The Self: Colonization in Psychology and Society

Kenneth J. Gergen

While the early Greek exhortation to "know thyself" has resounded compellingly across the centuries, the object of knowledge in this case has been in a state of continuous transformation. Precisely what it is that one is supposed to "know" in this case, and for what reason, remain continuously in flux. With the spread of Christianity across the West, the self was virtually equivalent to the human soul. And it was imperative that the state or condition of the soul be known, for indeed its degree of purity would determine the place of one's eternal residence. However, with the emergence of Enlightenment thought and practice, the soul as the essence of the self gave way to conscious reason. For philosophers such as Descartes, Locke and Kant, reflexive thought (reason gaining knowledge of reasoning itself) was a means toward a morality, personal integrity, and a coherent life.

I invoke a historical perspective here because we tend at any point in history to presume that our common language maps an independent domain of entities or events. Or more specifically, we tend to presume that our discourse for the self is ontologically secure. The names we share for the domain of the psychological interior refer to states or conditions that exist independently of the names: the spirit or soul in the case of the pre-moderns, and agentive reason with the birth of modernism. By historically contextualizing the discourse of the self in this way we are prepared to inquire into the functions of such discourse within society. How is the discourse of the self employed within our relationships; what traditions are sustained and which are marginalized; what are the gains and losses of such use in everyday life; what institutions are benefited by any particular discourse, and what forms of life are rendered dangerous or defective? In effect, through historical relativization of the self we begin to ask pragmatic as opposed to ontological questions (see also Graumann and Gergen, 1996).

A consciousness of historical contingency is central to the issues I wish to address in the present paper. In my view the varying traditions of self-discourse have contributed in significant ways to the central institutions of society. Indeed, the assumption of agentive reason has contributed to institutions of democratic governance, public education, the justice system, business and military organizational structures, and more. This is to say that the constructions of the self have been, and continue to be, of enormous consequence to the conduct of everyday life. Most important, because there are are variations in traditions of discourse, and the stakes are so substantial, there is an ongoing competition for control of the discourse. Or more dramatically put, most sub-cultures stand to gain through the discursive colonization of the society more generally. Self-definition and power relations walk hand in hand.

In what follows I shall first set the stage by illuminating more fully the problems inhering in the attempt to anchor our discourse of the psychological self in an

independent world of states or conditions. I will propose instead that all mental discourse is *essentially contested*, that is, in principle without a decidable referent. These arguments will first enable us to problematize the view that psychological science can terminate the contest of discourse through empirical study. More importantly, this will sensitize us to the ways in which the science actively participates in the conflicts of cultural power. To illustrate the conflicts in motion, I will then take up the issue of the "defective self," or more formally, the problem of mental deficit. Here I shall propose that the psychological science has had enormous success in colonizing Western culture within the past century, and with new coalitions in progress, the stage is set for a virtual elimination of all competing voices and values.

Mental Discourse as Essentially Contested

Typically we employ such terms as "thought," "emotion," "motivation," and "attitudes," as if they referred to existing states or entities within the individual. Yet, if we scan both the historical and anthropological literature on discourses of the person, we locate an enormous variety of terms and phrases, many of which do not correspond to those currently circulated either within contemporary Western culture in general or within the science of psychology. What, then, are the grounds for holding one vocabulary (and most especially a scientific one) superior to another?

Consider the emotions. Today we consider the emotional condition of the individual as a central to his or her well-being; many forms of therapeutic practice are focused on emotional processes; and the emotions are major objects of study within psychological science. Yet, while the discourse of emotion is fully naturalized, and functions as if it referred to independent processes or states within the brain, there are enormous variations across culture and history. Historically, for example, in the second book of the Rhetoric, Aristotle distinguished among fifteen emotional states; Aquinas' Summa Theologiae enumerated six "affective" and five "spirited" emotions; Descartes distinguished among six primary passions of the soul; the 18th century moralist, David Hartley, located ten "general passions of human nature"; and the major contributions by recent theorists, Tomkins (1962) and Izard (1977), describe some ten distinctive emotional states.

Not only did assays of the mind yield differences in the number of emotions detected, they also detected distinct differences in kinds. For example, Aristotle identified placability, confidence, benevolence, churlishness, resentment, emulation, longing and enthusiasm, as emotional states no less transparent than anger or joy. Yet, in their 20th century exegeses, neither Tomkins (1962) nor Izard (1977) recognize these states as constituents of the emotional domain. Aquinas believed love, desire, hope, and courage were all central emotions, and while Aristotle agreed in the case of love, all such states go virtually unrecognized in the recent theories of Tomkins and Izard. Hobbes identified covetousness, luxury, curiosity, ambition, good naturedness, superstition, and will as emotional states, none of which qualify as such in contemporary psychology. Tomkins and Izard agree that surprise is an emotion, a

belief that would indeed puzzle most of their predecessors. However, where Izard believes sadness and guilt are major emotions, they fail to qualify in Tomkins analysis; simultaneously, Tomkins sees distress as a central emotion, where Izard does not.

In effect, while each of these scholars presumably "scanned the internal depths," each secure in his conclusions, there is little agreement in their "findings." It is at this point that we may usefully pause to consider the grounds of knowledge in this case. What is the relationship between ourselves and the object of knowledge that we can justify our conclusions? In the present case, our empiricist tradition suggests that we have two major candidates for justification: self-observation and observation by others. In the former case, we might presume that we can know with confidence about mental states such as emotion because we are intimately acquainted with them. In contemporary parlance, we have metacognitive knowledge of our psychological processes. In the case of external observation, we might presume a warrant for psychological knowledge based on the reasoned conclusions of neutrally positioned observers.

Yet, let us consider the possibility of knowledge through self-observation. A brief scan of both philosophic and psychological analyses suggests that the very concept of internal observation is deeply flawed. To succinctly summarize some of the major problems:

- 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?
- 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 the color of hope, the size of a thought, or the shape of anger? Why do none of these attributes seem quite applicable to mental states? Is it because our observations of the states prove to us that they are not? What would we be observing in this case?
- Could we identify our mental states through their physiological manifestations - blood pressure, heart rate, etc. Do I know I am thinking by checking my blood pressure, or that I have hope by sensing my neurological activity? And, if we were sufficiently sensitive to differing physiological conditions, how would we know to which states each referred? Does increased pulse rate indicate anger more than love, or hope more than despair?
- How can we be 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.)
- By what criterion could we judge that what we experience as "certain recognition" of a mental state is indeed certain recognition? Wouldn't this recognition ("I am certain in my assessment.") require yet another round of self-assessments ("I am certain that what I am experiencing is certainty..." the results of which would require additional processes of internal identification,

and so on in an infinite regress?

- How could we identify an inner state save through a forestructure of a linguistic a priori? Could one identify an emotion that was not already given within the prevailing discourse on emotion? If one identified a mental state with an unfamiliar term it would wholly opaque.

Of course, many contemporary psychologists (along with many psychoanalysts) are quite willing to abandon inner observation (or introspection) as a valid source of psychological knowledge. For many, it is the external observer - rationally systematic and personally dispassionate - who is ideally situated to draw valid conclusions about people's internal states. Yet, the past 30 years of post-structural and hermeneutic deliberation leave the presumption of external observation as imperiled as that of introspection. Again in abbreviated form, consider some of the major flaws:

- If we were to base our knowledge on our subjects' descriptions of their internal states (e.g. "I am depressed." "I am angry.") how would we know to what the terms referred within their own mind/brain? We never have access to the states or conditions. What if one person's referent for "love" was another's referent for "anxiety?" Without access to the putative referents, there would be no means of sorting out the differences. Indeed, how can we be certain that mental terms refer to anything at all (e.g. "my soul is anguished?")
- If we abandon introspection as the basis of knowledge, how can we trust any self-reports (e.g. "I feel..." "I aspire to..." "It is my opinion that...") as the basis of external inference? How could the person know about these conditions, sufficient that the reports would count as inferential evidence?
- Even if self-reports converge (as in the items making up a depression scale, or "The Big Five"), how would we know to what (in the individual's mind/brain) the individual items referred - if anything (could we not also generate a 12 item scale of "soul anguish"?). How could we trust the subject to know?
- How can we determine the nature of what we are observing, save through the lens of a theory already established? Could we identify "cognitive conservation" without a theory enabling us to interpret a child's action in just this way? Could we observe aggression, moral behavior, altruism, conformity, obedience, or learning, for example, without a pre-understanding (forestructure) that would call our attention to certain patterns of activity as opposed to others? Can we observe a "causal relation" without at least a rudimentary theory of cause already in place? Or, in effect, aren't our observations of psychologically relevant behavior theory determined?
- If we propose to identify psychological states through their physiological correlates (as in "the physiology of memory"), how can we determine to what psychological states the physiology provides the underpinning? If we cannot determine when a "memory," "a thought," or "an agitation of the spirit" has occurred, how are to establish the physiological correlates?

We find, then, that the discourse of the psychological self, cannot be anchored in a referential base sufficient to constrain our usage. The character and content of the

internal world is open to infinite contestation. For illustration, the reader may wish to consult Mary Boyle's (1991) careful critique of diagnoses of schizophrenia. As she shows, such diagnoses are not evidentially based, but are highly interpretive, and rife with conceptual confusion. See also Wiener's (1991) critique of the concept of schizophrenia.More broadly, this is to say that there is no means of halting the process of cultural colonization through a referentially anchored discourse.

Although this is not the proper context for elaboration, it is worth noting that largely because compelling answers to questions such as the above have not been forthcoming, many contemporary scholars have moved to an alternative view of psychological discourse. They have replaced the ictorial orientation to mental language with a more pragmatic view. They bracket the view of mental language as a picture of inner states, and consider it as communicative action. Or, with Wittgenstein (1980), it is held that psychological language obtains its meaning and significance primarily 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, emotions, or cognitive schema. 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 further opinion. Both the conditions of the report 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 greeting, an invitation to laughter, or a commendation. In this sense to use mental language is more like a handshake or an embrace than a mirror of the interior, more like a strong grip between trapeze artists than a map of inner conditions. In effect, mental terms are used by people to carry out relationships.

Knowledge, Power and Discourses of the Self

Foucault's (1978, 1979) writings on knowledge and power are an effective entry to the present analysis. Language, for Foucault, serves as a major medium for carrying out relations. Because language constitutes what we take to be the world, and rationalizes the form of reality thus created, it also serves as a socially binding force. By acting within language, relations of power and privilege are sustained. And, by engaging in the further circulation of a form of language, the array of power relations is further extended. Thus, as disciplines such as psychology, psychiatry, and sociology are developed, so do they operate as discursive regimes. They specify a world and a normative domain of relevant action. As these languages are further elaborated and disseminated, so then is the configuration of power extended. In this sense, power relations possess a productive capacity. The relevance of this perspective for psychology has been effectively demonstrated in Rose's (1985, 1990) analyses of psychological theory and measurement as forms of cultural control.

Yet, there is a strong tendency in Foucault's work to treat discursive regimes as

unitary forms. That is, regimes tend to be treated as internally coherent and hegemonically accelerated. As Foucault proposes, beginning in the 18th century and extending into the present, "the formation of knowledge and the increase of power regularly reinforce(d) one another in a circular process...First the hospital, then the school, then, later the workshop were not simply 'reordered' by the disciplines: they became, thanks to them, apparatuses such that any mechanism of objectification could be used in them as an instrument of subjection, and any growth of power could give rise in them to possible branches of knowledge; it was this link, proper to the technological system that made possible within the disciplinary element the formation of clinical medicine, psychiatry, child psychology, educational psychology, and the rationalization of labor. It is...a multiplication of the effects of power through the formation and accumulation of new forms of knowledge." (p.224) This line of argument has also been fortified by much Marxist theory, particularly as inspired by Althusser, of a unified, hegemonic order

The view I wish to propose, and indeed which might be supported with alternative quotes from Foucault's capillary view of power, is that life within what we take to be the existing regimes is seldom unitary. Rather, regimes themselves are composed of variegated discursive practices, drawn from sundry contexts, ripped from previous ecologies of usage and stitched awkwardly together to form what - with continued usage and considerable suppression - is seen as a coherent view ("a discipline"). Ontologies and rationalities are thus only apparently and momentarily univocal; they harbor multiple tensions and contradictions even for those who dwell within. In a sense, I wish to augment (or shift the emphasis of) a Foucauldian perspective with important theses from Bakhtin (1981) and Derrida (1976). While Bakhtin points to the hybrid or heteroglossial character of any given domain of language, Derrida's writings emphasize the failure of any language to carry autonomous meanings - to stand independent of its multiple signifying traces. The present analysis agrees, then, with Raymond William's (1980) view that "Hegemony is not singular. Its own internal structures are highly complex, and have continually to be renewed, recreated and defended; and by the same token...they can be continually challenged and in certain respects modified." (p.38) This view is also reflected in Laclau and Mouffe's (1992) vision of radical politics.

The inability to ground psychological discourse creates a condition in which there is enormous latitude available for creating vocabularies of inner being. The creation of such vocabularies can be highly consequential, owing to their functions or uses within ongoing relations. For example, the rich range of terms for states of attraction (e.g. love, liking, passion, respect) do not index states of mind, so much as they serve to create (justify, perform, sustain) various forms of relationship. In this sense, the objectification of the soul, as a state of the individual mind, sustains a hierarchical relationship between priest to supplicant, in the same way that the presumption of repression is essential to the relationship between analyst and analysand.

In a broader sense it may be said that the realities created by people together are functionally insinuated into their daily relationships. The discursive ontologies and

ethics are embedded within normal and normative practices. Or more succinctly, the discourses of daily life are constitutive of living traditions. In this sense, to control the vocabularies of the self within society, is to set the grounds for much of its social activity. Alien traditions are often suspect because their traditions of discourse and action are neither ontologically nor ethically acceptable. Because one lives in a tradition of the real and the good, and other traditions may constitute threats, there is a strong tendency not only to defend one's own tradition, but to expand its perimeters.

When efforts to expand the realm in which one's local vocabulary of the self also serve to enhance the outcomes of one's tradition, we may speak of colonization. For example, the attempt to secure Western psychology a place in the curricula of Indian and Japanese universities, is an obvious form of colonization. When behaviorists extinguished the discourses of phenomenology and introspection, and cognitivists subsequently reduced behaviorist discourse to a historical artifact, colonization was successful within the discipline of psychology. And in the same way, today we find power struggles among cognitivists, humanists, psychoanalytic psychologists, hermeneutic psychologists, critical psychologists, feminist psychologists, and more. Power in such cases depends on such instruments of colonization as control of journal content, research funds, appointment policies, tenure procedures, and award committees.

The Deficient Self: Colonization and Conflict

My concern in the present offering is not principally with the internecine conflict within psychological science, but with the relationship of the science to the surrounding culture. The case is an interesting one, and also replete with political and cultural significance. During the 20th century, and the full flowering of modernism, the discipline of psychology slowly (if fitfully and unevenly) established itself as the authority on matters of the individual interior. Through its self-definition as a science - along with its development of experimental methods, statistical analyses, psychological testing, and treatment programs - it displaced all competition in claims to authority. Not only were religious and spiritual assays of the mind reduced to mythology, but so were the argots of myriad folk traditions placed in jeopardy. Even the individual's claims to self-knowledge were no longer to be trusted, as it is only the scientific expert who can offer reliable judgements - for example, in therapy, courts of law, and psychiatric hospitalization. In effect, with no viable or organized resistance, psychological science has achieved the capacity for full-scale colonization of the culture. The common definition of the self is fully within its grasp.

In certain respects, this potential is trivial. So long as the scientific community continues to write primarily for its own - sharing findings, mutual critiques, and abstract theories among themselves alone - there is little political or cultural consequence. However, when the science attempts to share its knowledge with the public, to influence policy issues, and to sell merchandise (such as psychological tests, books, educational programs), we confront significant issues of cultural concern. The public resistance to IQ testing, homosexuality as mental illness, and

empirical justification for child abuse are only representative of the conflict in discourse - and associated ways of life - that can result when cultural colonization is in motion.

Yet, there is one domain in which broad colonization has been enormously successful, and which now reaches the point at which we, as cultural participants, might indeed wish to join in resistance. My concern here is with the domain of mental illness, or the deficiencies of self. The tendency to attribute undesirable behavior to undesirable states of the mind has a long history in Western culture - from spirit possession, to impure thoughts, to failings in moral character. Within the 20th century, as psychological science (along with psychiatry) became the arbiter of interior, it also fell heir to the opportunity of defining the deficiencies of self. I do not use the word "opportunity" lightly here, because the language of deficit, in particular, is also a language of moral and political control. For example, there is nothing intrinsically wrong with prolonged sadness or lethargy; in themselves they are morally and politically neutral. However to classify these as "mental illness" creates them as undesirable, inferior, and flawed. "Normal" behavior, in this sense, is simply behavior that is socially acceptable. (This was indeed the realization of the gay community when homosexuality was deemed a mental illness.)

Concern continues to mount when we inquire into the uses of this power of definition. For in this case, to define a condition of the self as an illness or a disease, is also to imply that a treatment or cure is possible. And indeed, clinical psychology and psychiatry have also offered scientifically appropriate forms of "intervention." Thus was established "the business" of cure. Or, to put it bluntly, the conditions were established in which the colonization of the culture with respect to deficiencies of the self, served the business interests of the professional community.

I am not at all casting aspersions on the relevant professionals in this case. For the most part, professionals indeed share with the culture a sense of what is unacceptable behavior. Within the profession the political and moral sensibilities are simply removed from view in the earnest attempt to bring science to bear on human problems, and to provide reliable treatments for the anguish most clients bring into the therapy room. Classifying, studying and curing illnesses of the mind, no less than the body, is a noble calling. It is the largely unnoticed, "collateral damage" that concerns me here. For, if we view the case historically, we begin to approach a condition of infinite infirming.

Progress in Mental Health

It is useful here to consider the colonization process in terms of phases. While this is an idealized version of historical change, it does enable us to understand the colonization process and its problems for society.

Phase l: Deficit Translation

We begin at the point at which the culture accepts the possibility of "mental illness," and a profession responsible for its diagnosis and cure, a condition of ever increasing prevalence since the mid-19th century (Peeters, 1995). Under these conditions the professional confronts clients whose lives are lived out in terms of a common or everyday language (e.g. "unhappiness," "fear," "loss," "aimlessness.") Because life management seems impossible in terms of everyday understandings the client seeks professional help - or, in effect, more "advanced," "objective," or "discerning," forms of understanding. In this context it is incumbent upon the professional to l) furnish an alternative discourse (theoretical framework, diagnosis, etc.) for understanding the problem, and 2) translate the problem as presented in the daily language into the alternative and uncommon language of the profession. In effect, this means that problems understood in the profane or marketplace language of the culture are translated into the sacred or professional language of mental deficit. A person whose habits of cleanliness are excessive by common standards may be labelled "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.

Phase 2: Cultural Dissemination

Since the 18th century scientific analysis has placed great importance on classifying the various entities in its domain (e.g. animal or plant species, tables of chemical elements) (Bowker and Star (1999). Emulating the natural sciences, the mental health professions have thus attempted to classify all forms of dysfunction in terms of mental illness. As a result, not only is "mental illness" created as a reality, but all problematic action becomes a candidate for such classification. Further, because people lack knowledge of these illnesses, it becomes a professional - and indeed political - responsibility to alert the public to the fact. They must learn to recognize the signals of mental disease so that early treatment may be sought, and they should be informed of possible causes and likely cures. Early in the century this dissemination process was realized in the U.S. in the mental hygiene movement. For millions of people Clifford Beers' famous volume, A Mind That Found Itself (going into 13 editions within 20 years of its publication in 1908) first served to substantiate mental illness as a phenomenon, and to warn the general public of the existing threat of such illness. In the same way that signs of breast cancer, diabetes, or venereal disease should become common knowledge within the culture, it was (and is) argued, citizens should be able to recognize early symptoms of stress, alcoholism, depression and the like.

Although the mental hygiene movement is no longer visible as such, its logic has now been fully absorbed by the culture. Most large scale institutions provide services for the mentally disturbed - whether in terms of health services, guidance counselors, clinical social workers, or insurance coverage for therapy. University curricula feature courses on adjustment and abnormality; national magazines, newspapers and self-help books disseminate news and information on mental disorder (e.g. depression and its cure through chemistry). And, the National Institute of Mental Health provides a range of authoritative pamphlets and a website informing the

public of how to recognize the "symptoms" of mental illness. An informative illustration of the way in which the media contributed to the cultural construction of anorexia and bulimia is furnished by Gordon (1990).

Phase 3: The Cultural Construction of Illness

As vocabularies of deficit are disseminated to the culture, 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" to the public. Terms such as split personality, identity crisis, PMS (premenstrual syndrome), attention deficit disorder and post-traumatic stress also enjoy a high degree of popularity. And, as such terms make their way into the cultural vernacular, they become available for the construction of everyday reality. Veronica is not simply "too fat;" she has "obese eating habits;" Robert doesn't simply "hate gays," but is "homophobic;" and so on.

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 deficit interpretation; actions once viewed as "good and proper" can now be reconceptualized as obsessive, phobic, or repressive. Once terms such as "stress" and "occupational burnout" 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." As we furnish the population with hammers of mental deficit, everyone can take a pounding.

Nor is it simply deficit labeling that is at stake here. For as forms of "illness" are described in the media, educational programs, public talks, and the like, the symptoms come to serve as cultural models. It is in this vein that Szasz (1960) has argued that hysteria, schizophrenia and other mental disorders represent the "impersonation" of the sick person stereotype by those confronting insoluble problems of normal living. Mental illness, in this sense, is often a form of deviant role playing, requiring a form of cultural knowhow to break the rules. Sheff (1966) has made a similar case for many disorders serving as forms of social defiance. As Sheff proposes, others' reactions to the rule-breaking behavior are of enormous importance in determining whether it is finally labeled as "mental disease."

As people's actions are increasingly defined and shaped in terms of mental deficit language, there is also an increasing demand for mental health services. Counseling, weekend self-enrichment programs, and regimens of personality development 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 organized support groups for their "incest victimization," "co-dependency" or "obsession with gambling." And, of

course, many enter organized programs of therapy.

Thus we find that the prevalence of "mental illness" and the associated expenditures for mental health are propelled upward. For example, in the 20 year period between 1957 and 1977 the percentage of the U.S. population using professional mental health services increased from 14% to over a quarter of the population (Kulka, Veroff and Douvan, 1979). When Chrysler Corporation insured its employees for mental health costs, the annual use of such services rose more than six times in four years ("Califano Speaks," 1984). Although mental health expenditures were minuscule during the first quarter of the century, by 1980 mental illness was the third most expensive category of health disorder in the U.S., accounting for more than $20 billion annually (Mechanic, 1980). By 1983, the costs for mental illness, exclusive of alcoholism and drug abuse, were estimated to be almost $73 billion (Harwood, Napolitano, and Kristiansen, 1983). By 1981, 23% of all hospital days in the U.S. were accounted for by mental disorders (Kiesler and Sibulkin, 1987).

Phase 4: Vocabulary Expansion

The stage is now set for the final revolution in the cycle of progressive infirmity: Further expansion in the vocabulary of deficit. As people increasingly construct their problems in the professional language, as they seek increasing help, and as the professional ranks expand in response to public demands, there are more individuals available to convert the common language into a professional language of deficit. There is no necessary requirement that such translation be conducted in terms of the existing categories of illness, and indeed there are distinct pressures on the professional for vocabulary expansion. In part, these pressures are generated from within the profession. To explore a new disorder within the mental health sciences is not unlike discovering a new star in astronomy: considerable honor may be granted to the explorer. In this sense "post-traumatic stress disorder," "identity crisis," and "mid-life crisis," for example, are significant products of the "grand narrative" of scientific progress (Lyotard, 1984). They are self-proclaimed "discoveries" of the science of mental health. At the same time, new forms of disorder can be highly profitable for the practitioner, often garnering book royalties, workshop fees, corporate contracts, and/or a wealthier set of clients. In this respect such terms as "co-dependency," "stress," and "occupational burnout" have become able economic engines. The construction of Attention Deficit Disorder, and its application to populations of both children and adults, children has unleashed a virtual epidemic of deficit.

On a more subtle level, there are pressures toward expansion of the professional vocabulary produced by the client population itself. As the culture absorbs the emerging argot of the profession, the role of the professional is both strengthened and threatened. If the client has already "identified the problem" in the professional language, and is sophisticated (as in many cases) about therapeutic procedures, then the status of the professional is placed in jeopardy. The sacred language has become profane. (The worst case scenario for the professional might be that people learn to diagnose and medicate themselves without professional help.) 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 cognitive-behavior therapy, is required by an increasingly sensitive understanding of mental dynamics. Indeed, each wave sets the stage for its own demise and replacement; as therapeutic vocabularies become commonly known 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."

In this context it is interesting to examine the expansion of deficit terminologies. Interestingly we find here a trajectory that is suspiciously similar to those encountered in the case of mental health professionals and mental health expenditures. The concept of neurosis did not originate until the mid-l8th century. In l769 William Cullen, a Scottish physician, elucidated four major classes of morbi nervini. These included the Comota (reduced voluntary movements, with drowsiness or loss of consciousness), the Adynamiae (diminished involuntary movements), Spasmi abnormal movement of muscles), and Vesaniae (altered judgment without coma). Yet, even in l840, with the first official attempt in the United States to tabulate mental disorders, categorization was crude. For some purposes it proved satisfactory, indeed, to use only a single category to separate the ill - including both the idiotic and insane - from the normal (Spitzer and Williams, l985). In Germany both Kahlbaum and Kraepelin developed more extensive systems for classifying mental disease, but these were tied closely to a conception of organic origins.

With the emergence of the psychiatric profession during the early decades of the century, matters changed considerably. In particular, the attempt was made to distinguish between disturbances with a clear organic base (e.g. syphilis) and those with psychogenic origins. Thus, with the 1929 publication of Israel Wechsler's <u>The Neuroses</u>, a group of approximately a dozen psychological disorders were identified. With the 1938 publication of the <u>Manual of Psychiatry and Mental Hygiene</u> (Rosanoff, 1938), some 40 psychogenic disturbances were recognized. Many of the categories remain familiar (e.g. hysteria, dementia praecox, paranoia). More interesting from the present perspective, many of these terms have since dropped from common usage (e.g. paresthetic hysteria, autonomic hysteria); and some now seem quaint or obviously prejudicial (e.g. moral deficiency, vagabondage, misanthropy, masturbation.).

In 1952, with the American Psychiatric Association's publication of the first <u>Diagnostic and Statistical Manual of Mental Disorders</u> it became possible to identify some 50-60 different psychogenic disturbances. By 1987 - only twenty years later - the manual had gone through three revisions. With the publication of DSM IIIR the line between organic and psychogenic disturbances had also been obscured. However, using the standards of the earlier decades, in the 35 year period since the publication of the first manual, the number of recognized illnesses more than tripled (hovering between 180-200 depending on choice of definitional boundaries). At the

present time, one may be classified as mentally ill by virtue of cocaine intoxication, caffeine intoxication, the use of hallucinogens, voyeurism, transvestism, sexual aversion, the inhibition of orgasm, gambling, academic problems, antisocial behavior, bereavement, and noncompliance with medical treatment. Numerous additions to the standardized nomenclature continuously appear in professional writings to the public. Consider, for example, seasonal affective disorder, stress, burnout, erotomania, the harlequin complex, and so on. Twenty years ago there was no category of illness termed Attention Deficit Hyperactivity Disorder. At present there are over 500 authoritative books and 900,000 websites that describe, explain and offer alleviation.

Toward Infinite Infirmity

As I am proposing, when the culture is furnished a professionally rationalized language of mental deficit, and persons are increasingly understood in these ways, an expanded population of "patients" is created. This population, in turn, forces the profession to extend its vocabulary, and thus the array of mental deficit terms available for cultural use. More self-deficits are thus located within the culture, more help sought, and the deficit discourse again inflates. 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 disseminating their language; some professionals attempt to speak with clients only in the common language of the culture, and many popular concepts within both the culture and the profession lose currency over time (see for example, Hutschmaekers, 1990). Rather, we are speaking here of a general historical drift, but one without an obvious terminus.

It is also important to realize that in the past decade the upward spiraling of mental illness has been dramatically intensified. This intensification is due to the addition of two new parties to the process, the psychopharmacology industry and managed care programs. In the first instance, the pharmacology industry has been enormously successful in marketing drugs that promise to alleviate most forms of daily suffering (anxiety, social phobias, unhappiness, tension, distress). Putting aside the large percentage of people who experience little positive effects from such drugs, and the range of negative side-effects, the public is invited by such marketing into a new utopia. All that is required is to seek psychiatric help. The result has been dramatic. Consider the major antidepressant, Prozac. According to a <u>Newsweek</u> (March 26, 1990) report, a year after the drug was introduced to the market sales reached $125 million. One year later (1989) the sales had almost tripled to $350 million. By 2002, Prozac was a $12 billion industry. At present there are over 25 million prescriptions for Prozac (or its generic equivalent) in the US. A similar number of prescriptions are written for Zoloft, a close cousin, and another 25 million for a combination of other competitors. (<u>New York Times</u>, June 30, 2002). And, with the enormous profitability of such drugs, the pharmaceutical industry has launched myriad new initiatives for the future expansion of the market (see also Breggin, 1991).

The use of drugs to treat unhappiness has been additionally favored by the managed

care movement in hospital administration. In an effort to reduce expenditures managed care has favored drugs over "talking cures" simply because it is more economical to dispense pills than pay for therapist time. By encouraging drug centered treatment, managed care programs also send a message to therapeutic practitioners more generally: if you wish to sustain a practice supported by insurance programs, it is essentially to shift to drug centered treatments. A case in point is the increase in the use of psychiatric drugs in treating children and teenagers. In less than a ten year period in the US, the use of psychotropic drugs tripled, and with scant research on their efficacy or side-effects (Philadelphia Inquirer, Jan. 14, 2003). The result has been that organizations such as the American Psychological Association, have mounted intense programs to license their therapists to prescribe "meds" for their "patients." Such programs are now achieving success, and within the next decade we can anticipate a dramatic increase in both the number of prescribing practitioners, and the percentage of the population dependent on drugs to "get them through the day."

There is an important sense in which the average citizen today faces a trap door into a land from which exit is difficult. There are at least three institutions of substantial size and means coordinating their efforts to effectively "seduce" people into mental illness. As day to day problems of living are progressively translated into the authoritative discourse of mental illness, and drugs are offered as a secure means to restoring happiness, the attraction of drug centered "cures" is obvious. In a broad sense one might say that pharmacology is now taking the place of religion as the favored means of achieving salvation on earth (see also Farber, 1999).

Ultimately my concern is not simply that the power of naming the defective self is increasingly lodged within a singular set of interlocking institutions. Nor is it only that the colonization process in this case leads to an exponential increase in mental illness. My concern extends as well to the slow eradication of alternative discourses of understanding the self, and the alternative forms of action that are invited by these discourses. We are losing, for example, the rich discourse of deficit provided by various religious traditions. The discourse of "guilt," "need for spiritual fulfillment," and "getting right with God," does not invite therapy and medication, but prayer, spiritual consultation, and good deeds. There are also many common vernaculars, or grass-roots terms, that can be enormously serviceable. Being "hung up on her," has entirely different implications than being "obsessed;" having a "case of the blues" is indeed an honorific term, in contrast to having a "depression." "Working too hard," having an "overly indulgent chocolate craving," or "loving sex too much," invites dialogue with friends, loved ones and colleagues, as opposed to entering an addiction program. As "quick to anger," "highly excitable," "fear of flying," "unrealistically suspicious," "too active," and "shy" are increasingly translated into a professional terminology so are the capacities of people in their locale surrounds to deal with the normal infelicities of life in a complex society. Much needed at this juncture are instigations to grass-roots resistance, movements not likely to kindle the interests of professional psychologists.

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