Constructions of Disorder

Meaning-Making Frameworks for Psychotherapy

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14

FROM DISORDERING DISCOURSE TO TRANSFORMATIVE DIALOGUE

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> Lovers and madmen have such seething brains,
> Such shaping fantasies, that apprehend
> More than cool reason ever comprehends.
> —William Shakespeare

In this chapter, we explore the discourse of mental disorder. Our attempt is to augment the already articulated "merits" of diagnosis by proposing some of the limitations of such discourse. Specifically, we discuss the ways in which diagnosis—or the discourse of mental disorders—invites therapists into patterns of stigmatizing and blaming clients, desecrating traditions, deteriorating relationships, and disempowering people. We offer, instead, the metaphors of dialogue and multiplicity as possible openings toward transformation.

We begin this chapter with a simple query: Of what therapeutic value are the diagnostic categories of mental disorder? Because such terms have been generated largely within the context of what is understood as a knowledge-generating process, this question is seldom voiced. Yet—momentarily putting aside the problems and prospects of a science of mental disorder—what therapeutic benefits or liabilities accrue from the standard practices of assigning terms of mental disorder to the actions of individuals seeking therapeutic treatment? For whatever the capacities of the science, it is ultimately the well-being of society's members that is at stake. If the diagnostic categories are problematic, or possibly injurious, in terms

of a client's well-being, then serious reconsideration is required with respect to therapeutic practice, managed care requirements, and possibly the knowledge-generating process.

We raise this question from the standpoint commonly identified as "social constructionist" (Gergen, 1994; McNamee, 1996; McNamee & Gergen, 1992). Of central concern to constructionists are the processes by which human communities generate meaning. Particularly focal are the multiple possibilities for meaning that exist within a culture and indeed around the globe. As people coordinate their actions within a community, so do they typically generate a language that is functionally integrated into their practices. Perhaps the clearest illustration is furnished by the game. For example, the game of baseball not only requires a set of coordinated activities but also a functionally integral vocabulary. There are pitchers, fielders, and batters, just as there are innings, outs, and foul balls. The terms are an integral part of the game as traditionally played. To destroy the discourse (or its functional equivalent) would render the game impossible. Note, however, that the discourse of baseball, although essential to those engaged in the game, is of marginal relevance outside the domain. If this discourse were suddenly imported into another game—let us say, eliminating a tennis player from a match because "he missed the third strike"—the results would be chaotic.

So it is within the various professions. The discourse of law is not that of physics or chemistry, the language of botany is of little use when launching a rocket, and the discourse of literary theory would be counterproductive for a disaster relief agency. Here we must ask, then, Whose interests are being served by the discourse of mental disorder? How does this discourse function outside the mental health establishment? In particular, how does it function when transported into the lives of clients?

Let us increase the stakes: Social constructionist theory also calls attention to the close relationship between meaning and value. In particular, as communities of coordination emerge, so do they generate (and typically articulate) standards of conduct, or views of what constitutes "good" behavior within the community. Because the discourse of the community is thus inextricably wedded to its traditions, it also carries with it either implicitly or explicitly the values of the tradition. Failing to play by the rules of baseball, which includes calling events or people by their conventionally sanctioned names, is grounds for expulsion. Much the same holds true in physics, botany, and firefighting. To participate is to accede to the values of the community in question. To put it more broadly, a community's construction of the world sustains what Wittgenstein (1953) called its "form of life." Thus, when one credits people with the capacity for "independent thought," one acts to sustain a tradition of democracy; when one attributes to them a spiritual dimension, one favors the sustenance of religion. Every

discourse invites a way of life while discouraging or repelling others. The discourse of mental disorders does not differ in this respect.

Again, to rephrase our initial query, What values are carried by the discourse of mental disorder? What traditions are sustained? What traditions are lost? If the language of mental disorder becomes the primary means of generating meaning, whose voices are suppressed?

> One is left to wonder how such a strange set of odd and irrational, ever-changing diagnostic categories (the DSM) has come to be so widely used to extend all-powerful control over the field of psychopathology.
>
> —George W. Albee

To properly set the stage for what follows, one must recognize a final constructionist concern: the social and material context of meaning generation. To the extent that any community functions within a cultural or geographic vacuum, it may comfortably rely on a single, strong tradition. Its traditional discourses may serve it well, and its values may go unchallenged. Coordination could approach perfection. For example, members of inner-city gangs coordinate their activities around particular beliefs and practices. In so doing, their day-to-day lives are somewhat seamless, and their collective understandings of themselves and their surroundings are not at risk. They know what it means to be a member of the community (gang) and what is expected of each participant. They listen carefully to each other's accounts of what they are doing, and their values rarely waver. However, as other communities whose realities and values are potentially antagonistic increasingly populate the environment, then their commitment to a singular tradition becomes problematic. Not only do "true believers" become insensitive to the needs and interests of those around them but also, with such insensitivity, potential for action is reduced. Each vocabulary offers a way of life, alternative possibilities for action and value. At worst, intense commitment sets the stage for open hostility and possible attempts to eradicate the other.

In this context, we are invited to consider the "mushrooming" of communication technologies, particularly during recent decades. With the rapid expansion and increased efficacy of telephone systems, jet transportation, television, and computers, the possibilities for communal coordination—from the very local to the global—become enormous. In effect, one of the chief hallmarks of what is variously called the "age of information," "culture of chaos," or "postmodern culture" is the multiplication and expansion of discursively coordinated communities (Gergen, 1991). The emergence of multiplicity is accompanied by increasing challenges to the established truths and values of any group.

Again we reframe our initial query: On what grounds, save those that are shared within their own community, can mental health professionals claim superiority in naming? On what grounds, save their own, do they function to eliminate alternative possibilities? Is resistance to the multiple possibilities of interpretation desirable? Is the "single calling" possibly injurious not only to the profession but also to those clients who live in alternative realities?

> Clinicians appear to ascribe violence, suspiciousness, and dangerousness to Black clients even though the case studies are the same as the case studies for the White clients.
>
> —M. Loring and B. Powell

In light of the challenges posed by these questions, we propose the following. First, we consider a range of problems deriving from the traditional discourse of mental disorder. Our intention here is to unsettle the tranquility of the conventional, the secure sense that the vocabulary of mental disorder is either neutral or harmless. We then open discussion on an alternative direction for mental health professionals. We attempt to replace the urge toward certainty—the closed community—with a telos of protean potential. More succinctly, we propose that in both therapy and diagnosis we may profitably move from disciplinary determination to dialogues of difference.

DISORDERING THE DISCOURSE OF DISORDER

> Psychiatrists are physicians, and physicians are supposed to help people. That is true. But it does not follow that the result is necessarily helpful for the so-called patient—as he, the patient, would define what constitutes help.
>
> —Thomas Szasz

For people working within the mental health professions, the value of diagnostic categorization is seldom questioned. Standardization of terms is essential to carrying out the practices that represent the goal of the profession. Yet much hangs in this case on what is considered to be the goal of the profession. If the goal is to cure the patient, then a diagnostic vocabulary seems reasonable enough. However, the discourse of "disease" and "cure" is itself optional. One person's "mental illness" may be another's "salvation." If the goal of the profession is to aid the client—which seems more supportable—

then the door is opened to the more pragmatic questions. In what senses is the client assisted and injured by the demand for classification? Although we touch on possible ways in which the client could be assisted, our aim here is more catalytic. To instigate dialogue, we focus on five particular ways—some now well documented—in which both the client and society may be harmed by constructing people within the discourse of mental disorder.

Stigmatization

Much has been said about the implicit value systems underlying the concept of mental health and the contrasting concepts of mental illness or disorder. Images of the "fully functioning," "well adjusted," or "normal" person are burdened with values and ideals, both in one's daily relations with peers and family and in the mental health professions (Laing, 1972; London, 1986; White & Hellerich, 1998). Kleinman (1988) offered many beautiful illustrations of the cultural variation in diagnosis. A form of schizophrenia deemed severe in Western culture is viewed as a minor oddity in Asian culture. These variations can be traced in large measure to different conceptions of value. Because of this valuational component, diagnosis does not function neutrally, to merely describe. It renders a moral judgment. It communicates a deficit in worth. "You are not active enough," or "you are too active." "You are not sexual enough," or "you are too sexual." "You don't eat enough," or "you eat too much." "You don't make rational sense," or "you are excessively rational." In effect, the diagnosis can function as a form of stigmatization, rendering one undesirably different. The repercussions of social stigmatization are well documented (see, e.g., Goffman, 1963; Rosenhan, 1973).

> A diagnosis of schizophrenia is worse in some ways, than being told you have cancer. What would it be like if nobody who got cancer got better, and they were called by their illness? If people said, "What should we do with these cancers? Isn't it too bad. Let's send these cancers to the hospital since we can't cure them."
>
> —Marcia (diagnosed with schizophrenia)

The problems owing to stigmatization are exacerbated by two factors. First, diagnostic procedures are unreflexive. The categories of disorder are treated as if neutral, as dispassionate assessments of "what is the case." This is not to deny that "something is the case." However, to treat these callings as if they were not value-loaded interpretations, representing the investments of particular subcultures in society, is to leave the client with little means of deliberating on the issues. There is no opening for debate on the values embedded in the diagnosis, nor on these values as compared with others.

Thus, for example, the diagnosis of attention deficit disorder, although treated as objectively neutral, reflects traditional investments in a quiet and well-ordered classroom. It is the diagnosed individual who is "disordered." In contrast, if parents, teachers, and children could talk over the assets and liabilities of "ordered education," rather than focusing on the child's "illness," the child would not be stigmatized and Ritalin would not be a million-dollar business.

Furthermore, there is little way for a client, once stigmatized, to escape. Labels for mental disorder are notoriously vague; they typically refer to mental tendencies, dispositions, and afflictions not available to public scrutiny (Kutchins & Kirk, 1997). As diagnostic procedures demonstrate to the clients, they are not in a position to judge for themselves. The result is that one can never be certain that he or she has ever been "cured." One remains with the sense that beneath the veneer, lurking in the unconscious, will always remain the obsessive, the anorexic, the multiple personality, or the schizoid tendency. In effect, to be diagnosed in terms of mental disorder is for many to embark on a lifetime of existence on the boundary of normalcy. It is to carry forever a sense of self-enfeeblement, self-doubt, incompetence, and general deficiency.

Individual Blame

It is not only that the discourse of mental disorder stigmatizes the client but also that the cause of the dysfunction is located within the person. The attribution signals a personal flaw or failing, an inability or incapacity. To be sure, preceding conditions (e.g., child-rearing practices, environmental tensions, molestation) may be initially responsible for the "disordered mind," but the result of these conditions is now a disability within the person (e.g., "my anxiety," "uncontrollable desire," "chronic depression"). With individuals now carrying with them the weight of "evil origins," the invitation is to withdraw from a relationship. If it is one's problem, then one must worry about inflicting it on others and about their justified blame. The logic invites one into privacy, "working it out for oneself" (or with one's private therapist and an appropriate regime of drugs). In effect, the tendency may often be toward disengagement from a relationship.

> They would have labeled me an ego-dystonic homosexual. They pretend to be hip now, so they say it's normal to be homosexual. Of course they don't think it's normal at all, but that's what they're giving lip service to these days. But they think you're even more abnormal if you do not accept your abnormality.
>
> —Ruby (a patient)

This tendency is often intensified by the way in which the same diagnosis invites others into a posture of blame: "She's at it again," "you never know what he will do," "she always does that." The diagnosis, then, places therapists in a position as righteous and all knowing, with the disordered individual subject to the therapist's judgment. This distancing of oneself from others is encouraged further by the very diagnostic that places the other in a different category: ill or infirmed. The diagnostic informs therapists that they are different, better, and correct. In the diagnostic laying of blame, the wall between the therapist and client grows higher.

Of equal importance, with individual blame established through diagnosis, the therapist may suspend inquiry into other contributions to the condition, including his or her own. Explorations of family conditions, peer relationships, the workplace, technology, and the like are bracketed. The "buck" has stopped. For example, in the case of sex offenses, there is good reason to inquire into the cultural conditions—the erosion of moral consensus, the reduction of religious influence, the influence of television and pornography—and the way in which many people contribute to these conditions. Yet once the individual is diagnosed as a sex offender, the need for such reflection is reduced. With individual blame in the vanguard, one closes off possibilities for relational responsibility (McNamee & Gergen, 1998).

Desecration of Tradition

Consider a person who becomes listless, loses enthusiasm and ambition, sleeps long hours, and begins to take little interest in food. These are all classic symptoms of the mental disorder called depression. There are numerous therapeutic treatments for depression, with psychopharmacological solutions increasingly favored. Yet there are other traditions in which these symptoms might be recognized, with far different outcomes. For example, there is a strong folk tradition in which one can "feel blue." To "have the blues" is not an illness; it is an honorific state; it signifies that one truly knows life and has experienced its depths and defeats. It is to elicit sympathy, not because one is ill but because people recognize the condition as a "poor lot." The afflicted one is not weakened by disease but is strong in his or her resistance. To have the blues enables one to serve as a witness, to inform others of one's journey. In a good blues club, one pays handsomely to hear others' experiences related.

Other traditions are capable of rendering intelligible what might otherwise be called depression. The "loss of meaning" in life has been of chief concern to traditions of the spirit; in response, not therapy but teachings from the Bible or the Koran, along with pastoral counseling services, are favored. There is also a longstanding folk tradition, stemming perhaps from the Germanic tradition of *bildung* (roughly translated as character develop-

ment), that views life as a challenge to one's strength and simultaneously an invitation to grow stronger. To avoid the challenges of daily life, as in the case of what might be called depression, would be to abandon the "good fight." The proper reply in this case is not sympathy but remonstrance and encouragement: "Pull up your socks," "get a grip," or "you can do it."

> A spiritualized society would treat in its sociology the individual, for the saint to the criminal, not as units of a social problem to be passed through some skillfully devised machinery and either flattened into the social mold or crushed out of it, but as souls suffering and entangled in a net and to be rescued, souls growing and to be encouraged to grow.
>
> —Sri Aurobindo

In summary, in demanding terminologies of mental disorder, we imply or presume the inferiority or irrelevance of alternative traditions. Therapeutically speaking, the client is discouraged against reliance on many of the existing resources within the culture. By implication, there is only one resource, made available only by the mental health professional.

Deterioration of Relationship

We already discussed the way in which tendencies toward individual blame, invited by disordering discourse, can undermine relationships. The precarious state of such relationships is further underscored when one considers the way in which such discourse invites the client into a state of dependency on the mental health professions. To be diagnosed by the profession is to be informed that the professionals—not family, friends, community, spiritual advisors, and the like—are the proper source of guidance, support, and cure. In this way, as the disordered individual enters a treatment program, the problem may be removed from its normal context of operation; others are encouraged to "back off," "avoid interfering," and "let the professionals do their work." The mental health professions thus disrupt the processes of relational realignment that might otherwise take place within the community. Relations organic to the community are undermined, communication is attenuated, and common patterns of interdependency thwarted. In effect, the deficit terminology functions within a process that removes the client from his or her ecological niche.

> [Hysteria] is not a disease; rather, it is an alternative physical, verbal, and gestural language, an iconic social communication.
>
> —Mark Micale

One may argue that processes of natural realignment are often slow, anguished, or brutal and that life is too short to endure the seemingly chronic deviant. However, the result is that problems otherwise generating significant "challenges to the community"—those that give strength and identity to a community—are largely "removed from the ledger." Marriage partners may carry out more intimate conversations with their therapists than with each other. Partners of "problem" people are invited away into codependency support groups, where they discuss the now-objectified partner with strangers. Parents may discuss their problems with a specialist or send problem children to treatment centers and thereby reduce the possibility for communication with their offspring. Organizations place alcoholic executives in treatment programs and thereby reduce the kind of self-reflexive discussions that might elucidate their own contribution to the problem. In each case, the ties of communal interdependency are injured or atrophy, and the client's resources for recovery are reduced.

Disempowerment of the Person

Although the therapeutic process is often justified on the grounds of its empowering the otherwise infirm and dependent, there is an important sense in which the reverse is true and in which diagnostics are a chief vehicle for disempowerment. In the works of Michel Foucault the logic of disempowerment becomes most clear. Foucault (1979) was particularly concerned with the way in which people unwittingly subjugate themselves to subtle forms of power. Language is a critical feature of such power relations, especially the discourse of knowledge. Foucault was centrally concerned with subjugation by various groups who claim "to know" or to be in possession of the "truth," about who people are as human selves (e.g., professionals in the disciplines of medicine, psychiatry, sociology, anthropology, and education). Professionals within these "disciplinary regimes," as Foucault called them, generate languages of description and explanation—classifications of selves as healthy or unhealthy, normal or abnormal, upper class or lower class, intelligent or unintelligent—along with explanations as to why they are so. Professionals also use various research procedures whereby individuals are scrutinized and classified in the terms of these regimes. In effect, when one offers oneself for examinations of various sorts, from medical examinations to college board assessments, one is giving oneself over to the disciplinary regimes to be labeled and explained in their terms. When one carries these terminologies into one's daily lives—for example, speaking to others of one's depression or anxiety—one engages in power relations, essentially extending the control of the disciplinary regimes. As these disciplines of study begin to influence public policy and practices, one becomes further ordered in their terms. As diagnostic terminology is increasingly

sanctioned by managed care systems, so is it increasingly difficult to escape. As pharmaceutical companies increasingly profit from curing those labeled in these ways, so are these companies contributing to the disempowering of the individual. In the current condition, the client has virtually no freedom to reject psychodiagnostics.

> For drug companies, the unlabeled masses are a vast untapped market, the virgin Alaskan oil fields of mental disorder.
>
> —Herb Kutchins and Stuart Kirk

TOWARD TRANSFORMATIVE DIALOGUE

There are significant ways in which the discourse of mental disorder functions to the disadvantage of the client. This is surely not all there is to be said about such discourse, particularly in terms of its positive potentials. Countless individuals have been helped within the terms of this discourse and its attendant therapeutic practices. Many clients are both pleased and relieved to have their otherwise complicated and unintelligible problems identified with the following standard nomenclatures: "At last someone understands"; "I am like many others"; "they understand"; and "my problem can be solved." As Showalter (1997) argued, people often feel that problematic behavior is symptomatic of an underlying cause. Professional authority figures soon furnish a name for the illness. Support groups are formed, publications generated, and a sense of bonding may emerge. Furthermore, such terms function to coordinate teams of researchers seeking physiological or pharmacological means of reducing the intensity or consequences of reported problems. Regardless of the pervasive criticism of biological reductionism in such cases, countless individuals look to psychopharmacology with gratitude.

Clearly, we do not propose here an abandonment of the discourse of mental disorder. Rather through our critique, we are primarily attempting to set the stage for alternatives to the prevailing movement toward universal diagnostics. We seek means of replacing the automaticity of diagnosing clients, using these terms as a standard aspect of treatment, and requiring these diagnostic labels for purposes of insurance claims. We do not favor a "fight to the finish," where the mental health establishment finds itself increasingly placed on the defensive by various advocate groups. The image of psychiatry, in particular, suffered greatly when it succumbed to the persuasive arguments of gay men and lesbian activists that homosexuality is not a mental disorder. Feminist criticism of the pathologizing of women becomes

increasingly sharp. Groups of former mental patients are more effectively organizing to do battle with the mental health establishment over the inhumanity and injustices they feel they suffered. It is only a matter of time before those handicapped by the diagnosis of attention deficit disorder organize against the established order. The battle lines are forming, and the ethos is turning increasingly hostile.

In this context, we turn to the potentials of dialogic processes, in general, and, in particular, to what may be called "transformative dialogue" (Gergen, McNamee, & Barrett, in press). Through dialogic means, the range of participatory voices (traditions) can be expanded and traditional forms of argumentation can be abandoned in favor of mutual exploration of options, assets, and limitations. The point of such dialogue is not to battle over the "correct" interpretation; all interpretations can be correct within a particular tradition. Rather, the hope would be to emerge with an expanded array of possibilities, an array that would sensitize professionals, clients, and the surrounding community to myriad factors possibly at play and a range of possible strategies, relational forms, or institutional arrangements that can serve as resources. Finally, with multiple options on the table, moment-to-moment adjustments to changing circumstances could replace lock-step regimens that result from confident labeling.

We do not view this invocation of dialogue as mere academic idealism at play. Rather, there are significant explorations already in motion, practices that may be interrogated and used to seed further variations. We consider here two domains of dialogic practice, the first relevant to the "diagnostic moment," and the second, to the ongoing process of therapy.

Diagnostics as Dialogue

Contemporary diagnostics typically take place within the professional compound, by professionals who largely share the same training and conventions of labeling. An outstanding exploration of alternatives is furnished by Jaakko Seikkula et al. (1995) in the western Lapland province of Finland. Their work is based largely on the dialogic orientations of Mikhail Bakhtin (1981), Valentin Volosvinov (1973), and Lev Vygotsky (1970). The corpus of writing on dialogism draws a distinction between dialogue and monologue. In a monologic interchange, the utterances of each participant are designed only to achieve his or her own ends—much like the traditional way of diagnosing and forming therapeutic treatment plans without involving patients, family members, or others invested in the conversation. In the traditional therapeutic conversation, the professional searches for answers that will support his or her hypothesis about the client's "problem." The professional "knows" how to put the pieces together, what to look for, and what counts as "normal." In contrast, Seikkula et al. proposed a dialogic approach

to therapeutic conversation in which emphasis is placed on what people do together. In their work, they focus on expanding the voices that have knowledge of the problem by including patients, family members, and invested others in the conversation. As Sampson (1993) put it, "if we are dialogic, conversational beings, we cannot be understood by probing inside for personal and private processes taking place deep within each individual" (p. 98). To involve a multitude of voices in the conversation about the problem invites each member's truth about the situation into discussion. Each "utterance has an equal value in constructing a polyphonic truth; we must not aim at one truth or solution but at generating a dialogue between the different voices" (p. 69).

Seikkula et al. (1995) described diagnosis and the therapeutic process as "open dialogue," by which they mean that rather than draw boundaries around the treatment team, all interested and invested parties, including the patient, are invited into the discussion about diagnosis and treatment. Seikkula et al. (1995) felt that "by opening the boundaries of discussion, the joint process itself started to determine the treatment, rather than the team itself or the treatment plan of the team. . . . All participants are in a mutual co-evolving process so that the treatment team is also changing all the time" (p. 64). One of the most salient features, then, of the Finnish work is operating "on the boundary." By repositioning the therapeutic conversation away from the "experts" and into the polyphonic arena of all participants, each with an array of expertise (both local and professional), the potential resources of all involved are made available and are used. The open dialogue created includes "the risk of vulnerability, because one's own utterances are open to the other's comments" (p. 73). In such a conversation, "psychosis is no longer seen as some independent quality in the patient but as one voice of the therapeutic interaction taking place at the moment" (p. 74).

We see Seikkula et al.'s (1995) work as a form of transformative dialogue that largely avoids the stigmatizing, alienating, blame, and evaluation that accompanies the monologic attribution of mental disorder. In their guiding principles, they include (a) mobility and flexibility, a special team is organized to diagnose and treat each case; (b) network perspective, an attempt is made to include in the team those who are worried or involved in the case; (c) tolerance for uncertainty, the team does not give solutions too quickly or understand the situation too early; (d) dialogical orientation, the task of the team is to generate dialogue (rather than diagnose the problem) and, therefore, all opinions can be voiced and all voices can be heard; and (e) therapeutic orientation, the team leader takes care of the continuity of the therapeutic process and ensures that all topics, including difficult ones, are discussed. The major task of the team is to develop a

treatment plan with the patient, family, and involved others. By so doing, the distinction among diagnosis, therapy, and management of everyday life is blurred. The therapeutic conversation is less "institutional" and more like human dialogue. Also the participatory process of the team seems to generate a participatory relationship among family and involved others. The skill of the team is in its ability to generate dialogue among different voices using all available resources. In so doing, all voices are seen as resources rather than obstacles. Consequently, the meaning is recognized as a by-product of the community of people in relation rather than the sole possession of one individual. Psychosis is not seen as an "obvious quality" of the client but as one way of understanding complex and ever-shifting patterns of action.

Significantly, this dialogic orientation effectively reduced the number of people diagnosed with schizophrenia, the number of psychopharmacological prescriptions, and the number of hospital beds occupied in this region of Finland from 320 to 63 (Seikkula et al., 1995). The open dialogue initiated by Seikkula et al. worked to establish new relational networks within the community. With these expanded webs of relations, community members now had a multitude of resources to draw on (collectively) in helping each other help "the mentally ill."

Therapeutic Movements Toward Multiplicity

Although the Finnish work fruitfully blurs the distinction between diagnosis and treatment, there are also advantages in focusing on therapeutic process itself. Dialogic process may be stimulated effectively within the ongoing process of therapy. In particular, any move within the therapeutic relationship that brings a new or alternative voice into the conversational arena increases the dialogic potential. As voices, opinions, interpretations, values, and the like are added to the conversational mix, opportunities for moving beyond the tyranny of the coherent monologue are increased.

The most simple openings to dialogue may result from such questions as the following: What do you think X would think about this? Would your husband agree with this interpretation? Another opening may result from the therapist's thoughts on how various others (employers, spouses, etc.) might consider the case. In a more sophisticated way, the Milan Associates (Boscolo, Cecchin, Hoffman, & Penn, 1987) introduced to the field of family therapy the idea of circular questioning. Here, family members are asked to comment on their situation from each other's position. This enables them to see the situation from another perspective and thereby reflect on their own. They are encouraged to see things differently, to understand as someone else might understand. In so doing, they are inspired to entertain the variation they also harbor.

One of the most dramatic ways of introducing other voices was developed by Tom Andersen (1991, 1995). He and his colleagues ask a team of individuals to observe family therapy proceedings. At a certain juncture, this reflecting team is admitted into the presence of the family and is asked to talk about what they have heard and seen. There is no attempt in this case to reach consensus or to apply a standard diagnosis. The team members simply give voice to their more pronounced sense of what is occurring. When the observing group finishes offering their reflections, the family is invited to talk about what they heard. This shifting from what Andersen calls the "listening position" to "reflecting position" invites the clients into a dialogue with the observers.

This practice not only brings fresh voices and otherwise absent perspectives to the therapeutic conversation. Of equal importance, it allows clients to understand the constructed character of the realities in which they live, to see them as contingent and negotiable. Furthermore, as the family engages in conversation with the reflecting team, it comes to see itself increasingly as forming an interdependent unit. As a further variation on the reflecting team, Andersen (1995) sometimes asks all participants (patients, family members, therapy team members, others involved) to shift between listening and reflecting stances. Those who listen are given a moment to offer their reflections on the conversation they heard. As the others adopt the listening position to hear these reflections, they are invited into a moment of self-reflexivity, encouraged to suspend their certainty of their own position and to entertain other possibilities. Then those listening are invited to reflect in turn. This constant movement back and forth between listening and reflecting stances among varying groups of participants in the therapeutic conversation contributes further to the transformative potential.

Also relevant here is the work of Penn and Frankfurt (1994) on therapeutic letter writing. Drawing from Bakhtin's (1981) work on dialogism, Penn and Frankfurt (1994) reasoned that the construction of self requires the "other": "Voice . . . is generative; it is unfinished and awaits a reply[,] . . . it invites the other into what one might call a dialogic space" (p. 222). Using these ideas, they found that different voices can be invited into the therapeutic conversation through letters written by the client to others. Because writing takes place at a different pace than talking, they found that it makes room for the "thickening" of "layering" of sensitivities and reactions and thereby stimulates the creation of multiple readings of the self, other, and relationship. Writing, they explained, "encourages us to develop many different readings of our experience" (p. 230). It also invites clients to consider otherwise silent voices as possible resources for relating or as voices that further contribute to understanding. As they work inside and outside of the therapeutic context, clients can also review their writing. They are

invited to reexamine, edit, elaborate, and retain their prose. This work not only demonstrates a way of actively bringing others' voices into the situation but also adds a significant new element. It brings into focus the sense in which one's actions are always "for another," always directed to a particular audience. As one begins to recognize the particular audience to whom one is addressing in one's actions and realize that this is only one audience among many, one can see possibilities for expanding one's sensitivities to the multiple potentials within oneself. In addition, as the descriptions are realtered for these various audiences, the "hard reality" of the present becomes relativized.

Mony Elkaim (1990) also developed a therapeutic practice that helps to generate multiple realities. As the client describes him- or herself or the problem at hand, Elkaim suggested that the therapist should listen internally to his or her own voices of reply. The therapist listens by asking him- or herself a series of questions: What is this description inviting in the way of a response? Is this description asking me to speak as a father, a combatant, or an admirer? Elkaim theorized that if a longstanding pattern is to be broken, it is important that the therapist avoid responding in the invited way. Rather, the therapist explores alternative voices available to him or her that would also be intelligible as reactions but would not fortify or sustain the well-rehearsed patterns that contribute to the client's anguish. By drawing on these alternative voices, the client is invited to tap into alternative selves, to give expression to other capacities for being.

Finally, Harlene Anderson (1997) generated a significant means of aiding therapists to multiply the perspectives available to the therapeutic conversation. Participants are invited into what she calls an "as-if exercise." Whether they be therapists in training, family members, or other professionals, they are given a brief synopsis of a problem case with all relevant parties to the problem described. The participants are asked to listen to the story from the position of one of the parties involved. After the short summary is presented, all those who have listened from one member's point of view are invited into a conversation with each other. For example, there are three people listening from the position of the mother in a problem family and two people listening from the position of the father or an adolescent boy. After the presentation, those listening from a given position are invited into a conversation; they generate many different possibilities for understanding the individual's situation. These discussions are followed by an open meeting in which each group introduces its members' thoughts on the party whom they represent. This exercise has an enormous impact on expanding the voices of those involved, and it opens avenues for self-reflexivity and options for action. Anderson's practice effectively helps people move beyond one, unified voice—the voice of certainty—and enter further into transformative dialogue.

CONCLUSION

These various innovations demonstrate the possibilities for open and generative dialogue in our attempts to understand actions frequently serving as candidates for therapeutic treatment. In our view, transformative dialogue is vastly superior to the attempt of any one group to fix the domain of interpretation. The discourse of mental disorder, and the tradition in which it was spawned, may be enormously valuable as an entry into the dialogue of problems and prospects. However, as we proposed, to allow this discourse to dominate can be an enormous disservice to clients seeking help and injurious to society as a whole. In terms of implications, it seems essential to dismantle requirements demanding psychiatric diagnosis as an entry ritual for clients seeking insurance coverage. Whether a client receives a diagnosis in terms of current "conventions of pathology" should be optional, for both client and therapist alike. As we noted in this chapter, many constructionist therapists are experimenting with ways to broaden the psychotherapeutic dialogue. Now therapists are challenged to expand the dialogue beyond the therapist–client relationship to develop alternative means of determining whether a client deserves insurance coverage. Clearly, the broader issues at stake here are likely to depend on another site of transformative dialogue: one among the many communities concerned with mental health, such as clients, drug and insurance companies, religious leaders, and others concerned with society's future. Problematic behavior should not be placed in the hands of any single profession; instead, it should command sustained dialogue among all involved.

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