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## The tyranny of expert language

Dave Harper

Harper, D. (2002). The tyranny of expert language. *Open Mind*, 113, 8–9.

### Diagnosing our ills

When we think of the kinds of concepts that are currently available to professionals and the public to describe emotional difficulties and distress, we come across terms like 'anxious', 'depressed', 'schizophrenic', 'chronic', (treatment) 'resistant' and so on. It can become easy to treat these terms as if they were unproblematic and to think that this naming is like calling the thing you sit on a chair. However, ways of looking at emotional distress are continually in flux, and some descriptions of distress, like reductionist biological psychiatric views, currently get much more prominence than the alternatives.

We can track changes in the way distress is viewed by comparing different versions of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorder* (DSM), as some authors have done. One example is the vast increase in the number of problems for which we now have names, from 106 categories of diagnosis in DSM I in 1952 to 357 in DSM IV in 1994, a trebling of diagnoses in the space of 42 years. The striking thing about this though is not just how many categories there are but also the *kinds* of concepts used. As Ken Gergen puts it, there has been a creation of huge 'vocabularies of deficit'.<sup>1</sup> Go to any mainstream research journal examining psychotic experiences and you will see words like 'deficit', 'abnormal', 'irrational', 'bias' and 'pathological'. If users of mental health services were to construct an identity for themselves based only on such deficit-laden terms would this help or hinder their self-esteem?

Stephen Madigan touches on this in his definition of identity as 'being who you say you are, through what *they* say you can be'.<sup>2</sup> Expert language is, as Diana Rose (OM 108), quoting from Foucault, puts it, a 'monologue of reason about madness'. However, she reminds us that the subjects of this 'monologue' have not been allowed, by the very nature of the discourses, to make it a 'dialogue'. To some, such terms may seem simply like a description of the facts: for example, people who believe in strange things must be *abnormal* in some way. But this point of view rests on a number of important assumptions and has powerful social effects.

### The assumptions of concepts

The assumption is that mental health problems originate within individuals rather than in our relationships with others or with society. Since problems are seen as individual, then the solutions offered to people are individual too. Thus we see medication and individual therapy being offered rather than more social and political interventions. Similarly, Liz Sayce has argued that the notion of 'stigma' individualises what is really societal discrimination.<sup>3</sup> Thus, we become diverted from developing communities which are more accepting and from dismantling what some have called 'able-minded' assumptions.

An effect of this is that we start to mark off people as irrational, as different and as 'other'; an example of what Rufus May has called 'us-and-them thinking' (OM 106). As a result, we are invited to ignore the diversity of everyday life and to forget that few, if any, of us are entirely rational. Moreover, by creating a 'them' with problems, 'we' get to see ourselves as normal.

Not only do these concepts depend on a particular version of normality, but they are also defined by a set of socially sanctioned experts. An example of this is the increasing popularity of psychological models of psychosis.<sup>4</sup> Whilst I would see aspects of this as helpful, there are also dangers here, namely in setting up a new orthodoxy of *correct* explanations of psychotic experiences to which service users have to sign up. For me, such a position is not necessarily any better than the old psychiatric orthodoxy because it simply replaces one dominant and powerful explanation with another. I would argue that it is in diversity, both of power and of ideas, that we are likely to find a way forward. One of the strengths of the Hearing Voices Network, for example, is precisely its willingness to embrace a variety of explanations for hearing voices.

### **The social effects of language**

The concepts we use can often contribute to the creation of a culture of blame and guilt. It is no longer rocket science to recognise that terms like 'manipulative', 'attention-seeking' and 'resistant' have moralistic overtones, but it is easy to forget that terms like 'non-compliant' and 'lacking insight' are moralistic too, though perhaps in a more subtle manner. Such terms rest on the assumption that experts are always right. For example, the notion of 'non-compliance' assumes that service users should take their medication as instructed by professionals regardless of their own wishes (and this is the assumption behind recent government proposals to reform the Mental Health Act). But, as we know, there are often legitimate reasons for not taking medication: it may not work; there may be other medications which are better for the person; the

drugs may lead to side-effects worse than the original 'symptoms'. Indeed, some survivors like Rufus May have noted that they recovered despite, or indeed because, they stopped taking their medication.

Another effect of these concepts is that we can be deceived into thinking we're explaining things when actually we're not. Thus, people may be told they have 'residual' or 'treatment-resistant' symptoms. They may feel this is an explanation, but all it means is that their symptoms remain untouched by medication. They may be told they have a 'chronic' problem when, again, this simply means they have a long-standing difficulty. At times, these terms can have a paradoxical effect: on the one hand they make it appear that symptoms and illnesses have a life of their own - the service user is simply experiencing a 'relapse' or a 'remission' – yet on the other hand there is an overt or covert blaming of service users and their 'illness', shifting the focus of responsibility away from professionals and their treatments. Terms like these can invite us to limit our horizons. Thus, the notion of 'maintenance' implied by the concept of 'maintenance medication' suggests that problems will resurface without medication: here maintenance is made to look like progress.

A further issue is that many psychiatric diagnoses are often tautological. For example, the notion of personality disorder at the heart of the government's approach to 'high risk patients' is inherently circular. Thus, 'people may receive the diagnosis because their behaviour is considered aggressive or anti-social, and then their violent and antisocial behaviour is seen as being a product of the "disorder"'.<sup>5</sup> The problem is that wider society trusts such expert descriptions.

So what do we do? It is not enough just to change the words we use or to attempt to police language. This language creates a tyranny precisely because we ourselves get recruited into these dominant ways of thinking. More fundamentally, it is about who gets to speak and who gets to choose the words we use to talk about madness.

This is the first of two articles, and in the second I will sketch out some possibilities for action.

I would like to thank Anne Cooke and Diana Rose for comments on an earlier draft of this article.

1. Gergen, K. J. (1990) 'Therapeutic professions and the diffusion of deficit', *The Journal of Mind and Behavior*, 11: 353-68.

2. Madigan, S. (1999) 'Inscription, description and deciphering chronic identities' in I. Parker (ed.) *Deconstructing Psychotherapy*. London: Sage.

3. Sayce, L. (1998) 'Stigma, discrimination and social exclusion: What's in a word?' *Journal of Mental Health*. 7: 331-44.

4. Division of Clinical Psychology (2000) *Recent Advances in Understanding Mental Illness and Psychotic Experiences*, Leicester: British Psychological Society ([www.understandingpsychosis.com](http://www.understandingpsychosis.com)).

5. *Ibid*, p. 50.