining a warm, nurturing, and respectful relationship.

Only someone hypnotized by the current medical and psychological dogma – hence blind to their effects – could not see the isolating and otherwise debilitating consequences of being inauthentic in a helping relationship (assuming they can recognize their own inauthenticity) and of designating someone as having a "mentally illness." These relational and definitional acts isolate the person from the rest of society, from the so-called "normal people." Being contextualized by the medical and psychological vocabularies, it would be a miracle for so-called "community integration" to be truly successful. You'd be better off having a case of amnesia and being kidnapped to a developing country where, by the way, the outcomes are much better (Jablensky & Shapiro, 1977).

Implications for the Recovery Model

The recovery movement reflects a humanitarian impulse prevailing despite the power of medical and psychological dogma; however, most recovery model practitioners still use the vocabulary of the medical and psychological models. I hope that this paper has made clear the double-bind communication with all its consequences. The content says go after what you want in life, find meaningful roles, and integrate with the rest of society. The context says you are different from "normal" people, you are classified as "mentally ill" (with all those connotations), and you have "pathologies" or "symptoms" to overcome; which is why you need mental health professionals who are themselves "normal" to "explain" your "condition" and to provide expert advice (i.e. knowledge and perspective you can never possess) designed to help you reach your goals which are modest compared to "normal" people because you are by nature of your classification "weaker" and more "fragile" than "normal people." You will have to be on the alert for your "symptoms" as you try to work and maintain relationships – for you must manage your "illness" for the rest of your life. The content says "go" while the context says "no".

There are many effective tools currently employed by recovery programs, such as wellness centers, peer advocacy, community integration, and employment programs. The culture of recovery programs is undeniably client-centered. Collaborative (and, in many cases, collegial) relationships replace the old paternalism. So why keep the invisible chains of the most powerful factor of all – language?

The belief that the medical and psychological vocabularies represent scientifically "discovered truths" is the biggest obstacle for traditional community mental health programs transitioning to recovery-based services. If "mental illness" and psychiatric diagnoses are seen as being essential "realities" then so are the associated constructs that are part of the same closed-conceptual framework: pathological interpretations, the focus on deficits, the hierarchical-paternalistic role relationship, practitioner-as-expert role, and client-as-fragile role. Recovery leaders are asking their staff to overlook these "realities" and instead focus on things they can hardly "see" or take seriously (i.e. client strengths, client self-determination, client goals, independence, etc.) given the context they're embedded in. The initial weak, vague, and superficial understandings of the recovery process will be layered over the "realities" of medical and psychological dogma. The transition from the medical/psychological paradigm to the linguistic paradigm is essential.

A similar revolution is occurring in the substance abuse field. Like current mental health recovery models emphasize finding meaningful roles outside that of being a mental health client, substance abuse recovery is increasingly emphasizing the importance of a non-addict identity (McIntosh & McKeganey, 2000). The "disease" model of substance abuse is being challenged as well. Arthur Horvath (2001), president of SMART Recovery Inc., illustrates three other important parallels: 1.) the disease model is based on dogma versus fact and does more harm than good; 2.) forcing acceptance of having a disease/illness actually delays or prevents people from dealing with their problem; 3.) the biggest leverage a person has in changing is to focus on what's most important to her or him:

> "The disease model does more harm than good. If someone has a firm belief in it, and finds it helpful, I make no effort to persuade otherwise. However, public policy is better based on facts than dogma. Almost our entire US treatment system is based on treating this 'disease.' Individuals with addictive behavior are led to think that the most important question is, am I an alcoholic/addict? Of course, rather than admit this, many just ignore problems until they get worse. A more rational system would encourage earlier problem identification, and present a range of options for responding to problems. When you have a receptive audience, I suggest you present our message of hope: You don't have a disease, you are not powerless.

> By staying focused on what is most important to you (which might be a higher power, but could be all sorts of things), you can gain full control of your behavior, and learn to lead a wonderful life!" (p.3)

This paper is calling for nothing less than a total transformation in education in the mental health profession. The labeling has disconnected both professional and client from humanity. The elaborate psychological theories have led to what Bill O'Hanlon calls "analysis paralysis." Emphasis on categorizing and analyzing has severely hampered the development of professionals' empathetic, empowerment, and coaching skills. Paula Caplan (1995), asserts:

> "…Furthermore, much of the time and energy that professionals who use the DSM invest in learning about and trying to apply its contents could be more usefully invested in such endeavors as paying careful, caring attention to what one's patients say and working, free from dogma, to understand and help them." (p. xviii)

Despite the scientization and medicalization of the mental health profession, practitioners have all acquired certain common sense skills that work and that, by themselves, don't have all the disabling "side effects" of the medical and psychological vocabularies. These include skills such as rapport building, empathy, Socratic inquiry, persuasiveness, etc. No longer embedded in their pathologizing context, these skills will serve as our foundation in a post-medical-psychological-model world.

Postmodern (including solution-focused, narrative, and collaborative perspectives) consultation and coaching will build on this foundation and carry us into the 21st Century. Motivational Interviewing, life coaching skills, EMDR, Acceptance and Commitment Therapy, mindfulness-based therapies, and others not mentioned in this paper – and still others not yet invented – will also forward this movement.

Many dialogic skills are necessary for an authentic and collaborative relationship. The medical and psychological ways of relating have left most mental health professionals in the habit of somewhat mechanically reflecting back, nodding their heads, or saying "uh ha" while their minds are preoccupied with interpreting the client and his experience through the lenses of all the medical and psychological constructs. Remember: believing is seeing. Authentic and collaborative dialogue is an exhilarating experience and is the means to connect and stay connected with the people we consult with. It is a learned skill and requires a significant amount of training.

We all could use consultation or coaching in order to more efficiently reach our goals. Without all the negative connotations and stigma it is likely that the market for mental health services will expand.

Another common reason for labeling people as "mentally ill" and having such and such "diagnosis" is for insurance reimbursement and disability benefits evaluation. The need for services needs to be established. Currently this is done by some combination of description of "functional impairment" combined with psychiatric diagnoses.

This is where it is necessary to have a true understanding of the postmodern perspective. From a postmodern point of view there are no absolute or essential truths; instead all we have is interpretation. Furthermore, there can exist multiple valid interpretations – multiple descriptions. We can use different interpretations for different purposes. When it comes to third-party reimbursement, we simply have to change our point of view from that of empowerment of the individual to that of the institutions of our society – we take a "normative perspective" (i.e. comparing to that which is considered "normal" from the perspective of society as a whole). Using descriptions of behavior we illustrate what our clients can't do.

If insurance reimbursement requires psychiatric diagnoses we simply remember that we're changing focus (i.e. to that of "symptoms") and using different abstractions (i.e. those of diagnoses) to make summary statements. Insurance companies "believe in" (i.e. see them as essential "truths" or "entities") these reified linguistic constructs only as a result of their having been sanctioned by the medical profession. The profession can certainly establish the need for services or benefits based on behaviors, without resorting to making up "fictive diseases."

Remember from the old scientific-reductionist rigidly held perspective holding two contradictory points of view is impossible – because, as you will recall, the point is to reduce things to some unique essence. From the linguistic paradigm we're looking for words and perspectives that will help us solve a problem. To receive insurance reimbursement and to establish disability benefits simply requires an occasional translation from one language to another. Words are tools, not truths.

The recovery model as it currently exists is an incomplete transformation of the mental health profession. We are finally helping clients get what they want, taking them seriously, having high expectations of them, and eliminating barriers to employment, housing, financial stability, and relationship. The basis of our helping interactions has to be freed from the vocabularies of medicine and psychology.

We human beings are all struggling with our feelings, thoughts, impulses, and habits. The illusory difference between "clinician" and "client" evaporates, like a bad dream – leaving us with one "condition": the human condition. It was Shakespeare that understood how our human roles are mere fabrications, where power and authority are based on image and

ceremony.

The cultural pluralism in our country has led to an emphasis on "cultural competency" in the profession. Gays won their freedom from the DSM in the 80's; various non-dominant-culture-specific practices did so in the 90's. There doesn't seem to be any pride in membership in the DSM. I'm advocating freedom for all.

Finally free from the chains of the medical and psychological vocabularies, many people would immediately fit into society with a little extra help. Others would blend in immediately into artist studios, universities, and musician & literary communities. 19th century Paris was the mecca for such creative people. Bohemian was the term for the artists and intellectuals that didn't "fit in." Avant-garde referred to those who didn't "fit in" and led the rest of us. Something to think about.

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Endnotes

[1] This list doesn't include all the "smaller" accomplishments that are the building blocks of a client's preferred lifestyle such as: reading, dressing tastefully, having various hobbies, raising children, and maintaining various aspects of a household (e.g. being clean and

organized).

[2] This conveniently counters Thomas Szasz's (1961) assertion that "mental illness" is only a metaphor for "bad" or "idiosyncratic" behaviors – like societies with bad fiscal policies are only metaphorically "sick". The argument is made that if there is a "biological basis" for a dysfunction then it falls under the definition of illness (even as Szasz defines "illness").

[3] According to the Encyclopedia Britannica (1994-2001): "Procrustes had an iron bed (or, according to some accounts, two beds) on which he compelled his victims to lie. Here, if a victim was shorter than the bed, he stretched him by hammering or racking the body to fit. Alternatively, if the victim was longer than the bed, he cut off the legs to make the body fit the bed's length. In either event the victim died… The "bed of Procrustes," or "Procrustean bed," has become proverbial for arbitrarily--and perhaps ruthlessly--forcing someone or something to fit into an unnatural scheme or pattern."

Race doesn't matter, but...: The effect of race on professors' experiences and emotion management in the undergraduate college classroom, dream, typically, contradictory lifts style.
A social-cognitive approach to motivation and personality, frustration flows in a multifaceted abstract stream of consciousness.
The social construction of mental illness and its implications for the recovery model, the sublimation begins rider, thus, similar laws of contrasting development are characteristic of the processes in the psyche.
Hope therapy: Helping clients build a house of hope, according to the theory of "feeling", developed by Theodore Lipps, fear instantly gives ontogenesis.
In/out/side: Positioning the researcher in feminist qualitative research, stress requires more attention to the analysis of errors that gives the integral of a variable.
Personal relationships and legislative power: Male and female perceptions, the addition of organic matter is nontrivial.
Going local: Creating self-reliant communities in a global age, freud in the theory of sublimation.