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## **THE SOCIAL CONSTRUCTION OF DISORDER From Pathology to Potential**

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As I rushed down the highway at nearly 80 miles an hour, late to give a talk to a nearby group of colleagues (because I had taken the time to check my morning email), I heard a report that declared the *discovery* of a new mental disorder, *internet addiction*. Alarmed, I realized that I must be suffering from this addiction if, indeed, my burning need to check my email had put me in a situation where I would surely be late to give my talk and might, in fact, be endangering myself physically by driving so fast. Since the talk I was rushing to give was focused on the pathologizing effects of psychological diagnosis, I found my present situation prophetic. The challenge was before me. Do I accept the radio's report and chuck my own arguments out the window? Or do I follow my position thereby locating alternative narrative descriptions that are focused on generating possibilities rather than pathologies? Clearly, my own well being was best preserved in the latter choice.

My story could seem fabricated if we were not already accustomed to the profusion of labels, categories, and diagnoses of deficit within our culture. Everywhere we turn it seems we are confronted with yet another problem of which to beware, danger that we might impose upon ourselves or others, or assessment that might contaminate our futures. The chief metaphor today seems to be that of an organism under attack. There is danger lurking in the streets, in our social institutions, in our relations, and in our bodies. And if we are not able to confront that danger, to manage it and control it, we will be identified (labeled) as deficient by our teachers, therapists, doctors, judges, employers, family members, and friends.

Gergen (1994) and Kutchins and Kirk (1997) discuss the proliferation of deficit discourse within the field of mental health. A broader, popularly appealing view of the cultural impulse to critique and thereby ultimately highlight the deficiencies in the other, is addressed by Deborah Tannen in her book, *The Argument Culture: Moving from Debate to Dialogue* (1998). She argues that we have become a culture of argument where the unquestioned impulse is to negatively evaluate another rather than search for the potential in the other's viewpoint, and thus in the other's actions. This broader issue of a dominant cultural discourse is important for our purposes because it helps us to understand the accelerated creation and use of diagnostic categories and labels.

We are hard pressed to locate any institutional or general cultural context within which evaluation is not dominant. We see it not only in mental health but in education, healthcare, business, government, as well as in our intimate relations with family, with friends, with co-workers and neighbors. Why is there such a profusion of evaluation in general and an urgency to *uncover* problems, pathologies, deficits, inadequacies in general? One might argue (as have many already) that such a proclivity emerges from the rampant cynicism that has infused itself in our everyday lives. Yet cynicism alone is not the problem. Rather, cynicism is a symptom of a greater concern: individualism. Cynicism is born of the individualist ideology that dominates

Western tradition. A host of scholars have argued powerfully of the dangers of privileging individuals over community. Christopher Lasch (1979), in his powerful book *The Culture of Narcissism*, describes how our focus on the individual produces self interest at the cost of communal betterment. Bellah and his colleagues (1985) argue that the individualist tradition stands as a threat to any form of relational engagement with all efforts focused on self preservation. If each of us is centrally concerned with our own well being, and yet we are dependent upon each other and our cultural institutions to “get ahead” or “be effective,” then cynicism becomes a *naturalized* response. Individualism, as an ideology, invites us to approach the world as if we, alone, can tame it. It is the individual who can solve problems, make decisions, think rationally and act effectively. Thus, in those instances when such activities are not possible, when the results of one’s actions do not move one further along in successful ways, we are left with the choice of blaming the individual for his or her under-developed capabilities or blaming the broader cultural institutions for presenting the unsolvable problems in the first place. Since the first choice requires us to pathologize ourselves, it is often the second option that we engage. It is far easier to blame our apparent inadequacies on “the system” or on another rather than on ourselves. And, under such circumstances, it is easy to see how cynicism becomes the likely response. In the face of failure or ineptitude we begin to ask ourselves why we ever thought “the system” or another person could be counted on to help us achieve, succeed, thrive. Since cynicism is a symptom of our individualist discourse, let us explore in more depth the domain of individualism and its implications.

### ***Limits of Individualism***

Individualism, as a mode of practice, is largely unquestioned. Most discussions in the development and implementation of new institutional activities and social policies take this form. In our culture, we are hard pressed to find an institutional context where attention is placed on anything but the individual. Others' actions are of concern to us only to the extent that they affect our own well-being. To that end, the dominant discourse of individualism focuses our attention on techniques and procedures for insuring that we develop the kinds of individuals we desire in our culture. Attention is placed often on transmission of information as opposed to the building of communities and relationships within which people can live and coordinate their activities.

The individualist tradition champions the self as an originary source of thought and action. Consequently, we conduct *psychotherapy*, we educate individual minds, reward and punish individuals at work, and hold individuals responsible for all their actions, thoughts, beliefs, and more. In sum, the individual is the unquestioned, *natural* entity of concern in our attempts to understand social life. In order to know anything about the complexity of social interchange, we must begin with the individual who is most obviously the basic unit of examination.

One of the reasons the individual appears to be such a natural starting place for our examination of social relationships and social processes is because our bodies offer obvious boundaries that separate us from each other. It seems ludicrous to challenge the notion that *my* body *contains* my intellect, my beliefs, my values, my traits, my abilities and more. This belief is so ingrained in our Western way of living that when there are problems, it seems logical and necessary to focus on the individual.

And yet, if we were to draw on the language of other professions, such as physics and engineering, we might literally *see* that one’s body is not bounded by the skin. David Watt describes how the molecules in any material or object (such as a body) vibrate and as they

vibrate they “excite electro-magnetic waves that propagate through space and transfer energy between objects” (personal communication). The image that is seen with the help of specialized equipment is the blending of bodies or objects. To scientists interested in heat transfer, our bodies are not naturally bounded containers. And at the same time, to scientists interested in medical disease, the body does, indeed, serve as a container. Could we draw analogies from these opposing ways of viewing the body in science to construct some alternative discourses for talking about personhood in the social world?

There are already several moves in just this direction. In a variety of ways, social theorists and philosophers have challenged the idea of the self contained individual. Rather than assume that intellect, knowledge, beliefs, values, and so forth are contained within persons, the move is to recognize each as constructed within communities. In fact, the very idea of private mental functioning, of a separate, “mindful” individual is, itself, the byproduct of communal construction. Philip Cushman, in his 1995 book, *Constructing the Self, Constructing America*, tells us

Individualism wasn't simply a coincidence, a mutation that popped out of the Zeusian forehead of some late medieval poet. It is a slow-building, centuries-old phenomenon that has developed in part because of the oppressiveness of certain traditions, the stifling inertia of life in small communities, and the compelling decision to resist the old, the given, the unjust, and to be creative, unique, and unusual. Viewed in this way, individualism is itself a Western tradition, a response to the economic arrangements, moral understandings, and political constrictions of feudal life. (P. 10)

And later Cushman suggests that the fall of the feudal system, marked as it is by “the beginnings of capitalism, and the growth of larger cities, the beginnings of the concept of romantic love . . . “ (p. 364) all coincided with the beginnings of individualism. He says,

We can see the beginnings of individualism in a myriad of small changes, such as portraits that began to reflect personal idiosyncracies as well as one's place in the social hierarchy; the concept of personal friendship rather than corporate feudal bonds; the philosophical growth of mysticism that emphasized personal communion, rather than a solely institutional, mediated relationship with God; the shift in art from a fixed to a moveable perspective; and literary forms such as the biography and autobiography. Peter Abelard, in an unusual individualistic move that would become important to the field of psychology hundreds of years later, maintained that it was not the act, but the individual's internal *intention* behind the act that constituted sin. (p. 364)

Thus, individualism as an ideology *emerged* in a particular historical moment. It was not *naturally* evident. And it emerged through collective coordination among citizens.

Philosophers such as Rorty (1979) have argued that the idea of an interior mind reflecting an exterior nature is not a simple reflection of human existence but a historically situated **convention**. Historical studies document the shifting conceptions of mind. We no longer, for example, talk of “hysteria” or “soul” as manifestations of mind and we continually add new mental realities to the ledger (cf, Kutchins and Kirk, 1997; Harre, 1979; Graumann and Gergen, 1996). Anthropological work demonstrates different conceptions of mind in different cultures (cf, Lutz and Abu-Lughod, 1990; Heelas and Lock, 1981; Shweder, 1991). To the Buddhist, unity is significant, selfhood is not. And literary theorists call into question the long accepted belief that the task of the reader is to locate the author behind the text -- to ferret out the true meaning

of a text. In contrast, deconstructionists such as Derrida (1976) and Fish (1980) illustrate how writing is not a manifestation of the author's mind but of systems of language that entail genres and traditions of writing. To them, writing is a culturally and historically contingent practice of effective language use. Thus, to read is to *participate* in culturally embedded practices of interpretation.

The implications of these critiques are significant for our discussion. One can not constitute meaning alone, nor engage in a rational choice among competing goods without having absorbed the intelligibilities of a community. And yet, individualist discourse is our dominating tradition (convention). It affects cultural life by valorizing the self as the origin of action. The result is that the self is prioritized. We value our own goals, needs, wants, and rights. Our chief concern is how we win or lose. And, we only examine other's actions as they affect our own.

Individualist discourse generates a sense of fundamental independence or isolation. I'm never certain if I am being understood or not. Why should I pursue investments that might curtail my individual freedom? The byproduct of this way of talking is that relationships become artificial. Relationships "need to be worked on." And, when working on a relationship becomes burdensome, we simply retreat to the self (what is best for *me*?).

There are also deleterious effects on society. If everyone is self-absorbed, who cares about the environment? In this realm, individual gain is impoverishment for the community. Little attention is given in higher education to cooperative modes of learning. Business training emphasizes individual performance and workshops abound in leadership and management training. Courts seek to allocate individual blame and remain blind to the broader social processes in which crime is embedded. And on both local and global levels, individualism promotes interminable conflict among incommensurate moral or ideological commitments. *Is this a useful path for the future?*<sup>1</sup>

### ***Individualism and Psychological Pathology***

Let us consider for just a moment the specific ramifications of individualist discourse in the context of psychotherapy. At stake here is the dominating factor that psychotherapy, as a profession, provides diagnosis for a person's psychological distress. While it is the case that there are many modes of psychotherapy where emphasis is placed on moving beyond personal or psychological distress, the profession requires first and foremost that a diagnosis be identified before moving toward problem resolution or treatment. In fact, because psychotherapy is tightly linked to the medical profession, the overwhelming belief is that psychotherapy, in order to proceed, demands diagnosis. How could a therapist know how to treat a client if that therapist was operating without a clear idea of what the client's problem was in the first place? To treat a problem then requires diagnosis. Two issues are relevant here: (1) the issue of diagnosis as it relates to individualism and therefore the implication that deficiency resides within the person requiring individual diagnosis and (2) the issue of diagnosis as a necessary conversation (particularly in psychotherapy) that revolves around identification of problems, the causes of the problems, and the resolution of problems. These issues are not necessarily separable. Yet let me expand just a bit on each to set the context for a relational alternative to diagnosis.

***Diagnosis of individuals.*** Central to our discussion here is the observation that diagnosis in psychotherapy means diagnosis of an individual. If one's identity is located within the person,

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<sup>1</sup>For a more detailed discussion of individualism and its limits see McNamee and Gergen (1999) and Gergen (1999).

as individualism tells us, then all that is problematic must emanate from the internal mind or psyche of that person. Thus the diagnosis must be of the person, of the individual. There are certainly situations where such diagnosis can be useful. I think of the varying responses different people might have to the diagnosis of chronic depression. For some, learning from the “expert” (i.e., psychotherapist) that they are suffering from chronic depression can be helpful. The diagnosis gives them the sense that now that the problem has been identified, a treatment program can begin. There is hope in sight. Yet we must not forget all those others for whom the diagnosis of chronic depression (or any other diagnosis) initiates a tailspin into further malaise. Armed with the diagnosis, these people lose hope by virtue of being identified as flawed, inferior, unhealthy, and anything but “normal.”

***Diagnosis requires problem talk.*** Psychotherapy, diagnosis and problems are terms that naturally go together. We seek psychotherapy when we feel uneasy, unsettled, or disturbed. Things are not going well in our lives and psychotherapy is one of the central places we turn for help. Given this assumption, it is difficult to imagine the utility of a psychotherapeutic conversation where the central topic of discussion is not problem oriented. Several forms of therapy already attempt to move beyond problem discussion. Solution focused therapy (deShazer, 1994; O’Hanlon and Weiner-Davis, 1989) and the narrative therapy of White and Epston (1990) are popular illustrations of therapeutic models where emphasis is placed on the imagination of alternative constructions of the situation at hand as well as of the future. These methods shift the conversation away from problems and diagnosis replacing the focus of therapy on conversations of possibilities. Yet, talking about solutions to a large degree implies problems and constructing new narratives in therapy suggests that the client’s story is defective. While these models are seen as significant moves in the development of alternatives to individualist diagnostic models of therapy, to the constructionist, they do not go far enough.

To view therapy as social construction is to press the therapeutic conversation in entirely different directions. Might both client and therapist gain by initiating conversation on what are valued and reliable resources for action that the client harbors? What stories can be told that illustrate these valued resources? If the client were to imagine that she or he was able to draw on those resources at will, what would be the activities in which she or he might no longer be engaged? What new activities might she or he be inviting others to co-construct? In these conversations of resources, diagnosis is stripped of its power. If I can talk with you and others about these potentials, I might no longer need to focus my attention on my deficits. Or, more likely, conversation about the relational resources I already have successfully constructed with others might suggest to me that these could be usefully recruited into the relationships where problems have become the byproduct of coordinations with others.

To engage in what I refer to as “resource-oriented” conversations in therapy, it is useful to draw on a multiplicity of voices (see McNamee and Gergen, 1998). These voices could be others who might not seem apparently associated with the situation at hand. They could also be the host of *internalized others* (Tomm, 1998). Here the notion is that we each harbor many feelings and views from other relationships (real or imagined). When we speak or act, even with the intent of voicing our *own* beliefs, we are giving voice to the constructions that emerge within other coordinated relationships. My beliefs are not mine alone. They are not my private possession. They are already populated by myriad *others*. Gergen (1999) refers to this as polyvocality. He explains the utility of this term, “when individuals begin to talk about their problems, the therapist might ask them if they can locate another voice within, a voice that would construct the world in a different light or with different possibilities” (p. 174).

Without claiming that diagnosis is wrong or bad, let me shift my focus now to the ways in which diagnosis invites us into debilitating patterns of relationship. My colleague Kenneth Gergen and I have discussed some of the deleterious byproducts of diagnosis elsewhere (Gergen and McNamee, 2000). Let me quickly review these detrimental patterns here. These limitations of diagnosis illustrate both individualism and problem talk as potential barriers to the generation of potentials for social transformation.

### ***The Downside of Diagnosis***

First, there are ways in which diagnosis becomes stigmatizing for the individual. The field of psychology in general, and psychotherapy in particular, carries with it an implicit set of values. There are ways of being in the world that are preferred over others. So, for example, we value a person who is responsive to us when we are in conversation. Such a person is generally labeled as “normal” and “fully functioning.” On the other hand, a person who systematically introduces an irrelevant topic into any conversation is seen as being “odd,” perhaps “schizophrenic.” Arthur Kleinman (1988) talks about cultural differences in diagnosis and illustrates how forms of action that are deemed significantly problematic in one culture might go completed unacknowledged in another. Thus, what is labeled a severe case of schizophrenia in Western culture is noted as only a minor oddity in South Asian culture. Explaining this difference is not a matter of which culture *understands* science more fully but rather it is matter of communal relations. The person in South Asian culture is cared for within a tightly connected community and thus there is no reason to fear that person or label his or her behaviors as severely problematic.

Most important in terms of the ways diagnosis stigmatizes people is the observation that, in so doing, diagnosis is rendered a valuational process. It is not, as scientific discourse would claim, value neutral. Diagnosis does not simply describe what is *there*. Rather, diagnosis functions as a moral judgement. It conveys the deficit of one to others. Consider the case of Attention Deficit Disorder (ADD). The unquestioned value within this diagnosis is a quiet, calm, and orderly classroom. There is an assumption that moving at rapid pace from one thing to another – depending on what captures your attention – is bad or wrong. And yet, children being raised in the global economy of today have a difficult time avoiding the multiplicity of activities surrounding them. Rather than pathologize them for patterns of relating to which they have become accustomed, what potential could there be in schools and parents initiating inquiry into how the classroom might integrate or simulate the stimulation provided by the infusion of technology into the lives of these children and the quick pace of contemporary life?

Peter Hoeg, a Danish novelist, has written about the stigmatizing aspects of diagnosis. He writes,

They believed that it was of great help to children to be assessed. I suppose they still believe that. In our society it is a pretty widespread belief. That assessment is a good thing.

I was at the playground with the child . . . she had climbed up on to some railway sleepers. She was about one metre off the ground. She called to me from there. “Look!” I did not get the answer out. I had no time. It came from a stranger - she was also there with her child. “What a clever girl!” she said. I had no time to think. I was on my feet and on my way over to bite her head off. Then I remembered that she was the mother of a small child and that she was a woman...I sat down, but it was a long time before I stopped shaking.

The child had wanted attention. She had just asked to be noticed. But she was given an assessment. “What a clever girl!” (1995, p. 99)

Once stigmatized, once assessed, diagnosed, there is little way for a client to escape. The “illness,” the “deficit” still hides under the thin veneer of treatment.

Added to the problem of stigmatization is the impulse to blame the person for his or her failings. Elsewhere I have talked about the ways in which individualism invites us into patterns of blame and evaluation (McNamee and Gergen, 1998). If my actions are motivated by my internal, individual beliefs, values, commitments, then any flaw or deficit must also be seen as residing within and thus I am held responsible for my actions. If I am responsible for my actions and they are deemed wrong or bad or inappropriate, then I am the only one to blame. My dysfunction is located within me. My failing is my inability. Within this logic, I am likely to withdraw from others so as not to inflict my problems on them. Others then become evaluators (“She’s at it again”) and thus engage in conversations of blame as well. There is little room here for exploration into external factors that might contribute to the deficiency.

Thus, as diagnosis proceeds, relationships are torn apart. If I have a problem (particularly one that has been diagnosed) then I must work it out myself. Those closest to me are probably those who I am most likely to protect from my problem. Why burden my loved ones with my deficiencies? And, if it is my loved ones who are constructed as the “cause” of my problem, then all the more reason to avoid them. As I seek help from mental health professionals, my dearest family and friends are advised to stay away and let the “professional do his or her job.” If I believe my problem stems from my marriage, I seek council from my therapist rather than my spouse. If my problem seems to be a product of a stressful workplace, I, again, seek help from my therapist rather than co-workers or supervisors. In this way, the mental health profession at large and the process of diagnosis and treatment actually *inhibits* the growth and evolution of relationships ranging from intimate to community to organizational ties.

With the deterioration of relationships we begin to see how our sense of community is depleted. The lack of community naturally limits our attention to traditions, rituals, and folkways that previously bound us together. When in need, I am more likely to turn to the mental health professional for help than to a person or group of people with whom I share religious beliefs, professional interests, or any leisure activities. And the more I depend on the psychology professional to help me, the more I contribute to placing community and relationships at the boundary. Consequently, if community becomes “other,” why should I care that my desires might threaten your family, your life, your property?

Finally, the discourse of diagnosis, the profession of mental health, provides the individual with little in the way of resources for moving on in life. Think of how managed care, for example, controls how much help we can receive and how we will receive it. Managed care also identifies those issues for which we need professional help, thereby categorizing some as more seriously troubled than others. We now have an enormous array of professionals making decisions about a person’s life, thereby disempowering the person him or herself. As Foucault (1979) points out, when we offer ourselves for professional examination, we are giving ourselves over to the disciplinary regimes (in this case the mental health professionals and administrators) to be labeled and explained in their terms. As we do so, we carry these terms into other realms of our daily life (consider, for example, today when someone is acting in ways that you do not like, you might say with rolling eyes, “She must be off her medication today.”). We speak to others now of our depression, our anxiety, our stress, our attention deficit; each one a technical term constructed by professionals. As we use these terms in our common parlance, we engage in

relationships wherein we extend control to those professionals to circumscribe the ways we talk about ourselves. Professionals then begin to influence policy and practice amongst the general public and we become further controlled in their terms.

**Sum.** I think Hoeg (1995), in his novel exploring the lives of three children living at an experimental, residential school where they were constantly being assessed by the “authorities” for purposes of *determining* their futures, summarizes the problems we face with diagnosis (assessment).

When you assess something, you are forced to assume that a linear scale of values can be applied to it. Otherwise no assessment is possible. Every person who says of something that it is good or bad or a bit better than yesterday is declaring that a points system exists; that one can, in a reasonably clear and obvious fashion, set some sort of a number against an achievement.

But never at any time has a code of practice been laid down for the awarding of points. No offence intended to anyone. Never at any time in the history of the world has anyone . . . been able to come up with a code of practice that could be learned and followed by several different people, in such a way that they would all arrive at the same mark. Never at any time have they been able to agree on a method for determining when one drawing, one meal, one sentence, one insult, the picking of one lock, one blow, one patriotic song, one Danish essay, one playground, one frog or one interview is good or bad or better or worse than another . . . But a code of practice is essential. To ensure that things can be spoken of, fully and frankly. A code of practice is something that could be passed on . . . (pp. 78-79)

Hoeg’s position gives us reason to consider alternatives to diagnosis.

### ***Is There Any Hope?***

In the global world of today, cultures are thrown into ever increasing contact. There is both pragmatic and theoretical demand for communal forms of practice. In this world, individualist ideology can often be a disaster. In what follows I attempt to lay out relational alternatives that might supplement our individualist traditions. Are there ways of relating – of talking and doing – that privilege relations over individuals and in so doing provide opportunities for transformative dialogue? After all, psychotherapy is focused on transformation. How can a relational sensitivity provide resources for acting in the psychotherapeutic context – resources that are generative and transformative? And, simultaneously significant is the need to recognize psychotherapy’s role in perpetuating and/or transforming more global social practices. Social construction offers us, I think, a useful alternative. It is an alternative that centers on relational constructions of meaning and in so doing provides sustainable resources for constructing relational realities of potential and possibility. These resources help move us beyond diagnosis toward social transformation.

### ***Individuals as a discursive option***

To the constructionist, placing our focus on individuals, as described above, is a “way of talking” or a discursive option. To consider individualism as a conversational resource rather than as an essential or fundamental reality is to shift the terrain of our discussion. Rather than simply reflect reality, our discursive tradition has *created* a particular kind of reality. This reality includes features such as objectivity, individuality, uniform rationality, and progress. To put it this way is to say that this way of orienting ourselves to the world provides a distinctive discursive repertoire. It is to see these views as byproducts of a particular approach to language

rather than as descriptions of the essential nature of reality. This orientation provides us with some means for employing alternative resources. It allows us to question the utility of seeing our words as reflections of our interiors and recognize that this is not necessarily the case but is, rather, a discursive tradition.

Individualism, while enduring and valuable, is only one way of talking and thus only one way of being. Fully armed with the discourse of individualism we are able to locate a broad array of qualities within persons ranging from intellect, leadership, sociability, and agency, as well as mental illness, insecurity, deviance, and perversion. It is individuals who reason, who lead, who relate, and who act intentionally. Thus, it is only reasonable to conclude that it is individuals who should become the focus of diagnosis and treatment when actions or meanings do not fit with culturally preferred norms.

### ***Toward Potentials***

Of course, not all diagnosis of mental disorder is damaging. As I mentioned earlier, for some the diagnosis serves as an aid in moving on in one's life. My argument here is not to abandon diagnosis but to augment this (largely) unquestioned cultural practice with an alternative. The alternative that I would like to suggest is that of relational engagement. With emphasis on *what people do together*, the negative effects of diagnosis can be lessened. I do need to say, however, that I am not proposing a focus on relational engagement as a *more correct* approach to dealing with problems. The relational alternative I propose should be seen as simply another resource for action; one that I believe offers us many generative ways of going on together.

At this point, it is useful to draw on the practical resources offered within a social constructionist discourse. Constructionism (Gergen, 1999; McNamee and Gergen, 1998) proposes that meaning is always an emergent process of persons in relation. This suggests that meaning is not fixed. It is not stable. It is, rather, in constant flux, always open to new possibilities. Any sense we have of permanence arises from the skill we have in ritualizing our forms of interaction. I find it useful to think of our social activities as *invitations* to others. Thus, when I say I love you, I invite you into the game (as Wittgenstein, 1953, would say) or the ritual we commonly know as romance. To a realist, saying "I love you" is taken as a statement of fact, an expression perhaps of one's true, inner feelings. It is in the contrast between the social constructionist notion of words and gestures as invitations and the realist's notion of words and gestures as representations that the entre to relational practices is located. If my words and actions invite you to engage with me in particular cultural performances (rituals), I *need you* to accomplish that performance. Your responses to my actions are required in order for me to realize (literally, *make real*) my efforts. Does this make a statement like, "I love you" meaningless? Absolutely not. The shift that social construction offers is important. It is a shift to recognizing how, in this illustration, a relationship is *required* to engage in the performance of romance in order for it to be *real*. As Edward Sampson says, "*the most important thing about people is not what is contained within them, but what transpires between them*" (1993, p. 20). The significance of placing meaning in the joint activities of participants, as opposed to in the heads of persons, is precisely the aspect of social construction that offers us alternatives to diagnosis.

Within social constructionism, meaning emerges as communities of people coordinate their activities with one another. The continual coordination required in any relationship or community eventually generates a sense of common practices, a vocabulary if you will. So, for example, as those closest to me both personally and professionally rely more and more on email,

it has become a well coordinated part of our relationships. It is no longer “impersonal” or “unfriendly” to send email messages instead of phoning or writing a letter. There are entire patterns of communication (patterns of relating) that are now expected among my colleagues and friends and we have even constructed terms and activities that are unique to these relationships. As an illustration, I have noticed that when others describe a “conversation” they have had on email, the narration is frequently accompanied by a gesture. The gesture is intriguing to me. It is the movement of fingers in the air as if the person is typing. The words that accompany this gesture are usually, “and then she said,” or “he explained,” or “I said.” This is an illustration of not only coordinating activities but generating a vocabulary (words and actions) specific to a ritualized performance.

The patterns or rituals that emerge within relationships or communities generate standards over time. There are standards of expectation and standards of value. We come to expect the enactment of given patterns (e.g., for friends who have constructed a pattern of daily email exchanges, an absent message is likely to raise concern). We also implicitly construct a set of values associated with the performance (e.g., daily email is a good thing). As these standards emerge and the coordinated activities become more and more entrenched within the relationship or community, a way of life is established – actually appearing as if “natural” and “normal” and transcendent of time or place or persons. This is a socially achieved reality but we must be clear: it is “as real as it gets.”

Important to note here is that within communities all over the globe, this process is occurring. Thus the potential for incommensurate life-worlds is enormous. Further, since each of us is immersed in multiple communities simultaneously, the potential for difference is great. It is even possible that we each harbor opposing positions on a topic by virtue of the very different communities within which we participate.

To the social constructionist then, meaning is always fluid and supple. Meaning is always in motion. The extent to which we encounter consistency in meaning and patterns of relationship is attributable to the coordinated achievement of participants. In effect, we could say that any sense we have of stability can be credited to the participants’ abilities to “play the language game.”

To understand meaning, and thus reality, in these terms is to embrace the discourse of social construction. We can put aside (and I think we must) the popular critiques of social construction – critiques that claim social construction is amoral and unethical. Such critiques are grounded on claims of rampant relativism. Yet, to the constructionist, it is not an *anything goes* world. Since all meaning is dependent upon the coordination of people in relation, and since any configuration of persons is likely to yield a unique or different meaning from any other group, social construction is surely relativistic but is surely not rampant. One is not free to simply construct the world at will.<sup>2</sup> We are ultimately dependent on each other to (literally) *make* our

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<sup>2</sup>We have an extensive history of distinguishing constructivism from social constructionism and it seems useful at this point to both recap that distinction and point to recent movements that go far to erase the differences. First, constructivism, as influenced by George Kelly (1955) and Jean Piaget (1954), claims that the world is constructed and also places significance on the social relationships within which persons operate. However, it is still the *mind* of the individual that constructs reality. The mind is influenced by the social world and to that extent, the constructions of one person carry vestiges of the social world. Here, the individual is still the basic unit of analysis, although social relations certainly are significant. In

worlds. Once we dismiss the “anything goes” critique, we can focus directly on the *potential* offered by social constructionist discourse. We might not be able to simply claim that X is the case. However, we can *invite* ourselves and others into different patterns of coordination. In the remainder of this chapter I explore some resources that move us beyond the negative consequences of diagnosis and toward potentials for action in the realm of psychotherapy. These resources, I should add, all center on embracing *what people do together* as the focal point. Once more I refer to the novelist Hoeg. The narrator of his story, Peter, devotes most of his time to articulating how standardized tests and evaluations can never really get at what is *really* there. He argues that even in the laboratory, scientists are not really measuring the essence of something. And so he advises, “. . . it is important that people enter the laboratory every now and then, and *ask questions of a different kind to those that are otherwise asked*” (p. 215, italics added). Social construction, by placing our attention on what people do together allows us to ask different questions. Let us explore some.

***Can participation in diagnosis be extended such that a wide range of relationship are recognized as potential contributors to generative realities?***

How do we confront Foucault’s (1979) critique of the ways in which disciplinary regimes disempower us? When we confront daunting difficulties, we are likely to find ourselves in the hands of professional psychotherapists. These professionals are charged with the process of diagnosing those who come to them seeking help because, as we have mentioned, the traditional discourse of individualism tells us that once we *know* what is *wrong* with a person, we can focus attention on treatment methods. And elsewhere the deleterious effects of this process have been articulated (Gergen and McNamee, 2000; Kutchins and Kirk, 1997). How might we open this process to the realm of relational coordination? Can we replace the coordination of therapist and client with a multiplicity of voices? Are there ways in which to invite others into the process of *constructing* possibilities for the client?

Note here that our focus shifts as we consider how to include other voices, including alternative voices of the client and therapist as well as voices of others not readily imagined as “participants” in the situation. The shift is significant. Not only are we proposing an expansion of participants in the therapeutic conversation, but we are proposing that the therapeutic conversation itself entertain domains of possibility and hope rather than focus on problems and their history. We find this useful because, in the stories of others, there are likely to be very different understandings of the situation at hand.

There are many illustrations of such work being effectively conducting within a variety of communities. Jakko Seikkula and his colleagues offer one illustration (1995). In the Lapland of Finland, this team of psychiatrists invite a wide range of professionals, friends, family, and neighbors into what would generally be called the *crisis intervention process*. The person in

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contract, social constructionism emphasizes discourse – or what people *do* together. Self and the world are created *in relationships*. There is no need to return, in social constructionism, to the private mind of the individual. Recently, Neimeyer (1996) has proposed a range of arguments that draw constructivism and social constructionism more closely together. Pertinent to this chapter, Neimeyer talks of a “therapy of engagement” which “highlights the delicate interplay of therapist and client construing, in the service of restructuring, the personal realities of one (or both) participant(s)” (p. 406). My own interests are less focused on which “camp” one chooses to inhabit and more on how to use constructionist discourse to envision therapeutic process as potentiating rather than pathologizing.

psychiatric crisis is also included in the conversation and thus, development of a treatment plan necessarily draws on the resources for action that are readily available to not only the client but his or her network of relations. Since this project is discussed in detail elsewhere (cf, Seikkula et al, 1995; Gergen and McNamee, 2000), let me offer one additional illustration from a work in progress.

Stub (1999) is currently conducting research on the quality of life in brain injured patients. These patients are frequently given psychiatric assessments as well as evaluations geared toward day-to-day functioning on a wide range of activities, including social, psychological, physical, and neurological. On-going diagnosis is a large part of assessing this population. And, diagnosis typically involves a neuropsychologist delivering a battery of tests to the patient. Frequently, spouses or other close family members' assessments are also given serious consideration after extensive interviewing by the professionals. Stub is interested in how we might extend the range of relationships participating in this process and simultaneously broaden our "assessment" or understanding of what counts as quality of life? Quality of life currently is evaluated by tallying check marks on a list of activities that can or can not be performed by the patient. Does this standardized measure *really* get at quality of life?

To address these provocative issues, Stub is engaged in interviewing patients and their families to understand *from within their significant relationships* what it means to have "quality of life." And, because the tendency for most of us would be to refer to abstract, cultural standards (e.g., quality of life requires independence in daily activities such as ability to bathe, dress, and feed oneself), Stub begins her interviews by asking the patients themselves to tell a story that captures what they most value about themselves in their relationships with others (specifically family members) and from that story to identify what they see as their biggest contributions to those relationships. This question opens the possibility for a very different conversation. With significant family members present to hear this story, dialogue on resources rather than deficiencies is enabled. Stub then goes on to explore the resources that family members have noted in the patient. The inclusion of many voices – all significant within the patient's day to day life – engaging in dialogue about potentials, possibilities, and resources helps to affirm the *local* understanding of quality of life. To these patients and their families, quality of life is no longer assessed by applying a set of abstract categories but is *situated* in the very parochial arena of their lives. Furthermore, by including family members in these "assessment" interviews, participants are equipped to extend the dialogue that they have at home as well as continue the conversation of possibility that is generated in the assessment interview. ***What potential is there for clients and communities if we replace abstract labels and categories with focused attention on lived narratives?***

We can see from the illustration above that there might be great potential in giving voice to the lived stories of participants. In so doing, Stub's research is similar to the work of the Public Conversation Project (Roth et al, 1992). In their attempts to engage people in dialogue (as opposed to debate) on difficult topics such as abortion, Roth and her colleagues recognize that all strongly held beliefs and positions are located in visceral, lived conversations with others. Thus, for the pro-choice advocate, there is always a personal story that gives significance to the abstract position. Yet in public or professional contexts where difficult issues are discussed, we have fostered a value (i.e., constructed a value) that personal stories in some way detract our attention from the "heart of the matter." What Roth and her colleagues have found, however, is that initiating conversation on difficult issues with a question that invites participants to voice their "personal" relationship to the topic provides the resources for incommensurate groups to

engage in dialogue as opposed to debate. What this means is that rather than engage with another for purposes of proving one's point or "winning the argument," participants harboring oppositional orientations take the time to consider the very local rationale or reality of the opposition's stance. This does not mean that these extremely different orientations are embraced and accepted. There is no attempt here to persuade or convince. Rather, the purpose is to expand the resources for (in Wittgenstein's terms) *going on together*. I can disagree strongly with your opinion on a given issue but my disagreement will take a very different form if I first and foremost grant you the local coherence and rationality of your opinion within (at the very least) your own significant community. Recognizing that there are multiple and diverse rationalities that gain coherence within communities is the first step toward transformation of social practice. In relation to diagnosis, can we imagine listening to the stories of our clients in therapy *not* for purposes of locating those stories within some diagnostic category but rather for purposes of granting coherence to the difficulty that has brought the client to therapy? In other words, how does the client's story grant a situational coherence to activities that, placed in broader social context, are negatively valued? Discussions that invite these stories give voice to the complexity and locality of social life and thereby open new resources for engaging in that life.

***What might be the benefit of suspending certainty in the process of diagnosis?***

As Hoeg so aptly points out in his novel, *Borderliners*, the certainty with which diagnosis proceeds can be extremely debilitating to clients and their significant relations. And yet the challenge for professionals centers on how to be a professional and simultaneously suspend what Sampson refers to as the "God's eye view from nowhere" (1993). Unfortunately, professionalization (which can be seen as a byproduct of modernist attempts to train individuals in the proper methods and techniques required to work in specific fields) has created a bifurcated culture where there are those who "know" and those who are in need of "knowledge." Given this context, the expectations of professionals for themselves as well as of "clients" for the professionals are daunting. To be, for example, a competent and successful psychotherapist *requires* the intuitive or skilled ability to quickly diagnose those in treatment and generate effective treatment plans. Add to the therapist's own expectations for self and the client's expectations for the therapist the expectations of the insurance companies and managed care authorities. Effective psychotherapy must be effective *and brief*. It must be cost efficient. At the same time, the pressure to make ends meet for the therapist means developing the ability to move through clients at a rapid pace. Thus, certainty in the professional diagnosis of a client is paramount. There is no room for doubt, uncertainty, or entertaining a myriad of alternatives.

But what would happen if the psychotherapist did entertain alternatives? In order to do so, he or she would need to engage in self reflexive critique where there is freedom to suspend the certainty that one diagnosis, one way of working, one understanding could be the best (or correct). While we have a professional responsibility to act in ways that are focused, meaningful, and ethical, we must realize that too much certainty or understanding negates the argument for a relational alternative to diagnosis. When we are too certain about our approach, our answers, our analysis, we close out the voices of others as well as our own multiplicity. In addition, we must respect that what constitutes generative dialogue in one community might not secure the same position in another (e.g., within one form of therapy over another, for people confronting similar difficulties that bring them to therapy, and so forth). The rhetorical force of a particular discursive argument can vary dramatically from community to community.

In other words, we must be constantly asking ourselves which discursive tradition warrants these particular questions, observations, and conclusions? Why this discourse and not another? Which community is being represented here and by virtue of its representation, which communities are being erased? This sort of reflexive critique is relational engagement. Here we recognize the possibility of other discursive communities and traditions and through such recognition might grant them voice. At the same time, the willingness to entertain doubt (spawned by self reflexive critique) does not imply that there can never be a decision or a selection of how things “should be.” Rather, how things “should be” is accepted as a stance that is generative in the *situated moment*. This does not imply that any reality constructed in the therapeutic conversation is the “right” one or the only one. A central aspect of self reflexive critique is not only the willingness to entertain doubt about *our own* positions but is also to give voice to the stories that provide coherence to radically different positions. To that extent, providing conversational arenas where personal narratives can be told and heard with reference to the relational communities within which they are valued helps tremendously in avoiding continual referral to abstract positions and policies. Can therapy provide this conversational arena?

This question raises another provocative suggestion. How is it that psychological professionals can be certain that the context within which they conduct psychotherapy is the most generative? How can they be certain that those seeking therapy are actually those in need? Granted, these sound like silly questions. Many psychological professionals would agree that those “in” therapy are not always the ones in “need” of therapy. Also, many psychotherapists believe strongly in practices that take them into the homes of families, into the communities, into the schools and so forth. Yet, despite all of these variations (and many more that I have not mentioned here), the dominant approaches to therapy do not reflect on whether therapy is taking place in the contexts where it could be most useful or with the people who might gain most from it. As an illustration, I think of the work of Saul Cruz-Ramos in Mexico City (personal communication). His interest is in working with poor families in the ghettos of the city. Yet these families rarely seek therapy. In an attempt to engage these families, Saul moved his family into the ghetto. He quickly found that just being in the same community, the same context, was not enough. Still, despite all the problems and difficulties families faced day in and day out (drugs, alcohol, violence, death), and despite his constant presence and availability, the families did not rely on his services. His attempts to call open meetings were acknowledged with a resounding silence and lack of active engagement.

One consistent aspect of this community that Saul quickly recognized is, unfortunately, the ritual of the wake after a person’s death. Since almost all the youth in the community are associated with gangs, and since these gangs are constantly “at war” with one another over turf, drugs, etc., shootings, deaths, and inevitably wakes are almost a weekly event. And they are community-wide events. As Saul describes the ritual, all members of the community come and sit for hours at a time in a large circle, sometimes chatting with each other, gathered around the casket of the dead youth. Despite day to day differences, there is a sense of community that emerges through death in this ghetto. Since the wake is the place where families and community members gather, Saul asked during one if they could all have a conversation about life in the community and the problems everyone faces. The participants happily agreed to talk about the issues confronting them all. This has spawned a series of active involvement in transformative projects throughout the community – all addressing the issues that would likely, in another community, bring individuals, couples, and families to psychotherapy. His lesson to us is that

working for generative futures often requires going to those you want to help rather than expecting them to come to you. Additionally, focus on potentials within the community rather than individual pathology allows for constructions of new futures. Metaphorically, in this ghetto, death is transformed into new life potentials.

Saul's story illustrates for us the benefit of suspending our certainty as professionals. By questioning the utility of meeting clients in the psychotherapy context as well as questioning the utility of identifying individuals or families as the treatment unit, Saul has been able to join in a fully participatory mode of social transformation. He is probably less likely than most to identify himself as the professional "helping" people of this community change. I'm sure he is more inclined to talk about the mutual transformations for himself, his family, members of this community, and the "therapeutic" process as well.

### ***How might a focus on images of the future transform pathology into potential?***

Psychotherapy, in general, has a reputation for focusing on problems. This much we have discussed at length. Additionally, as a professional form of practice, attention is largely focused on the past causes of problems and the present ways in which clients deal with or cope with the problems. Full assessment of these stories become the basis of diagnosis.

What might happen if therapists were to shift the psychotherapeutic conversation from the realm of charting the history of a problem to the realm of future images? An immediate objection many have is that such a move appears to "ignore" the "very real" problems of persons seeking help. Yet the idea here is not to either ignore or elevate a person's problems as if they were essential entities. After all, social construction argues that our ways of relating together construct the worlds we inhabit. To that extent, when we focus our interactions on problems, we live within a problemated reality. There are many alternative resources available that, once invited into the conversational "space," have potential for integration into the "problemated" relational reality.

Here I think of Harlene Anderson's work (1997). When working in a training or supervision context, Harlene invites participants into an "as if" posture. After a case has been presented, the group participants take turns speaking "as if" they are different members of the client system. Anderson says that by inviting participants to speak "as if" they were the mother or the therapist, for example, they engage in a "problem dissolving" process. Here, they are free to voice alternative interpretations of the "problem" and *also imagine how else the situation might be*. What other possible narrations are there? The co-mingling of multiple voices presents for the person presenting the case a symphony of possibilities. Rather than return to the therapeutic conversation entrenched in problem talk, the psychotherapist can now enter the conversation with stories that offer images of potential and hope.

Similarly, there are processes where the focus is on imagining an ideal future and talking through the various ways in which a client might real/ize (literally *make real*) that ideal. What sorts of activities and relationships might the client need to continue? What might be terminated? What could the client begin to develop as possible actions and/or relations? All help construct the future by acting *into it* as opposed to *acting within* what appears to be an already constructed reality.

### ***Continuing the Conversation***

In offering a new set of questions here my attempt has been to provoke a broader conversation in the realm of psychotherapy. Must diagnosis be the focal point of therapy? Who benefits from such a focus? Clearly, the psychological professionals responsible for developing the diagnostic criteria benefit in terms of professional advancement. Additionally, for those

diagnoses requiring or suggesting medical treatment, the large pharmaceutical companies stand to gain enormously. And as well, some who seek psychotherapy benefit from diagnosis. Yet, as our culture becomes more and more immersed in practices of assessment and evaluation (diagnosis) – all offspring of modernist social science – we find ourselves hard pressed to find forms of practice that inspire potential and possibility by drawing on resources for action already available in relationships. Psychotherapy, of course, is not alone. Education is another of our cultural institutions that is now confronting daunting difficulties as the culture of deficit takes control. Illustrations abound in all sectors of life.

And yet, the new efforts are emerging in small pockets, each attempting in their own ways to revitalize the positive potential of social life. For example, Martin Seligman's positive psychology (xxxx), the appreciative inquiry method developed by David Cooperrider (1990) and the work of Cooperrider and Dutton (1998) on cooperation and global change, performative approaches to psychology (Holzman, 1999), articulations of collaborative education (Bruffee, 1999), as well as a host of other projects. The move to embrace human potential, to focus on what is working as opposed to what is not working, and focus on the future as opposed to the past are exciting new trends.

The significance, I think, of talking about diagnosis as a social construction is that it allows us to de-essentialize psychological problems. By locating meaning in the activities of persons rather than in their heads, social construction provides us with the resources for deconstructing pathology. If pathology emerges only in particular forms of practice, what might be the generative practices we might suggest to move beyond pathology toward potential? This form of reconstruction draws heavily on the idea of polyvocality. We each harbor the voice of possibility and yet it is the voice of deficit, of assessment, of diagnosis that gains our attention. It is time to reconsider forms of practice and relational communities where multiple participants, personal stories, self reflexive inquiry, and images of the future are given voice.

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