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THE DIS-DISEASING OF MENTAL HEALTH

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> Nobody can truthfully say of himself that he is filth. Because if I do say it, though it can be true in a sense, this is not a truth by which I myself can be penetrated: otherwise I should have to go mad or change myself.
>
> Wittgenstein, *Culture and Value*

In the invitation sent regarding this symposium the claim was made, consistent with a Wittgensteinian position, that any reality that can be known is limited to a reality that can be only understood in terms of the language we have to describe it. It was further suggested that in the broad field referred to as mental health we have contributed a language of description: thousands of words over the last century, most of which might be called "deficiency language" in that they create a world of description that understands only through what is wrong, broken, absent, or insufficient. It was our conclusion in the letter of invitation that this deficiency language has created a world of mental health that can be compared to a black hole out of which there is little hope to escape whether we be clinician, theoretician, or researcher. In using the metaphor of the black hole I am trying to capture the essence of a system of meaning whose forces are so strong that it is impossible to escape out of the system and into other realities.

I do want to make clear, however, that I am not making certain claims. I am not saying that there are not those of us who behave in strange or troubling ways or have disturbing experiences or that some of us do not use various substances such as alcohol and cocaine in ways that are worrisome. I am not saying that there is no violence and abuse. I also am not saying that these ways of behaving may not cause considerable distress to others. Nor am I saying that these disturbances may or may not be preceded in some instances by changes in brain chemistry or that the behaviors may or may not be altered by chemicals. What I am saying and challenging is the prevailing interpretation of these phenomena. What I am challenging is the language of description through which we have created this world that we call

This article was written as a talk for the Galveston Symposium sponsored by the Houston Galveston Institute and convened at Our Lady of the Lake University, San Antonio, Texas, in 1991. The symposiums were created in 1988 by Harry Goolishian, Lynn Hoffman, and Harlene Anderson to bring small groups of critical thinkers and practitioners together to talk about relevant issues and new ideas and practices emerging on the edge.

mental health and mental illness. In other words, it is a challenge to our belief that our current diagnostic and therapeutic language of deficiency continues to be useful to us in our work, and to our legal system, in making determinations about these disturbing behaviors, in health care planning, in research, or in our daily clinical work. Quite the opposite, I will claim that this language is not only not useful but is now a major impediment that prevents us from reaching those with whom we work. In doing this I can only hint at the dimensions of the problem and some of the solutions suggested by others. In presenting this challenge I will focus mainly on some issues surrounding the history of schizophrenia. It is my strong conviction, however, that the dimensions of this problem and our continuing reliance on deficiency language permeate our entire endeavor and have created for us a social reality that will be most difficult to move and change. These problems are now embedded in our professional identities, our universities, our public language, our legal system, our educational systems, our economic system, and have become part of the fabric of our entire social narrative. At the same time, I am optimistic that change can take place and in fact that it is taking place. This very meeting is one evidence of this hoped-for change.

Another, and perhaps more compelling, reason for optimism is the realization that is rapidly overtaking all sciences and disciplines that we simply cannot understand human behavior independent of the social context, the historically situated narratives of identity of the concerned actors, the intentions and agency of the individuals concerned, and the broader socioeconomic and historical setting in which the behavior occurs. Even in as flourishing a field as genetic research there is developing a sensitivity to the issues that genetic development is not the simple unfolding of internal lineal causal chemical dynamics but rather a broader developmental understanding that involves the total organismic context in which the gene operates. A similar consciousness is, it seems to me, developing in our field. No longer can we afford to look for causes of mental illness in terms of internal dynamics alone.

Traditionally, the fields of psychological and psychiatric research are conceptualized as a story in which in a circuitous but nonetheless impressive series of developments by which the rationality of science has been brought to bear on the phenomena of psychosis, addiction, and violence. Implicit in this narrative is the view that the mentally ill, the alcohol and drug abusers, and those prone to violence have been ushered into the light of a more progressive and enlightened epoch. In this story, understanding issues such as schizophrenia proceeds in relative independence from social history and independent from political, economic, and other social forces. We are led by these scientific narratives to think of things such as mental illness, schizophrenia, and substance abuse as scientific discoveries independent of any surrounding political or moral discourse. In recent years, a number of historians have described this process differently. As Canguilhem (1966/1991) describes it, every science appropriates its domain. The object of science then takes on a new kind of meaning. Science no longer is the specific field in which problems are to be solved. It becomes a science that informs a theoretical consciousness.

In illustration of this phenomenon I would like to detour into a brief and incomplete history of the subject of chronic schizophrenia to illustrate that the "disease entity" known as schizophrenia is embedded in a social history and that it is not a "scientific discovery." What I hope to illustrate is that the concept of schizophrenia is inextricably woven into a social process that seems more to be the legitimization of contempt for those whom we could call hopeless than any well-meaning humanitarianism. Much of this material is based on the work of the social scientist and historian Peter Barham and is discussed in his book *Schizophrenia and Human Value* (1984).

A point of entry into this arena is provided by the debate that took place in 1871 and 1872 in the *Journal of Mental Science*, now the *British Journal of Psychiatry*. To place this debate in a historical context one should remember that was at the end of the 1860s and 1870s, when there was a critical reappraisal of the prevailing themes of Victorian thought. The prevailing cultural consciousness was not a disillusion with progress as such but a recasting of the grammar of progress. Organized responses to the poor, the unemployed, and the dangerous classes had given way from the earlier optimism of the reformers to a kind of enlightened pessimism. There had begun to appear on the scene biological and determinist interpretations of history and evolutionarily based doctrines of socially progressive social selection. It was generally agreed that the artificial preservation of those least able to take care of themselves was a form of interference in the natural expression of market forces. Galton had just published his work on hereditary genius (1869) and Herbert Spencer (1884) was peaking in his influence, reflected in his book *The Man Versus the State*.

In the case of the insane, the preceding 30 years had witnessed a massive increase in the populations of the asylums, the percentage of inmates judged to be curable had dropped sharply, and there was beginning to be an elaboration of many ideas regarding insanity. Bénédict Augustin Morel (1852) published his ideas regarding a process of adolescent intellectual deterioration that he termed *démence précoce* and shortly afterwards Karl Ludwig Kahlbaum (Barnes, Saunders, Walls, & Kirk, 1986) published his account of catatonic states. It was not until 1893 that Emil Kraepelin (Hoenig, 1983) brought together the syndromes of *démence précoce*, hebephrenia, catatonia, and dementia paranoides under the heading of a single "psychological degenerative process," which he endowed as representing a single disease entity. A response was not long in coming. Writing in the *Journal of Mental Science*, Edgar Sheppard observed about the situation in Great Britain,

> There is nothing elsewhere approaching the elaborate care which our asylum inmates receive from the hour of their admission to that of their discharge, and yet because they do not have the one thing which they know not how to use—liberty in its largest sense—men are now beginning to encourage the reactionary idea that the mad world is unnecessarily confined; and that those, from whom we should have expected better things, are found to talk to their professional brethren about "asylum-made lunatics." (1872, pp. 510–511)

Sheppard indicated that the best sites are selected for the asylum, cubic space per lung is measured and afforded, agricultural plots set aside for them, corn and wine made available, clothing and all others sorts of indulgence provided. Yet, he thought, so many were of the "most degraded type and [had] made themselves what they are by their own vice and wickedness" (p. 510), yet they remained malcontent and unable to appreciate or take advantage of the sympathy, kindness, and protection that was rained upon them. He further went on to say that we must remember what is due to society and the "baneful influence [of the insane] upon the sound members of the community" (p. 513). The looks of the insane,

> . . . his ways, his grimaces, his recognised unstrung condition, excite a curiosity, or interest, or fear, which cannot fail to be prejudicial to young and sensitive persons of both sexes. . . . Surely the sound members of the state have some claim to protection from the unsound members, a large proportion of whom have conditioned their own craziness by the vices and follies from which others have been preserved by self-discipline. (p. 514)

The debates must be set against the larger context in which they were taking place. There had been rapid changes in the populations of the asylums over the preceding 20 years, not only in actual numbers but also as a proportion of the larger population and particularly in the numbers of pauper lunatics. In Great Britain, from 1844 to 1870 the number of "private lunatics" had risen from 4,072 to 6,280. The number of "pauper lunatics" had risen from 16,821 to 48,433. Even worse, the number judged to be curable had declined rapidly in 1860 from around 12% to 7%. In a very short period of time the "loose and scattered madness of the country" (p. 510) had been brought under observation in vast aggregations of seemingly chronic and incurable lunatics.

During this period there was rapid growth in the numbers of persons who were institutionalized. Several factors were attributed to this growth. Primary in this was the shift to the growth of the capitalistic market system and to its impact on economic and social relationships. With the development of the capitalist system, economic relationships became more integrated into personal and social relations. The labor market more fully became the exclusive condition in which lives were lived and defined. This relationship was unsullied by paternalistic relationships or the traditional forms of obligation to the poor. The expansion of the labor market resulted in an erosion of those usual nonwage sources of income. For example, there was a rapid decrease in the availability of access to land, game, and fuel [by the Inclosure Acts], which heretofore were a major source of support and did not result in having to seek income from cash as a wage earner. Laborers found themselves more and more at the mercy of market conditions and the fluctuations of these conditions. There soon was no other alternative means of support, and people became more and more dependent on relief for the poor. The efficient functioning of the capitalistic system presupposed the existence of a large mass of wage earners who were not simply *free* to work, but who were forced to do so. Distinctions were

quickly made between the able bodied and the non–able bodied, the deserving and the nondeserving. Any relief to the able bodied threatened to undermine the whole system of the labor market. The expansion of the asylums can be seen against this dilemma, namely a series of social controls that permitted rigorous separation between the deserving and the undeserving. The asylum had to be maintained in order to unclutter and relieve the system and thus make inoperable the "legitimate" relief needed to support the labor market.

The story, of course, is more complicated, but we can see in the last half of the 19th century a set of social forces that were set in force by the invigoration of the market economy and the labor market as the essential condition of life and the dominant form for human relatedness. It provided a background against which there appeared to be a certain class or group of people—a range of human types—that could be considered as a human effluent whose only discernible attribute lay in their skill in corrupting others. This played a large role in the effort to mark off and segregate the wasteful from the valuable, the useful from the useless. Human power that did not demonstrate the capacity for labor power was destined for rejection. Thus, those demonstrating some form of mental tribulation in one form or another were soon designated to the category of the socially useless and dispatched to an asylum. Further, whereas before the outrageously mad were kept in asylums and the tranquil released, this was no longer the case. The asylum became the custodial institution. Doctors in asylums no longer defined success as rehabilitation or cure, but rather in the language of cleanliness, comfort, and freedom.

As suggested above, science research, medical diagnosis, and theories regarding the lunatic do not exist in a vacuum free from the socioeconomic value systems in which they are promulgated. The figure of the chronic mental patient was not produced by the asylum as such, but by an act of exclusion generated from within a wider field of social forces. Nevertheless, by virtue of its transformation into a custodial institution, the asylum came to play a crucial role not only in making mental patients what others thought them to be, but also in providing the conditions of observation in which the social judgments about these unfortunates could be given authoritative scientific rationalization. Medicine in general, and psychiatry in particular, played a central role in the last half of the 19th century in promoting the ideologies of "constitutional weakness" to deal with issues of failure in individual self-regulation.

Mental illness was seen as indicative of a diseased condition affecting the entire physical organism, a regression to lower evolutionary levels, and manifesting itself in a failure of inhibitory control by the higher levels of the nervous system. *We had discovered the science of deficiency language as the explanatory mechanism* for aberrant, puzzling, or strange behavior. The history of the writings of Kraepelin and later Bleuler (1950) in this saga of deficiency language is a complicated and fascinating one. The theoretical edifice constructed by Kraepelin was so strong that whatever misgivings existed carried little weight. In light of the chronic dementia praecox elaborated upon by Kraepelin and so encapsulated in a single case his-

tory, and the late Victorian fears that were hinted at above, that argument became impossible. The dementia praecox patient was morbidly apathetic and depleted in vitality. The patient was obstinate, truculent, and unpredictable. These were not the characteristics of the individuality of the well-regulated worker and private citizen, but a wayward uncontained form of individuality.

George Orwell (1937/1958), writing in the 1930s, described how at school he had "no notion that the working class were human beings." He wrote that "at a distance, and through the medium of books . . . I could agonize over their sufferings, but I still hated them and despised them when I came anyway near them. . . . '[C]ommon people' still appeared brutal and repulsive." The difference in this deficiency language and that of the insane was that scientific evidence had now been accumulated to justify these languages of descriptions. For the insane, things could only get worse. The patient was deemed to be "on the way down," "out of repair," "out of tune," "on the wane," "worn out," "used up," "broken down," "fit for the dust hole," "past work," and "past cure." These are powerful descriptions. Their language creates a condition that cannot be touched, and this history of description remains with us today. For example, in the book *Diseasing of America*, Peele (1991) points out that we are bombarded constantly with news about new drugs and diseases. He also complains about the medicalization of behaviors. It is his opinion that this only leads to an increase in that which we are trying to do something about, and it always carries, as with schizophrenia, the stigma of incurability. The humane view, according to this author, seems to be that we should treat mental illness as a disease, a medical problem, although—as yet—medicine does not know how to treat or prevent what we are calling an illness.

The spread and proliferation of the disease concept and its associated deficiency language is well spelled out in this book as the author answers the question, "How many people are affected by these diseases?" It is claimed that more than 20 million people are alcoholic. This means that in addition another 80 million suffer the disease of co-alcoholism. The Council on Compulsive Gamblers maintains that 20 million are addicted to gambling. Thirty-five million women are said to be suffering from bulimia and anorexia. Another 80 million suffer from the disease of obesity, and 75 million people smoke. Estimates of the depressed and anxious include about 50 million. There is a rapid increase in the numbers of multiple personalities and other so called neurotic disorders. Estimates vary but between 10 and 30 million live in an abusive relationship. Compulsive love and sex addicts are estimated at 25 million. Obsessive-compulsive disorder, according to the National Institute of Mental Health, is a disease now hidden that effects countless millions and is ready for discovery and treatment. And then of course there are the millions who are thought to be psychotic. These figures suggest a very perilous world.

In an insightful paper, "Therapeutic Professions and the Diffusions of Deficit," Gergen (1990) complains that the mental health professions operate largely so as to objectify a language of mental deficit. He further claims that when the profession does this and as this language is disseminated the culture comes to construct itself

in these terms. I would agree of course that this does indeed happen; however, I would add to this that the participation by professionals in this is also a reflection of broader cultural and economic forces. Gergen laments the fact that the spiral of infirmity continues to grow. He refers to a recent advertisement for a conference on addiction that announced that "Addictive behavior is arguably the number one health and social problem facing our country today." Among the addictions to be discussed at this meeting were exercise, religion, eating, work, and sex. There seems to be no principled means of termination. When the culture is furnished a language of mental and emotional deficits, and "persons are increasingly understood in these ways, an increasing population of 'patients' is created" (p. 364). This in turn mandates an increased profession with an increased language of deficit. More problems are constructed, more help is sought, and the array of deficit terms presses forward.

Gergen is clear that there is no easy way out of this dilemma. For the most part, he sees it as an unfortunate by-product of an earnest and humane attempt to enhance the life quality of the culture. Central to the problem is the reificationist's assumption of mental language, a problem that Gergen attributes to the continuing Cartesian mind-body influence that permeates our Western tradition. I agree with Gergen that there are no easy solutions and I would further agree that our languages of description are in great need of change. Gergen suggests a shift to relational language capable of describing an understanding of persons in relationship. It is his hope, as it is mine, that such a shift will ultimately lead to the demise of the concept of problem behavior and we can begin to see individuals as embedded in larger units. There can be no doubt of the importance of considering all behavior, including the strange and difficult, in a broader social context. The traditional mode of ascribing behavior as a product of internal, and in the case of serious strangeness, biological, explanations can only continue to add to the spiral of deficiency and infirmity.

I would add, however, another concern is the prevailing tradition of therapy as a correcting or rehabilitation of the impaired and broken. Since problems represent deficiency, therapy must represent an overcoming of this deficiency. This idea of rehabilitation was of course introduced in the 19th century, as there was a transformation away from the demoniacal, nonhuman, and animalistic explanations for insanity and a movement toward a more naturalistic explanation occurred. In the naturalistic explanation, the madman was viewed as exhibiting a defective human mechanism and therefore it was at least potentially remediable. This was the position of the moral reformers such as Dorothea Dix, who were no longer content to limit their efforts to external control but shifted into attempts to transform the lunatic into something approximating the bourgeois ideal of the rational person. Although perhaps more humane than control, this position, which still dominates our concepts of treatment, remains at best a normative position that focuses the process of therapy into making people what it is we think they should be. Perhaps even worse, it is based on a canon of understanding that permits us to group and classify behavior not in terms of the agent and the agent's intentionality but in

terms of broader paradigmatic language that reduces people to categories. It is this language of understanding that permits us to think in terms of uniform disease processes that run a constant course and from which we can predict with scientific certainty the prognosis.

Bleuler (see Hoenig, 1983), in introducing the concept of schizophrenia, was objecting to the practice of understanding the lunatic in terms of a disease process and suggested we *understand the person* with the disease.

Naturally a person in my position finds it easy to emulate what many other investigators have done, namely, at the end, to render a decision after a lengthy interview with a patient or a member of his family, to the effect that his mother was domineering, or that his father remained apart from the life of the family. But in the end I am not convinced that I have captured the entire truth of the situation in stating a summary judgment of that sort. And if I carefully allow the patient to continue to speak in a relaxed atmosphere, I find time and again that he himself begins quietly or vehemently to shake the erected structure of every summary judgment, even though earlier I had skillfully obtained his complete agreement.

It is unfortunate that Bleuler's thoughts have too much been overlooked and the focus has been on his other contributions. I would hold most of the difficulties the mental health project has encountered have arisen out of captivating but mistaken assumptions both about the nature of human language and how it is that we are to understand human action. A key to unraveling these difficulties seems to lie in the concept of narrative and the narrative conception of selfhood. I do not believe that we can characterize an agent's action independent of the beliefs and intentions that underpin those actions. Similarly, I do not believe that we can adequately characterize beliefs and intentions independent of the relational, social milieu, and institutional settings that give such beliefs their shape and significance. Another way of saying this is that we must pay attention to the narrative histories of both agent and setting.

Narrative provides a possible relief from the deficiency of our illness language in the mental health field. Narrative provides the possibility for understanding the actions of others, or, as the case may be, our not understanding. Narrative holds this importance because human action is basically historical as well as relational, and narrative enfolds both, enabling us to conceptualize the historical continuity of human life in its discursive context with others. It is only in fantasy that we live the lives that we please. The agent can never be more than the co-author of the narratives that are lived out, and thus the narrative enterprise can never be predictable. It will take more than relational language to move out of the linguistic black hole in which we are now captured. We must give up the notion of scientific understanding by the development of universal categories, we must give up the concept of disease and see the behavior we are interested in as a part of contextual life, and we must give up our attempts to reduce the concept of human nature to its lowest common denominator. We need to rely on the capacity that people have for the narrative construction of their life and we must redefine therapy as a skill in participating in this process.

I think at this time of a client, John, who had a history of strange and psychotic behavior that put him in and out of the hospital and commitment to state institutions. I asked him one time what might have made a difference for him earlier in his life that might have helped avert some of the tragedy and misery that he had experienced. In part his answer was that we need to listen to those we work with—be interested in what they have to say. He gave as an example a hypothetical question from an interviewer asking him what that was as he pointed to an ashtray. Typically, he said, the interest is "Do you see it as I, the interviewer, sees it?" You are checking me out. If you had talked with me when I was a kid about the overwhelming fear of failure that I was experiencing and if you could have talked with me about how I was trying to deal with this fear, maybe I would not have had to invent that crazy general.

I sometimes think that the so-called adolescent schizophrenic is one who in the face of failure experience is busy erecting private narratives in order to prepare for life. However, these narratives tend to remain private and are not enfolded in the social process of engagement with others. It is this that keeps them private and increasingly unsuccessful. It is this that increases the experience and panic of failure that John was talking about. In some ways, I think of the early experience of what is called adolescent schizophrenia as a repeated rehearsal of preparation for life that has slipped outside of the dialogical process that makes us all that we are. I would not doubt that most of the deficiency categories, the so-called diseases, that we are talking about here can be described in similar terms. This can only happen if we develop a language of description that moves us out of the linguistic black hole in which we now theoretically reside. There is no easy answer to this major problem but it is our hope that in this symposium we will begin the process of rethinking and renaming that can someday permit escape. Our languages of description are not only normative but they have, over the years, ended up forcing the development of socially constructed self narratives in our clients of uselessness and filth. Perhaps Henry Maudsley was more right than he even knew when, in the late 1800s he coined the term "asylum-made lunatics." As Wittgenstein said there is no way out, if you call yourself filth, but to go mad.

Good luck in your talks.

REFERENCES

Barham, P. (1984). *Schizophrenia and human value: Chronic schizophrenia, science and society*. Oxford, UK: Free Association Books.

Barnes, M. P., Saunders, M., Walls, T. J., & Kirk, C. A. (1986). The syndrome of Karl Ludwig Kahlbaum. *Journal of Neurology, Neurosurgery, and Psychiatry, 49*, 991–996.

Bleuler, E. (1950). *Dementia praecox or the group of schizophrenia*. New York, NY: International Universities Press.

Canguilhem, G. (1991). *The normal and the pathological* (Trans. C. R. Fawcett). New York, NY: Zone Books. (Originally work published 1966)

Galton, F. (1869). *Hereditary genuis.* London, UK: McMillan.

Gergen, K. J. (1990). Therapeutic professions and the diffusions of deficit. *Journal of Mind and Behavior, 11*(3–4), 353–368.

Hoenig, J. (1983). The concept of schizophrenia. Kraepelin-Bleuler-Schneider. *British Journal of Psychiatry*, *142*, 547–556.

Morel, B. A. (1852). *Études cliniques: Traité, théorique et pratique des maladies mentales. Vol. 1* [Clinical studies: Treatment, theory and practice of mental illnesses]. Paris: Victor Masson.

Orwell, G. (1958). *The road to Wigan Pier.* New York, NY: Harcourt Brace. (Original work published 1937)

Peele, S. (1991). *Diseasing of America: How we allowed recovery zealots and the treatment industry to convince us we were out of control*. New York, NY: Lexington.

Sheppard, E. (1872). On some of the modern teachings of insanity. *Journal of Mental Science*, *17*(80), 499–514.

Spencer, H. (1884). *The man versus the state.* London, UK: Williams and Norgate.