

‘The *Routledge International Handbook of Critical Mental Health* provides a comprehensive, wide-ranging, and up-to-date portrayal of a wide variety of critical approaches toward psychiatry in a global context. It is an essential tool for all students, researchers, and clinicians who are interested in alternative models of the theory, history, politics, and professional practice of mental health and illness.’

Allan V. Horwitz, *Board of Governors Professor Sociology, Rutgers University, USA*

‘Bruce Cohen has brought together a wide variety of critical scholarship on mental health issues in this new Routledge Handbook. Anyone seeking an overview of the diverse and often contradictory sorts of critique of psychiatric orthodoxy that have developed in the past half century will find this a provocative and enlightening volume.’

Andrew Scull, *Distinguished Professor of Sociology and Science Studies, University of California, San Diego*

Routledge International Handbook of Critical Mental Health

The *Routledge International Handbook of Critical Mental Health* offers the most comprehensive collection of theoretical and applied writings to date with which students, scholars, researchers and practitioners within the social and health sciences can systematically problematise the practices, priorities and knowledge base of the Western system of mental health. With the continuing contested nature of psychiatric discourse and the work of psy-professionals, this book is a timely return to theorising the business of mental health as a social, economic, political and cultural project: one which necessarily involves the consideration of wider societal and structural dynamics including labelling and deviance, ideological and social control, professional power, consumption, capital, neoliberalism and self-governance.

Featuring original essays from some of the most established international scholars in the area, the *Handbook* discusses and provides updates on critical theories of mental health from labelling, social constructionism, antipsychiatry, Foucauldian and Marxist approaches to critical feminist, race and queer theory, critical realism, critical cultural theory and mad studies. Over six substantive sections, the collection additionally demonstrates the application of such theoretical ideas and scholarship to key topics including medicalisation and pharmaceuticalisation, the DSM, global psychiatry, critical histories of mental health, and talk therapy.

Bringing together the latest theoretical work and empirical case studies from the US, the UK, Australia, New Zealand, Europe and Canada, the *Routledge International Handbook of Critical Mental Health* demonstrates the continuing need to think critically about mental health and illness, and will be an essential resource for all who study or work in the field.

Bruce M. Z. Cohen is Senior Lecturer in Sociology at the University of Auckland, New Zealand. He is the author of *Mental Health User Narratives: New Perspectives on Illness and Recovery*, *Being Cultural* and *Psychiatric Hegemony: A Marxist Theory of Mental Illness*.

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This collection is dedicated to

Thomas S. Szasz (1920–2012)

– a critical voice that never waned

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Notes on contributors

Clement Bayetti is a doctoral student at University College London. His current research explores the process through which trainee psychiatry students in New Delhi, India, acquire their professional identity and how this shapes clinical encounters and outcomes. Previously, he has worked in the UK and India with third sector organisations and NGOs supporting people with mental health problems. Additionally, he has worked closely with local and national authorities in the UK to develop and implement mental health policy and clinical services.

Meredith R. Bergey is an Assistant Professor of Sociology at Villanova University. Prior to joining Villanova, she worked as a biostatistician at the University of Pennsylvania in health outcomes research, as an epidemiologist at the Rhode Island Department of Health and as a consultant in health services research. Her research addresses such areas as medicalisation, the globalisation of medical categories, health-related coaching, health information technology and ADHD. She is the lead editor of *Global Perspectives on ADHD: Social Dimensions of Diagnosis and Treatment in 16 Countries* (Johns Hopkins University Press, 2017).

Pat Bracken is a freelance mental health worker and academic whose previous books have included *Rethinking the Trauma of War* (Free Association Books, 1998, co-edited with Celia Petty), *Trauma: Culture, Meaning and Philosophy* (Wiley, 2002) and *Postpsychiatry: A New Direction for Mental Health* (Oxford University Press, 2006, with Phil Thomas). He has worked with refugees and asylum seekers in Africa and the UK, as well as victims of institutional abuse in Ireland and the UK. Pat has sought to promote the importance of 'critical reflection' in mental health work and was one of the founders of the Critical Psychiatry Network (criticalpsychiatry.co.uk). From 2006–8, he was also Professor of Philosophy, Diversity and Mental Health at the University of Central Lancashire.

Damien Brennan is an Assistant Professor in the School of Nursing and Midwifery, Trinity College Dublin, Ireland, and the author of *Irish Insanity 1800–2000* (Routledge, 2014). After working as a psychiatric nurse and nurse tutor within mental hospitals in Dublin, he undertook his doctorate at the Department of Sociology, Trinity College Dublin, detailing and critiquing the use of mental hospitals in Ireland. His teaching and research focuses on the sociology of health and illness (particularly mental health), as well as examining the post-institutional context both in Ireland and internationally, particularly focusing on care provision capacity within contemporary community, family and domestic settings.

Notes on contributors

Bonnie Burstow (@BizOMadness) is an Associate Professor in Adult Education and Community Development at Ontario Institute for Studies in Education at the University of Toronto. She is an academic, a philosopher, a novelist, a radical feminist therapist and a leading antipsychiatry activist and theorist. A prolific author, she has articles in dozens of scholarly journals while also writing for *Mad in America* (madinamerica.com) and rabble.ca. Her books include *Psychiatry Interrogated* (Palgrave Macmillan, 2016), *Psychiatry and the Business of Madness* (Palgrave Macmillan, 2015), *Psychiatry Disrupted* (McGill-Queen's University Press, 2014, edited with Brenda A. LeFrançois and Shaindl Diamond), *The House on Lippincott* (Inanna, 2007) and *Radical Feminist Therapy* (Sage, 1992).

Bruce M. Z. Cohen is a Senior Lecturer in Sociology at the University of Auckland, New Zealand. He has previously undertaken research fellowships at the University of Bradford, Humboldt University in Berlin and at the University of South Australia in Adelaide. He has been writing on mental health issues for over 25 years now, and his books include *Mental Health User Narratives: New Perspectives on Illness and Recovery* (Palgrave Macmillan, 2008), *Being Cultural* (Pearson, 2012) and *Psychiatric Hegemony: A Marxist Theory of Mental Illness* (Palgrave Macmillan, 2016).

David Cohen is Professor of Social Welfare in the Luskin School of Public Affairs at the University of California, Los Angeles, where he studies iatrogenic harm, psychiatric drug withdrawal, pharmacovigilance, and law and mental health. He has practised as a clinical social worker with children, adults and families, and created and tested the CriticalThinkRx curriculum to reduce the drugging of foster care children. His co-authored books include *Your Drug May Be Your Problem* (Perseus, 1999, with Peter Breggin), *Critical New Perspectives on ADHD* (Routledge, 2006, with Gwynedd Lloyd and Joan Stead) and *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs* (Transaction, 2013, with Stuart A. Kirk and Tomi Gomory).

Shaindl Diamond is a psychologist who currently works in Nova Scotia, Canada. She has been involved in activism and scholarship about critical approaches within the psy-disciplines over the past 15 years.

Daniel J. Dunleavy is currently a doctoral student in the College of Social Work at Florida State University. He has previously worked in mental health and substance abuse settings. His current research interests are in mental health/substance abuse treatment and child welfare, with particular interest in psychiatric medications, applied ethics and social policy.

Gil Eyal is Professor of Sociology at Columbia University. He has researched and written on mental health issues, especially autism, for the last ten years, previously publishing in the journals *American Journal of Sociology*, *Berkeley Journal of Sociology*, *BioSocieties*, *Advances in Medical Sociology* and *Journal of Contemporary Ethnography*. His books include *The Autism Matrix* (Polity Press, 2010) and *The Disenchantment of the Orient* (Stanford University Press, 2006).

Suman Fernando is an Honorary Professor in the Faculty of Social Sciences and Humanities at the London Metropolitan University. He was formerly at the University of Kent, and a consultant psychiatrist in the British National Health Service for over 20 years. He has written several books on the issues of 'race' and culture in mental health services and mental health development in developing countries, the most recent being the third edition of *Mental Health, Race and Culture* (Palgrave Macmillan, 2010) and *Mental Health Worldwide: Culture, Globalization and Development* (Palgrave Macmillan, 2014).

Simone Fullagar is Professor of Physical Cultural Studies at the University of Bath. As an interdisciplinary sociologist she undertakes qualitative research into inequality and the embodiment of sport, leisure and health/mental practices. Simone has published widely, using feminist post-structuralist perspectives to explore women's depression and recovery, active living policy and alternative physical cultures (from cycle tourism and parkrun to roller derby). In 2015, Simone was awarded the Shaw-Mannell Award for Leisure Research by the University of Waterloo, Canada. She is currently working on a new book, *A Feminist Biopolitics of Depression and Recovery*, with Wendy O'Brien and Adele Pavlidis.

Tomi Gomory is an Associate Professor at Florida State University's College of Social Work. He has been a mental health clinician and administrator, and, for the last 18 years, an academic writing and researching mental health treatment and policy. His particular professional foci are evaluation of practice, psychiatric coercion, 'evidence-based practice' and alternate approaches to our current medically informed mental health treatments. He is the co-author of *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs* (Transaction, 2013, with Stuart A. Kirk and David Cohen).

Rachel Gorman is Associate Professor in the Graduate Program in Critical Disability Studies at York University, Toronto, and an artist working in dance theatre and curating. Her research is interdisciplinary, engaging fine arts, cultural studies and critical political economy. Her writing focuses on transnational social movements, anti-racist aesthetics of disability and critiques of ideology. Her research projects include: ending violence against people with psychiatric disabilities; disability and workplace ex/inclusion; and transnational narratives of disability. Gorman teaches choreographic process and physical theatre in disability and queer arts communities, and has 25 years of organising experience in feminist, anti-racist and anti-occupation movements.

Sumeet Jain is a Lecturer in social work at the University of Edinburgh. After achieving degrees in social work and international development from McGill University and the University of Toronto, respectively, he completed his doctorate in cultural psychiatry at University College London. His current research examines the nature of local 'innovations' in global mental health; the development of contextually grounded approaches to 'recovery' in north India; and the relationships between mental health, marginality and social exclusion. Sumeet is conducting long-term ethnographic research on community mental health services and policies in Uttar Pradesh state, India. He is Associate Editor of the journal *Anthropology and Medicine*.

Janaka Jayawickrama is a Lecturer in community well-being and the programme leader of the Masters in International Humanitarian Affairs at the University of York. He is a social anthropologist with experience in conducting research in multidisciplinary and culturally diverse contexts. His work has a particular focus on understanding the well-being of communities within the uncertainties and dangers of life presented by disasters, conflicts and uneven development. Janaka has played key roles in various humanitarian crises, including tsunami responses in Sri Lanka (2004), internally displaced people in Western Darfur, Sudan (2005), Afghan refugees in Pakistan (2006), refugees in Malawi (2006) and Iraqi refugees in Jordan (2007).

Annemarie Jutel is Professor of Health at Victoria University of Wellington, New Zealand. She is a critical diagnosis scholar, using a variety of disciplinary approaches to understand social issues in diagnosis, and is the author of *Putting a Name to It: Diagnosis in Contemporary Society* (Johns Hopkins University Press, 2011), co-editor of *Social Issues in Diagnosis* (Johns Hopkins University Press, 2014, with Kevin Dew) and numerous articles on, and commentaries about, diagnosis and

Notes on contributors

its impact on health, illness and disease. She has just completed a book entitled *Telling It like It Is: The Diagnostic Moment and Its Narratives*.

Stuart A. Kirk is Distinguished Professor Emeritus in the Luskin School of Public Affairs at the University of California, Los Angeles. His research has critically examined the conventional wisdom of professions, seeking to illuminate the unintended effects of professional beliefs and practices when they are inadequately supported by scientific facts. His co-authored books include *The Selling of DSM* (Aldine, 1992, with Herb Kutchins), *Making Us Crazy* (Free Press, 1997, with Herb Kutchins), *Science and Social Work* (Columbia University Press, 2002, with William Reid) and *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs* (Transaction, 2013, with Tomi Gomory and David Cohen).

Sela Kleiman is a doctoral candidate in the Counselling and Clinical Psychology programme at the Ontario Institute for Studies in Education, University of Toronto. Sela's research interests include whiteness, cultural countertransference, racial attitudes and microaggressions.

Brenda A. LeFrançois is a Professor at Memorial University of Newfoundland. She has co-edited the books *Mad Matters: A Critical Reader in Canadian Mad Studies* (Canadian Scholars Press, 2013, with Robert Menzies and Geoffrey Reaume) and *Psychiatry Disrupted: Theorizing Resistance and Crafting the (R)evolution* (McGill/Queen's University Press, 2014, with Bonnie Burstow and Shaindl Diamond). She has also been a guest editor of a special issue of the journals *Children and Society*, on 'psychiatrised children' (2014, with Vicki Coppock) and *Intersectionalities*, on 'mad studies' (2016, with Jasna Russo and Peter Beresford).

Jeffrey M. Masson is the author of some 29 books, many of them about animal emotions (including *When Elephants Weep* (Delta, 1996), *Dogs Never Lie About Love* (Broadway Books, 1998), *The Pig Who Sang to the Moon* (Ballantine, 2004) and *The Face on Your Plate* (W.W. Norton & Company, 2010)), but also about the flaws inherent in therapy (*Against Therapy* (Common Courage Press, 1994)) and in psychoanalysis and psychiatry (*The Assault on Truth* (Faber, 1984), *Final Analysis* (Ballantine, 1990) and *A Dark Science* (Farrar, Straus and Giroux, 1986)). He has previously edited and translated *The Complete Letters of Sigmund Freud to Wilhelm Fliess, 1887–1904* (Harvard University Press, 1985), as well as writing about the dangers of charisma (*My Father's Guru* (Ballantine, 2003)). He lives between Berlin and Sydney.

China Mills is a Lecturer at the University of Sheffield and the author of *Decolonizing Global Mental Health: The Psychiatrization of the Majority World* (Routledge, 2014). She has published in a variety of journals and edited collections on mental health and international development, the global governance of mental health and on psychopolitics. Her research explores how the psy-disciplines and psychopharmaceuticals function in local and global contexts of entrenched inequality, chronic poverty, (neo)colonial oppression and increasingly under the politics of austerity. China is a member of the editorial collective for *Asylum* magazine and a Fellow of the Critical Institute.

Barbara Mintzes is a Senior Lecturer in the Faculty of Pharmacy and Charles Perkins Centre at the University of Sydney, Australia, and an Affiliate Associate Professor with the School of Population and Public Health at the University of British Columbia. A key focus of her research is on effects of drug promotion, including direct-to-consumer advertising, on prescribing and medicine use. She is co-author of the book *Sex, Lies and Pharmaceuticals* (Greystone Press, 2010,

with Ray Moynihan), and has also worked for many years with consumer and women's health groups.

Roy Moodley is Associate Professor of Counseling Psychology in the Ontario Institute for Studies in Education at the University of Toronto, as well as the Director of the Centre for Diversity in Counselling and Psychotherapy. Roy's research interests include critical multicultural counselling and psychotherapy, race and culture in psychotherapy, traditional healing practices and gender and identity.

Peter Morral's academic background is medical/health sociology. However, he has been steeped in the field of 'madness' for decades. He worked in large mental hospitals, and has taught, researched and written about madness (for example, *Madness: Ideas about Insanity* (Routledge 2017)), madness and murder (for instance, *Murder and Society* (Wiley, 2006)) and *The Trouble with Therapy* (Open University Press, 2008). Latterly, he has been campaigning for academics and clinicians to go beyond knowledge accumulation and competent practice to engage in individual and collective 'moral action'. Such action should be, he suggests, directed towards resolving problems of physical and mental ill-health which are rooted in society. Other than his academic work and campaigning, Peter rides a motorbike, sings and plays the saxophone, but (so far) not all three at once.

Falak Mujtaba is a doctoral student in the Department of Social Justice Education at the Ontario Institute for Studies in Education, University of Toronto. Her work focuses on post-9/11 racial contact, securitisation and democratic citizenship. Falak is also a public school teacher in the inner city of Toronto.

Ian Parker is Emeritus Professor of Management at the University of Leicester. He was co-founder and is co-director (with Erica Burman) of the Discourse Unit (discourseunit.com). He is a member of the *Asylum* magazine editorial collective and a practising psychoanalyst in Manchester. His books include *Revolution in Psychology: Alienation to Emancipation* (Pluto, 2007), *Lacanian Psychoanalysis: Revolutions in Subjectivity* (Routledge, 2011) and *Revolutionary Keywords for a New Left* (Zero, 2017).

David Pilgrim is Honorary Professor of Health and Social Policy at the University of Liverpool and Visiting Professor of Clinical Psychology at the University of Southampton. His publications include *Mental Health Policy in Britain* (Palgrave Macmillan, 2002, with Anne Rogers), *Mental Health and Inequality* (Palgrave Macmillan, 2003, with Anne Rogers), *Understanding Mental Health: A Critical Realist Exploration* (Routledge, 2015) and, the winner of the 2006 BMA Medical Book of the Year Award, *A Sociology of Mental Health and Illness* (Open University Press, 2005, with Anne Rogers). All of this work is approached from the position of critical realism; the philosophy of science and social science is an overarching framework in relation to any topic. Currently, he is writing a book on child sexual abuse and public policy.

Jo Rose is an Associate Lecturer in Humanitarian Response and the deputy programme leader of the Masters in International Humanitarian Affairs at the University of York. Jo has worked intensively in complex political emergencies including Liberia, Somalia, South Sudan and Sudan. Her ongoing work on community involvement in the delivery of humanitarian aid seeks to shape future practice and policy on humanitarian interventions in disasters and conflicts. Jo focuses on understanding community and local stakeholder engagement in humanitarian responses and

Notes on contributors

development programmes. She has conducted major evaluations and research in Kenya, Liberia, Mozambique, Somalia, South Sudan, Sudan, Tanzania and, most recently, Afghanistan.

Stefan Sjöström is Associate Professor in Social Work and Senior Lecturer in Sociology at the University of Umeå, Sweden. He has conducted research on mental health issues for over 25 years. His primary focus has been on coercive practices, where he has researched clinical practice and legal protections in courts, as well as policy formation on a national level. He has also written about supporting practices for people with long-term mental illness in home-like settings and is currently involved in a project about new trends among service-user movements.

Phil Thomas is an author of four books on philosophy and mental health, and is probably best known for his writing with Pat Bracken on postpsychiatry. Until recently, he was a volunteer with a charity in Halifax that helps refugees and asylum seekers rebuild their lives. He was also chair of Sharing Voices Bradford, a charity that works with people from diverse communities with mental health problems. In a previous life, he was a consultant psychiatrist for over 20 years and a founder member and co-chair (until 2010) of the Critical Psychiatry Network. From 2006–9 he was Professor of Philosophy, Diversity and Mental Health at the University of Central Lancashire, and from 1998–2003 he was a judge for the national Mental Health Media awards sponsored by the *Guardian*.

Sami Timimi is a consultant child and adolescent psychiatrist and director of medical education in the National Health Service in Lincolnshire, as well as a Visiting Professor of Child Psychiatry and Mental Health Improvement at the University of Lincoln. He writes from a critical psychiatry perspective on topics relating to mental health and childhood and has published over 100 articles and tens of chapters. He has also authored four books, co-edited four books and co-authored two others on topics such as ADHD, autism and culture.

Alison Torn is Senior Lecturer at Leeds Trinity University, where she teaches social psychology and critical mental health. Prior to this, she spent nine years working as a psychiatric nurse, followed by eight years at the universities of Leeds and Bradford, as a qualitative researcher on health-related projects. Her doctorate used a narrative analytic approach to explore first-person accounts of madness, examining the relationship between identity, social positioning and recovery. She has published articles relating to nursing, mental health and narrative psychology. Current projects include: narratives of resistances to psychiatry, and narratives of paranormal and spiritual experiences.

Emma Tseris is a Lecturer in social work and policy studies at the University of Sydney, where her research and teaching areas include: the social construction of mental illness; mental health and social justice; and mental health in relation to gender inequality, therapeutic governance and responsabilisation. Her doctorate thesis was entitled 'Diagnosing distress? Psychiatric and therapeutic constructions of "traumatized" young women'.

Jane M. Ussher is Professor of Women's Health Psychology at the Centre for Health Research at Western Sydney University, Australia. Her research focuses on examining subjectivity in relation to the reproductive body and sexuality, and gendered experience of mental health. She is editor of the Routledge *Women and Psychology* book series and author of a number of books, including, most recently, *The Madness of Women: Myth and Experience* (Routledge, 2011). Her current research focuses on understanding and developing interventions for premenstrual distress,

sexual health in refugee and migrant women, sexuality and fertility in the context of cancer, and LGBTI experiences of cancer.

Kevin White is Reader in Sociology at the Australian National University (ANU). He has held previous appointments at Flinders University, Wollongong University and Victoria University of Wellington, New Zealand. He has published widely in the sociology of health, with five authored books, seven edited collections and over 50 refereed papers. At the ANU he lectures the large introductory class, 'Analyzing the social world: an introduction to social psychology', as well as teaching 'Classical social theory', 'Qualitative research methods' and 'The sociology of health and illness'.

Owen Whooley is an Assistant Professor of Sociology at the University of New Mexico. His research focuses on medical professionals – specifically how they make and maintain claims to expertise. He is author of the book *Knowledge in the Time of Cholera: The Struggle over American Medicine in the Nineteenth Century* (Chicago, 2013) and is currently writing a book on the history of the American psychiatric profession.

Preface

My attendance and participation at sessions on mental health at sociology conferences over the past few years have not been terribly happy experiences. Chuck a rock in these rooms and you will hit a researcher, postgraduate student or scholar who sincerely believes they are progressing knowledge by regurgitating the latest social correlates on mental illness (inevitably concluding that gaps in mental health services, targeted at the disadvantaged, desperately need filling). If you are lucky, that person will even have a theoretical justification to support his or her research, though this is becoming rare. So this is the cutting edge of the sociology of mental health in the twenty-first century – an almost entirely theory-free desert of over-qualified social workers in disguise.

Of course, this lack of critical engagement from my colleagues would certainly not be such a concern if the key questions that have hung over the psychiatric profession and the mental health system had now been solved – for instance, if they knew precisely what mental illness was; if they had found the causation for the focus of their expertise; if they could effectively treat mental illness; if they could accurately measure mental disease in the population; or if they could predict future cases of the disease with accuracy and certainty. Yet these answers – and many more – continue to elude the field, as they have done for over 200 years. Thus, there clearly remains a need for critical perspectives and critical approaches with which to problematise the system of mental health (despite how it might appear to your average sociology of mental health session attendee). In fact, given not only the continued existence of mental health services, but also their expansion over the last few decades, I would go further and state that – in the name of furthering our knowledge and understanding of key issues within the mental health field – health and social scientists have *a duty to the public* to think critically in this area.

So, for all my unhappiness at those conference sessions, it did facilitate the germination and eventual production of this collection. My aim has been to construct a resource which offers considerable breadth – the collection should act as a reference book for postgraduates, researchers, professionals and scholars of mental health to demonstrate the many diverse positions and possibilities that ‘critical approaches’ can offer. Through the *Routledge Handbook* series, it hopefully gives this critical work a mark of quality and permanence that cannot so easily be ignored by either the academy or mental health professionals. More broadly, the book demonstrates that thinking critically about mental health and illness is not as rare as your teachers, supervisors or colleagues may think: that it happens across the disciplines (among psychiatric practitioners as much as sociologists), and that problematising these issues does not (necessarily) make you an ‘antipsychiatrist’. And, finally, if there is a more selfish aim for putting this collection together, it is the hope that we – academics, researchers, students, practitioners – will spend more time in the future debating the many critical issues raised in this book, rather than pretending that they simply do not exist. These will be discussions, forums and even sociology conference sessions that I can look forward to!

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List of abbreviations

AAP	American Academy of Pediatrics
ABA	applied behavioural analysis
ACT	assertive community treatment
AD	Asperger's disorder
ADD	attention deficit disorder
ADHD	attention deficit/hyperactivity disorder
APA	American Psychiatric Association★
ASD	autism spectrum disorder
BBC	British Broadcasting Corporation
BPD	borderline personality disorder
CAMH	Centre for Addiction and Mental Health
CAPA	Coalition Against Psychiatric Assault
CBSD	community-based system dynamics
CBT	cognitive behavioural therapy
CME	continuing medical education
CPA	Climate Psychology Alliance
CPN	Critical Psychiatry Network
CR	critical realism
CSA	child sexual abuse
DMDD	disruptive mood dysregulation disorder
DRG	diagnostic related groups
DSM	<i>Diagnostic and Statistical Manual of Mental Disorders</i>
DTCA	direct-to-consumer advertising
EBM	evidence-based medicine
ECT	electroconvulsive therapy
EDH	ego-dystonic homosexuality
EMDR	eye movement de-sensitisation and reprocessing
EU	European Union
FDA	Food and Drug Administration
FPN	Free Psychotherapy Network
FSD	female sexual dysfunction
GAD	generalised anxiety disorder
GD	gender dysphoria
GID	gender identity disorder
GMH	global mental health

GST	general systems theory
HPD	histrionic personality disorder
HSDD	hypoactive sexual desire disorder
ICD	International Classification of Diseases
IPA	International Psychoanalytical Association
IQ	intelligence quotient
JCMIH	Joint Commission on Mental Illness and Health
LGBT	lesbian, gay, bisexual and transgender
MDD	major depressive disorder
MGMH	Movement for Global Mental Health
mhGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
MND	mild neurocognitive disorder
MRI	magnetic resonance imaging
NAMI	National Alliance for Mental Illness
NAS	British National Autistic Society
NGO	non-governmental organisation
NICE	National Institute for Health and Care Excellence
NIMH	National Institute of Mental Health
NSAC	National Society for Autistic Children
ODD	oppositional defiant disorder
OECD	Organisation for Economic Co-operation and Development
PCSR	Psychotherapists and Counsellors for Social Responsibility
PMDD	premenstrual dysphoric disorder
PMS	premenstrual syndrome
PMT	premenstrual tension
PTSD	post-traumatic stress disorder
RDoC	Research Domain Criteria
SAD	social anxiety disorder
SADS-L	<i>Schedule for Affective Disorders and Schizophrenia-Lifetime</i>
SDNOS	sexual disorders not otherwise specified
SMI	serious mental illness
SNP	single nucleotide polymorphism
SOC	standards of care
SRC	Scientific Review Committee
SSI	Supplemental Security Income
SSDI	Social Security Disability Insurance
SSRI	selective serotonin reuptake inhibitors
TBA	traditional birth attendant
TD	transvestic disorder
TF	transvestic fetishism
UCLA	University of California, Los Angeles
UK	United Kingdom
UN	United Nations
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations International Children's Emergency Fund
US	United States
USSR	Union of Soviet Socialist Republics

List of abbreviations

WHO	World Health Organization
WPATH	World Professional Association for Transgender Health

(*to distinguish the American Psychiatric Association from the American Psychological Association, the full name for the latter is always given in the text)

Introduction

The importance of critical approaches to mental health and illness

Bruce M. Z. Cohen

The primary purpose of the *Routledge International Handbook of Critical Mental Health* is to provide a one-stop source manual for students, scholars, researchers and professionals with which to systematically problematise the field of mental health. While this is not the first book to review a variety of critical positions in the area (for example, see Coppock and Hopton 2000), no previous text has offered the extensive range of different theoretical perspectives and critical analyses of topics which are collected together here. The main reason for producing such a resource now is to address the contemporary lack of systematic critical thinking on the practices, priorities and knowledge base on which psychiatric and related professionals lay claims to expertise on mental health and illness. The first part of this chapter takes a brief look at the history of critical work within the area, along with the recent 'retreat' from critical thinking and the dominance of conservative approaches, as well as the main arguments why such positions need to be challenged now more than ever. The second part of the chapter introduces the reader to each section and chapter of the book in turn, from the theoretical positions at the front-end of the collection, to the critical investigations of talk therapy which conclude the volume.

The foundations of critical work on mental health

The 1960s and 1970s can be considered a high point of critical theorising on the subject of mental health, with the development of labelling, social constructionist and antipsychiatric positions. While structural functionalists had previously theorised illness as a form of social deviance (see, e.g. Durkheim 1952; Parsons 1951), it was labelling theorists (see, e.g. Goffman 1961; Scheff 1966) who first highlighted the arbitrary nature in which professionals applied designations of 'mentally ill' to people and then judged their subsequent behaviour on the basis of such 'labels'. The research of labelling scholars significantly challenged the contemporary view of the mental health system as a relatively benign, medical enterprise; the view of psychiatric professionals as having an objective and neutral role in the treatment of their patients changed and, instead, issues were raised regarding power and inequality within the negotiation of what constituted classifications of 'mental illness' and how they were applied.

The view of labelling scholars that psychiatrists were ultimately 'moral entrepreneurs' responsible for labelling groups of social deviants (such as the poor, the working class, ethnic minorities,

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homosexuals, unmarried mothers and so on) with forms of mental illness proved highly influential to both Thomas Szasz's 'social constructionist' position and R. D. Laing and David Cooper's 'antipsychiatric' understanding of the mental health system. Szasz (1962, 1974) widened the analysis from labelling scholars through highlighting the lack of scientific evidence for mental illness and suggesting that the main purpose of the mental health system was, instead, the ideological control of deviant populations by state authorities. It was in the interests of both the government and the psychiatric profession, he argued, that such populations were incarcerated in psychiatric institutions and subordinated through 'treatments' such as drugs and electroconvulsive therapy (ECT). At its most radical, antipsychiatry shared a not dissimilar view, although rather than Szasz's libertarian approach, Cooper and Laing took inspiration from Marxism and existentialism to theorise their own psychiatric profession as agents of the state, responsible for the social control of those who would not (or could not) conform to the alienating tendencies of capitalism (see, e.g. Cooper 1967; Laing 1964, 1967).

The retreat from critical investigations

Together with the work of Michel Foucault (1967), labelling, social constructionist and antipsychiatric positions had a profound influence not only the academy but among practitioners themselves, as well as the growing user/survivor movement. As will be evidenced in this book, this early scholarship laid much of the foundation for the critical work on mental health that has followed. Some of the concepts from this work are now widely utilised both inside and outside medicine, including stigmatisation, labelling and medicalisation (which emerged from the social constructionist work on medical imperialism, see, e.g. Illich 1976; Zola 1972). Nevertheless, since the 1980s, there has been a growing reticence among scholars within the social and health sciences to be associated with, or even refer to, such positions in their work. Instead, we have seen a return to the dominance of conservative theory. Under this umbrella we can include various 'social causation' approaches including stress theory and strain theory (for example, see Cockerham 2017: 99–107, 114–20). Following Durkheim's (1952) structural functionalist theorising of the increasing rates of suicide as a result of the breakdown in the shared norms and values of society, such approaches, at best, recognise mental illness as being structurally caused. Yet, more usually, societal structures and processes are ignored by this dominant mode of sociological thought in favour of micro-analyses of socio-economic demographics that leave people more vulnerable to mental illness such as family structure, housing conditions, local environment, working conditions, income levels and so on.

Meanwhile, sociology textbooks have come to underscore this waning enthusiasm for critical approaches to mental health and illness with poorly outlined sections on 'sociological theories' which barely make mention of more than a single critical approach – usually labelling theory, sometimes social constructionism. A symbol of the growing ignorance of different critical approaches within the social sciences is the inclusion of the 'antipsychiatry' category by some textbook writers, in which it appears that any critical scholar on mental illness can be placed. This demarcation is made under the highly problematic assumption that thinking critically about the area of mental health now makes one, by default, 'antipsychiatry' (meaning to be fundamentally opposed to psychiatric professionals and the mental health system in general, rather than to be followers of the specific 'antipsychiatry' position promoted by Laing and his colleagues) – a falsification that one might expect to find in handbooks of psychiatry rather than sociology texts. Though far from non-existent in the contemporary environment, critical scholarship has certainly been pushed to the margins of debates within the social and health sciences in favour of more 'pragmatic' issues such as evaluating the impact of 'community care' policies, researching

the levels of mental health problems within the general population, studying the growth of user/consumer advocacy movements or evaluating the changing relationships between different groups of mental health expert outside the institutional setting.

Why have we witnessed a retreat from critical interrogations of the mental health system over the past few decades? One potential factor is that, just like public psychiatry, due to de-institutionalisation in 1970s, critical scholars lost their institutional base (that is, the psychiatric hospital) which had so often been the source of their theorising and fieldwork. It is also possible that some felt that the end of institution signified the end of the problem (and thus, the end of their research within this area). However, I believe that the more significant issue concerns the changing nature of the academy with the rise of neoliberalism from the 1970s onwards: as a result of changing education and research policies, competitive funding streams became increasingly important for universities, meaning that university management has, over time, become more prescriptive in directing (we might say dictating) academic workers to specific forms and styles of research. The populist discourse that, as public institutions, universities should be 'rewarded' for carrying out 'socially useful' research eventuates in pushing academics towards projects which demonstrate tangible 'benefits' (including those that can be easily measured, such as epidemiological studies) rather than highlight fundamental problems within social systems, institutions and structures. The obvious implication of these changes is that theoretical work – especially critical investigations – are not rewarded by funding bodies and are discouraged by university management. As I have stated elsewhere (Cohen 2016: 27–8), it has got to the stage now where the neoliberal university system is actively and forcefully scaring colleagues off theoretical and critical work for fear of being targeted by management as 'unproductive' and 'uncooperative' workers.

The urgency for critical thinking

There would, of course, be no pressing need to continue to problematise the mental health system if substantial progress had been made by mental health experts within the last 40 years. The striking reality, however, is that little has been achieved in that time – the 'science' of mental illness is as contested as it was in the 1970s. The evidence available suggests a clear set of continuing problems with the knowledge base on which mental health professionals lay claim to a growing expertise, and thus there remains good reason – particularly in the current environment of expanding mental health jurisdictions – why we need to think critically about the practices and priorities of the contemporary system of mental health. This evidence is reflected upon and added to by the scholars in the current volume, but the key issues (for further details, see, e.g. Burstow 2015; Cohen 2016: 9–17; Whitaker and Cosgrove 2015) can be briefly summarised here as:

- the causation for any mental illness has yet to be established;
- psychiatrists and other mental health experts cannot yet agree with any preciseness on the type of mental disease a person has, or indeed whether they are mentally ill or not;
- no 'treatment' (drugs, ECT, therapy and so on) has been proved to work on specific symptoms of a mental illness, or as an ultimate 'cure' for a mental illness;
- future cases of mental illness cannot be accurately predicted by mental health experts.

It follows from this summary that social and health scientists, now more than ever, need to engage and take seriously critical perspectives on the mental health system. Fundamentally, this is the reason why this collection has been produced: to demonstrate the wide variety of ways

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in which we can better make sense of the purpose of a part of medicine which has produced so little of substance to improve the health and well-being of the general population. In doing so, it has been necessary in this collection to approach the notion of being ‘critical’ in its broadest sense – namely, as challenging the common sense, taken-for-granted view of what mental illness is, what the mental health system does and the purpose of different groups of mental health professionals within that system. In separating ‘conservative’ from ‘critical’ approaches here, a fundamental demarcation is made through the ability of the latter to problematise the mental health system, including the knowledge base and practices of mental health experts. Each author in this book demonstrates a critical scepticism in engaging with their topic or theoretical approach as informed by the evidence (or lack of it) summarised above. That said, it will quickly become apparent to the reader that we do not all share the same point of view or positionality on the subject – for example, while some of us are radical scholars who argue for abolition, many others would prefer to be considered as pragmatists who can see the potential for a socially just mental health system in the future. This is probably less of a surprise when one considers the diversity of backgrounds brought together in this volume: almost half the writers are former or current mental health professionals, a similar number are scholars based in sociology, social work or a related area, while the remainder are scholars from a variety of disciplines including cultural studies, education sciences, anthropology, philosophy and development studies.

As summarised in more detail below, the book consists of six parts, with the first part outlining 12 distinct theoretical perspectives on mental health, from labelling and Marxist theory to queer theory and mad studies. The five subsequent parts consist of three to four chapters each which critically investigate the key topics: ‘critical histories of psychiatry’, ‘medicalisation and pharmaceuticalisation’, ‘the politics of diagnosis’, ‘colonial and global psychiatry’ and ‘critical approaches to therapy’. In total, the collection consists of 29 original contributions from 37 mental health scholars based in eight different countries (mainly from the UK and North America, but also Australia, Germany, Ireland, New Zealand and Sweden).

Part I: Theoretical perspectives

Stefan Sjöström (Chapter 1) appropriately begins the first part of the book with a reflection on ‘Labelling theory’ – a critical approach which he rightly states has been one of the most influential in understanding mental illness as a social phenomenon. Through outlining Thomas Scheff’s classic work, *Being Mentally Ill: A Sociological Theory* (1966), the objectivity of the mental health system – and with it, mental illness as a fixed disease entity – is questioned. Sjöström takes the reader through each of Scheff’s nine propositions on labelling to detail how designations of ‘mental illness’ confer a form of medical social control on groups of rule-breakers. The mentally ill, it is argued, are social deviants who have been successfully labelled as such; psychiatrists perform a pivotal role here as *moral entrepreneurs*, policing behaviour which is judged as socially unacceptable. Thus, unlike conservative theories, labelling theory begins to problematise the work of mental health professionals as well as the ultimate purpose of the mental health system. It also, importantly, introduces a more relativist view on the nature of mental illness itself. These ideas are strongly reflected, and taken further, in the two chapters that follow, on social constructionism and antipsychiatry, respectively.

Bringing together the work of R. D. Laing, Michel Foucault and Thomas Szasz, Kevin White demonstrates in his chapter (Chapter 2) on ‘The social construction of mental illness’ that the relativist view garners substantial weight from considering both the continuing lack of scientific evidence for the causation of mental disease and the use of such designations by the mental health system to label the less powerful as deviant and in need of ‘treatment’ (including women,

the poor and migrant groups). The conclusion, he argues, follows Szasz's famous proclamation that we have to consider mental illness as a 'myth' – something that can only ever be constituted as a form of social and ideological control by state authorities. The logical conclusion of these findings is outlined in Bonnie Burstow's chapter (Chapter 3), "'Mental health" praxis – not the answer: a constructive antipsychiatry position', where the case for abolition of the mental health system is forwarded. Contrary to the common perception that many maintain of the 'antipsychiatry' position forwarded by scholars such as Laing and Cooper in the 1960s and 1970s, Burstow notes that there still remained a commitment in their work to a variety of 'treatment' alongside social restructuring. In contrast, '[w]hen employed by activists today', she states, antipsychiatry 'generally denotes a Szaszian critique combined with a commitment to abolition'. The chapter not only rehearses the arguments of psychiatry as an unscientific, unethical, violent and, ultimately, oppressive institution, but also goes further in recommending practical ways in which we might understand differential experiences and behaviour, develop a 'mad literacy' and live without the pathologising labels handed down by the mental health system.

While Michel Foucault's work has been highly influential on social constructionist and antipsychiatry perspectives (indeed, he has at times been falsely accused of following one or other of these positions), Simone Fullagar's chapter on 'Foucauldian theory' (Chapter 4) takes us beyond such approaches to 'engage with poststructuralist debates that emphasise how power works through discourse to shape knowledge and subjectivity'. The discussion highlights the appealing quality of Foucault's ideas for many critical scholars in considering the mental health system as an increasingly important site for the surveillance and regulation of the subject within Western society. However, as Fullagar demonstrates through the application of the concept of 'biopower' to women's accounts of antidepressant use, the inscribing of such a biomedical discourse on the body can have both positive (e.g. the emancipation of the self) as well as negative effects (e.g. the stigmatisation of femininity). Power, for Foucault, has the potential to flow in both directions, not only top-down. It is a conclusion that is not supported in my own chapter on 'Marxist theory' which follows Fullagar's. It is the structural grounding of the business of mental health within the economic dynamics of capitalist society that I believe gives Marxist analysis the explanatory advantage over other theoretical positions. The chapter (Chapter 5) shows that, historically, the mental health system has been responsible for profit accumulation as well as the social control of problematic populations. With neoliberalism, however, I argue that the expansion of mental health expertise and discourse beyond the institution can be understood as the proliferation of (ruling-class) neoliberal ideology in which the socio-political realities of capitalism are increasingly individualised and medicalised by the psy-professions.

Sami Timimi's (Chapter 6) chapter on 'Critical cultural theory' continues the analysis of neoliberalism, concentrating on the discourses of 'scientism, competition and commodification', which he argues lead to the increased labelling of (especially) young people with diagnoses such as attention deficit/hyperactivity disorder (ADHD), autism and depression. Unlike Marxist theory, however, he suggests that a lasting solution to this form of medicalisation is possible without revolution – professional and user resistance to diagnostic labels, the development of authentic, evidence-based paradigms and the move towards a more cooperative form of economy and politics (at both the micro- and macro-levels) can all help to improve mental health outcomes. Timimi's argument is followed by David Pilgrim's cautionary discussion (Chapter 7) on the limits of social constructionism in his 'Critical realism and mental health research' chapter. A philosophical and empirical contemplation of social reality, critical realism (CR) argues while there is a continuing lack of evidence for observed states of 'mental illness', there is 'more to reality than the empirical'. This Pilgrim demonstrates through a comparison of psychiatric diagnosis and the study of sexually abused children; while the former lacks empirical credibility

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but is driven into existence by external interests (for example, the psychiatric profession and big pharma), the latter has an underlying evidence base – one which cannot be considered as simply ‘socially constructed’ – though, for a long time, it has been hidden from public view. Thus, the chapter forces critical scholars to contemplate the limits of taking a purely relativist position on mental health and illness.

Chapters 8–10 critically theorise the mental health system as a site of oppressive practice against women, ethnic and sexual minorities, respectively. Jane Ussher (Chapter 8) eloquently argues in her chapter, ‘A critical feminist analysis of madness: pathologising femininity through psychiatric discourse’, that the mental health system has held a historically important role in medicalising women’s emotions and behaviours through the designation of patriarchal labels such as hysteria, borderline personality disorder (BPD) and premenstrual dysphoric disorder (PMDD). It is noted that women remain over-represented as the victims of such negative labelling and ‘treatment’ practices, suggesting the need to consider psychiatric discourse as a system of knowledge production which legitimates male domination. A similar set of conditions are considered on the subject of race and ethnicity in Roy Moodley, Falak Mujtaba and Sela Kleiman’s chapter ‘Critical race theory and mental health’ (Chapter 9). The authors note a strong racist component that has run, almost continuously, through psychiatric theory and practice since the birth of the asylums in the nineteenth century. As a profession which remains dominated by white, middle-class males, it is shown how ethnic minorities have often been ‘racialised’ and essentialised by the mental health system as more susceptible to mental illness (something that has been reinforced by psychiatry’s continued reliance on reductionist, biological theories of mental disease). In contrast, Shaindl Diamond (Chapter 10) reflects on the changing position of queer and trans communities within the mental health system in her chapter ‘Trapped in change: using queer theory to examine the progress of psy-theories and interventions with sexuality and gender’. While acknowledging the often dark history of psychiatry’s engagement with the issues of sexuality and gender (as also outlined in Chapter 8) – culminating in the classification of homosexuality as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until 1973 – and the tendency of the mental health system to police gender binaries and promote heteronormativity, she also considers the potential for mental health services to be more holistic and inclusive in meeting the needs of queer and trans communities in the future. The system often pathologises such communities but, she argues, it also holds the potential to be life-saving as well.

The final two chapters in the first part of the book offer critical approaches on mental health and illness from quite different positions – the first from within psychiatry and the second from those associated with mad activism/academia. In their chapter ‘Reflections on critical psychiatry’, Pat Bracken and Phil Thomas (Chapter 11) offer a useful introduction to exactly what critical psychiatry is and its five critical dimensions (namely, ontological, epistemological, empirical, ethical and political). The fundamental problem with the mental health system today, the authors claim, is the following of a ‘technological paradigm’ – a model of human behaviour that conceptualises mental health problems as caused by faulty biology or cognitions, with no consideration given to experience or context. This reductionist view of human behaviour has served psychiatry poorly and caused much harm. Instead, Bracken and Thomas call for a return to the potentially revolutionary version of the ‘recovery approach’, as originally espoused by the service user movement. Appropriate then, that this discussion is followed by Rachel Gorman and Brenda LeFrançois’s chapter on the burgeoning area of ‘Mad studies’ (Chapter 12), the unapologetic centring of critical epistemologies (including many of the theoretical positions already surveyed in this part of the book) by those who have been deemed ‘mad’. In the words of the

authors, '[m]ad studies takes social, relational, identity-based, and anti-oppression approaches to questions of mental/psychological/behavioural difference, and is articulated, in part, against an analytic of mental illness'. As well as surveying developments and emerging issues within the area, Gorman and LeFrançois consider the potential for a unitary 'mad theory' to develop out of the eclectic mix of critical approaches that have inspired mad studies scholars and activists; they remain cautious on the subject, stating, '[a]t its best mad theory may help to elucidate and address some of the specific contours of broad concepts like "settler colonialism"'. At its worst, mad theory may reinforce white middle-class identity politics by valorising and recuperating less dominant white subjectivities.'

Part II: Critical histories of psychiatry

The second part of the book grounds the mental health system in four socio-historical analyses which allow us – unlike the official accounts of the history of psychiatry (see, e.g. Lieberman 2015; Shorter 1997) – to further problematise the area. The first of these, Tomi Gomory and Daniel Dunleavy's chapter on 'Madness: a critical history of "mental healthcare" in the United States' (Chapter 13) profiles the appropriation of the age-old 'madness' moniker by the medical profession and its transformation into the supposed scientific discourse of 'mental illness'. As the authors discuss, the 'advancement' of the psychiatric profession has not been due to securing the validity of the claim that madness is, in fact, a medical disease, but rather through their identification of deviant and problematic populations, and constructing methods of coercion and control 'under the cover of medicine'. The repositioning of human experience, emotions and behaviour under the psychiatric gaze is further illustrated in Alison Torn's fascinating chapter on 'Medieval mysticism to schizoaffective disorder: the repositioning of subjectivity in the discourse of psychiatry' (Chapter 14). Recounting the spiritual and physical journey of Margery Kempe from over 600 years ago, Torn discusses how this controversial historical figure has been retrospectively labelled by psychiatry as suffering from 'psychosis'. Through contemplation of scholarship from both Foucault and the Russian literary theorist Mikhail Bakhtin, the author in turn questions the denial of individual experience and meaning in the wake of a biomedical model which has come to dominate subjectivity.

The latter two chapters in this second part of the collection focus more closely on theorising the physical institutions of psychiatric confinement. Damien Brennan's discussion on 'The myth of the Irish insanity epidemic' (Chapter 15) investigates why, by the mid-1950s, Ireland had the highest rate of psychiatric incarceration in the world. In the process, the author debunks both the biological reductionist arguments of former colonial powers as to the supposed inherent nature of the Irish character, as well as the 'grand narratives' on psychiatric institutionalisation (and, subsequently, de-institutionalisation) from scholars such as Foucault and Andrew Scull. Outlined in detail by Brennan, the evidence from the Irish case forces us to think beyond the processes of industrialisation, religious authority, colonialism and independence, as well as changing mental health care policy, in considering why institutional populations dramatically rise and eventually fall in any given society. It is, however, the latter process – aided by 'de-institutionalisation' policies in the mid-twentieth century – that Gil Eyal (Chapter 16) argues is ultimately responsible for the current autism 'epidemic'. That is, as the institutions holding those children considered as 'mentally retarded' are closed down, the previously rare psychiatric classification of autism is utilised to encompass a much wider range of now mainstreamed children experiencing various 'developmental' or 'learning' difficulties. Eyal's thoughtful chapter on 'Autism looping' suggests that this process of category expansion should not be considered simply as a case of medical imperialism, but rather as the result of 'looping', which, at various historical points, has involved

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both professionals and parents in negotiation on the changing classifications and forms of ‘treatment’ for those now considered to be on the autism spectrum.

Part III: Medicalisation and pharmaceuticalisation

With the continuous expansion in the number of mental illness classifications given in the DSM, the mental health field has become an increasingly important focus for medicalisation scholarship. Meredith Bergey appropriately begins the third part of the book with a thorough introduction to the topic in her chapter ‘The changing drivers of medicalisation’ (Chapter 17). She reminds us that while the process of medicalisation (where ‘previously non-medical problems become defined or treated as medical conditions’) is often associated with medical imperialism, the social control of deviance and the de-politicisation of social problems, it has the potential to serve a positive function as well (such as highlighting new health-related concerns, reducing stigma and removing individual blame and responsibility). At the same time, the ‘drivers’ of medicalisation within the mental health area, she cautions, are increasingly to be found outside medicine itself – particularly with pharmaceutical corporations, who have an increasing influence on diagnostic expansion alongside the marketing of drug treatments for such conditions. This is perfectly demonstrated in Annemarie Jutel and Barbara Mintzes’s case study on the medicalisation of female sexuality (Chapter 18) and the construction of female hypoactive sexual desire disorder (HSDD), where the promise of a ‘pink *Viagra*’ means that research and marketing activities on ‘low’ female libido are dominated by pharmaceutical multinationals such as Procter & Gamble and Boehringer Ingelheim rather than independent mental health research institutions. However, the authors’ discussion in ‘Female sexual dysfunction: medicalising desire’ also highlights the involvement of grassroots women’s organisations in promoting the legitimacy of HSDD as a feminist issue – something which adds an additional layer of complexity in considering the drivers of medicalisation.

The querying of a single source or ‘driver’ for medicalisation is further contemplated in Emma Tseris’s analysis of ‘Biomedicine, neoliberalism and the pharmaceuticalisation of society’ (Chapter 19). Instead of conceptualising the ‘diagnostic creep’ in the DSM as a result of the increasing power of big pharma alone, she argues that it is the neoliberal preoccupation with the individual that has laid the crucial groundwork for biomedical accounts of distress to triumph in contemporary society. Disguising the wider socio-economic conditions of neoliberalism, ‘mental illness classification, and the prescription of pharmaceutical solutions’, claims Tseris, ‘should not be viewed as an unbiased, scientific process, but rather as a process arising within particular social contexts that elevate specific types of personhood as “normal”’. Psychiatric medicalisation within neoliberal society, then, becomes a thoroughly politically enthused process.

Part IV: The politics of diagnosis

How the psychiatric and associated professionals conceptualise, rationalise and utilise diagnostic constructions in their work, in spite of the continuing gaps in their knowledge on mental illness, is the focus for the fourth part of the book on the politics of diagnosis. In his chapter on ‘The DSM and the spectre of ignorance: psychiatric classification as a tool of professional power’ (Chapter 20), Owen Whooley investigates how American psychiatry has sought to manage and rationalise its ignorance of mental disease through four decades of nosological (medical classificatory) reform in the DSM. Comparing the construction of the DSM-III to the DSM-5, Whooley notes that it is the rhetoric of a ‘paradigm shift’ progressed by DSM committees that can aid

the maintenance of psychiatric ignorance and stave off periods of ‘existential crisis’. However, the usefulness of such a strategy, he suggests, has perhaps come to an end with the disastrous recent attempt to address the ‘validity question’ (of mental disease) by the DSM-5 committee. ‘Psychiatry can only carve and recarve, define and redefine, the poorly understood universe of mental disorder so much’, Whooley acknowledges, ‘before outsiders begin to suspect that it is merely rearranging deck chairs. Eventually the interpretive, extra-scientific dimensions of this strategy become evident.’

The broader issues with, and implications of, psychiatry’s increasingly fragile claims to knowledge and expertise on ‘mental illness’ are taken up by David Cohen, Tomi Gomory and Stuart Kirk in their discussion of ‘The attributes of mad science’ (Chapter 21). The authors outline in detail the ongoing problems of reliability and validity which have haunted the constructions of each edition of the DSM, as well as the regular distortions of double-blind random control trials focused on identifying the aetiology of mental disease. The result is the repeated reporting of false positives by ‘big science’ – supported by the psychiatric profession and big pharma – so as to maintain a biomedical agenda. They conclude that the science of mental illness has been ‘debased’, the only way forward involving a ‘multidisciplinary academic tsunami’ in which the biomedical model is replaced by a focus on addressing ‘deeply troubling behaviours and mood states non-medically’.

To complete the section, Suman Fernando (Chapter 22) offers a prime example of the ease with which categories of mental illness can be used to pathologise minority groups in his discussion of the ‘Racialisation of the schizophrenia diagnosis’. As psychiatry’s ‘sacred symbol’ (Szasz 1988), it is interesting to note how the schizophrenia classification has been so often utilised by the UK and US mental health systems to de-politicise and silence (particularly) young black men. Fernando’s discussion reminds us that the mental health system will tend to reflect the dominant values and norms of that society, and in this respect it is perhaps less surprising that we find evidence of such stereotypical representations of minority groups among experts or, indeed, traces of institutional racism within current mental health practice.

Part V: Colonial and global psychiatry

The work of Fernando (see Chapter 22) is broadened and extended in the fifth part of the book to consider the conceptions of the ‘other’ progressed first by colonial psychiatry and then through Western psychiatric imperialism (given contemporary form through the Movement for Global Mental Health (MGMH)). In ‘The mad are like savages and the savages are mad: psychopolitics and the colonality of the psy’ (Chapter 23), China Mills argues that Western psychiatry has, at various times, been used by the colonial authorities to ‘control, pacify, or eliminate indigenious, colonised and/or enslaved peoples’. In her forceful and persuasive critique of the expansion of psychiatric practices and discourse with colonialism and globalisation, she discusses the continual undermining of local knowledges, cultural differences and political realities due to a Western hegemonic discourse that previously sought to colonise land and now seeks to colonise the mind – MGMH, Mills concludes, ‘naturalises’ inequalities within the Global South through its conception of mental disease as the result of internal mechanisms, rather than as a product of global socio-economic processes.

Mills’s analysis is further illustrated by Janaka Jayawickrama and Jo Rose’s case studies of Western mental health interventions in Western Darfur, Nepal and Syria. Their chapter on ‘Therapeutic imperialism in disaster- and conflict-affected countries’ (Chapter 24) highlights an increasing enthusiasm among Western governments and non-governmental organisations (NGOs) to export mental health services to the Global South in times of crisis; a situation

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which, at best, is met with local amusement and, at worst, denies local coping strategies and seeks to pathologise survivors of war and natural disasters. The current situation of Western agencies ‘parachuting’ in ‘treatment’ has to end, argue Jayawickrama and Rose; instead communities themselves have to take back ownership and responsibility for identifying and developing ‘culturally appropriate interventions’ in times of crisis. Clement Bayetti and Sumeet Jain (Chapter 25) follow Jayawickrama and Rose’s argument by proposing practical ways in which MGMH’s top-down dictates can be altered to bottom-up approaches which emphasise community-based solutions. Their chapter, ‘Problematising global mental health’, discusses the current dominance of biomedical and technical interventions in the ‘global mental health’ arena, but also the potential to subvert this discourse into something empowering and emancipatory for local populations – for example, the utilisation of the narratives of local communities and the importance of genuine co-production of these, they argue, may be essential in generating culturally valid interventions. Bayetti and Jain believe this bottom-up approach could signal a move away from ‘tokenistic’ user engagement by global mental health advocates towards ‘systematically building competency and resilience in individuals and communities’.

Part VI: Critical approaches to therapy

Through utilising a number of critical theories, the sixth and final part of the book problematises ‘talk therapy’ as guilty of – among other things – individualising, de-politicising and pathologising our behaviour, emotions and responses within contemporary capitalist society. It is often assumed that what psychiatry lacks in knowledge of and effective treatment for mental illness can be compensated by turning to therapeutic interventions such as psychoanalysis, group therapy, counselling, cognitive behavioural therapy (CBT) or any of the many other forms of talk therapy currently on the market. Many critics of bio-psychiatry forward therapy as a means to develop a meaningful, trusting and compassionate relationship with clients through which trauma and distress can be successfully addressed and treated (see, e.g. Breggin 1991; Davies 2013). Such well-intentioned – if naive – notions of the true nature of the therapeutic enterprise are challenged here, and book-ended in the final chapter (Chapter 29) with a cautionary tale from the former director of the Freud Archives, Jeffrey Masson.

The problematisation of talk therapy begins with Peter Morrall’s chapter on ‘A sociology of and in psychotherapy: the seventh sin’ (Chapter 26) in which the author argues that – among other ‘sins’ – psychotherapy promotes a ‘cultural narcissism’ among clients, encouraging a ‘selfishness’ in them, as well as a learned ignorance of the wider socio-economic environment which has an impact on their lives. Though Morrall is not fundamentally against therapy (in contrast to, for example, Masson (1994)), he states that, in its current form, it is ‘inherently “asocial” and thereby markedly futile, as well distinctly unethical’. The solution, he concludes, is the establishment of a ‘socially responsible psychotherapy’ which will engage in critical discussion and form social-political alliances with other disciplines with the aim of transforming their practices and fight for social justice.

In the discussion on ‘Marxist theory and psychotherapy’ (Chapter 27) which follows Morrall’s, Ian Parker asks two fundamental questions with regards to the practice of psychotherapy within capitalist society: namely, what role does it play in supporting the circulation and expansion of capital, and in which ways might it be a force that can undermine the capitalist system? A similar point is made to Morrall’s, though framed more centrally by a Marxist understanding of the ‘reification’ of social relations under capital – the promise of psychotherapeutic practice, Parker argues, is that ‘at the very same moment that you are told to give up any hope to change the world, you are encouraged to believe that you can change yourself’. Thus, therapy de-politicises

the inherent inequalities and struggles within society and turns them into individual issues for personal ‘management’ and potential ‘transformation’. However, for psychotherapy to aid true, revolutionary transformation, Parker concludes that it is necessary to link such practices to the wider socio-political struggles against the individualising tendencies of capitalism.

Emma Tseris (Chapter 28) notes similar de-politicising practices in the therapeutic setting to Parker in her chapter, ‘A feminist critique of trauma therapy’. Drawing on critical feminist theory, she argues that trauma therapy for female victims of gender-based violence is not the radical alternative to traditional psychiatric treatment it might at first appear, but rather a further means of reducing ‘complex social justice issues into psychological symptoms, which are then thought to be curable through expert mental health treatment’. Thus, Tseris questions how ‘feminist’ – if at all – the recent move towards trauma therapy within mental health services actually is. She concludes that while such interventions have the *potential* to validate the distress that might be experienced by women after violence, they also have the ability to quickly transform the political into the personal – that is, to turn the issues of gender inequality into private mental ‘dysfunctions’, and thereby victimise women for a second time: a situation, lest we forget, which began at the very beginning of talk therapy with Freud’s abandonment (or suppression) of ‘the seduction theory’, which directed psychoanalysts to view their (mainly female) clients’ claims of sexual abuse as imaginary rather than real. The final chapter of the collection speaks directly to this issue through Jeffrey Masson’s personal narrative, ‘A journey into the dangers of orthodoxy from the former director of the Freud Archives’ (Chapter 29). Though told in detail before (see Masson 1990), Masson’s discussion of his research on Freud’s personal letters and the seduction theory – as well as the reception of his findings from the international psychoanalytical community – always makes for a fascinating read. It also continues to offer highly important insights into the arrogant and dogmatic tendencies of talk therapists. Masson’s own position on therapy remains the same as it was a quarter of a century ago: ‘I was not convinced then, and still am not,’ he concludes, ‘that there are elements of psychotherapy worth preserving.’

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Part I

Theoretical perspectives

Labelling theory

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Labelling theory is one of the most influential theoretical approaches that has been systematically applied to understand mental illness as a social phenomenon. It can be seen as a social constructivist approach with a kinship to notions such as medicalisation, stigma and normalisation. Broadly speaking, labelling theory takes an interest in the social processes whereby certain people are defined as 'deviant' by society. This always involves certain power dynamics, and the labelling is often understood as a form of social control. Groups that in various respects disturb dominant views of social order might be labelled as deviant – for example, 'criminals', 'adulterers' and 'homosexuals'. Since its introduction in the early 1960s, labelling theory has inspired empirical research into a wide variety of mental health issues investigating lay as well as professional settings. Labelling theory has fuelled intense debates regarding both the extent to which it can be verified empirically and what theoretical and epistemological implications it brings about. Furthermore, the specific application of such theory to mental illness has stimulated new theoretical discussions among those interested in labelling theory as part of a more general approach to deviance. This chapter discusses the labelling theory of mental illness as originally presented by Thomas Scheff in 1966, as well as the debates and developments that have followed his work. Within a mental illness context, the discussion of labelling theory has a natural starting point in Scheff's book *Being Mentally Ill: A Sociological Theory* (1966). His work was part of a broader strand of research on labelling and deviance founded in symbolic interactionism. The early contributions were primarily made by scholars interested in crime such as Tannenbaum (1938) and Lemert (1951), but also with other deviant groups in focus such as the classic research on drug takers from Becker (1963).

Deviance and labelling: a general perspective

Perhaps the most influential contribution to the early development of a general labelling theory is Howard Becker's book *Outsiders: Studies in the Sociology of Deviance* (1963). Becker is concerned with the social interactions leading to someone being recognised as a deviant, or an 'outsider'. He notes that this happens when someone violates formal or informal rules. For example, a person who spends a lot of time playing poker may be degradingly called a 'gambler'. Although the identification of deviant behaviour may appear trivial, Becker

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points out that there is vast variation in whether a rule violation leads to the individual being identified as a deviant. Rules are broken constantly and very often without any reaction from others. Nevertheless, Becker noted at the time of writing in the 1960s that the research on deviance had been far more occupied with the people who had broken the rules rather than those who made up and enforced those rules (and, arguably, outside a very limited field of research inspired by labelling theory and similar approaches, the same can be said about research into deviance today). Instead, Becker concluded that deviance should not be regarded as an inherent quality of rule infractions by deviants; the decisive factor determining when someone will be labelled as deviant is the reaction from others. Thus he argues against a strong common sense notion that deviance primarily stems from 'within' the people who break the rules. This position has political implications, since it serves to relativise deviant acts and puts emphasis on the power dynamics involved when certain behaviours, individuals or groups are labelled as deviant. Becker notes that, apart from legal powers, social structures and hierarchies (in terms of ethnicity, social class, gender and generation) form what is constructed as deviance in a given time and place. The negative reactions and potential sanctions to deviant behaviours are mediated through *moral entrepreneurs*, who in turn can be divided into rule creators and rule enforcers. Becker discusses the former in terms of moral crusaders who advocate that certain behaviours are unwanted and should be sanctioned by society. Modern examples of behaviours that have been questioned by moral crusaders include excessive computer gaming and public smoking. If they are successful, the behaviours moral crusaders object to may become viewed as deviant by larger groups in society. For example, clergy in certain Islamic contexts create rules about what clothing is appropriate for women to wear. Under certain conditions, such rules will be enforced widely in a society or subculture. The arbitrariness of such rules is obvious when we consider how the same items of clothes that are prescribed in some cultures may be banned in others. Becker also argues that the actual labelling of a behaviour as deviant can feed back to the rule-breaker in a way that reproduces and reinforces patterns of deviant behaviour. This can be understood in terms of *deviant careers*, where people may adopt a deviant identity, learn how to manage their deviant behaviour (improve it, hide it, rationalise it and so on) and become part of a subculture – all of which reinforces the negative reactions from those representing a 'normal' way of life. Becker argues that, especially with regards to features that define identity (e.g. Afro-American, gay and so on), these mechanisms can be so powerful that the labelling of someone as deviant can produce a self-fulfilling prophecy.

Thomas Scheff on the labelling of the mentally ill

Drawing from the work of Becker and others, Thomas Scheff (1966) then undertakes his comprehensive study of how mental illness can be understood in terms of labelling. His theory of mental illness is contrasted against a medical model which conceptualises the source of mental illness as residing within the individual; consequently, treatment measures aim at modifying internal patterns, whether psychological or neurological. What is unique in how people are labelled as mentally ill, Scheff argues, is the type of rule-breaking that instigates reaction from others. Broadly speaking, there exists a wide variety of more or less well-defined formal and informal rules in society, and people are generally capable of attaching certain types of deviant label to behaviour that breaks those rules. However, there also exists a residue of subtle, often unspoken rules that have no obvious connection to forms of deviance that already have a label. These are what Scheff calls *residual rules*, the rules at stake when someone is labelled as 'mentally ill'. Scheff claims that most features that are viewed as psychiatric symptoms can be regarded as residual

rule-breaking. For example, this would be the case when someone talks back to her internal voices, claims that she is the saviour of the world or insists that her life is so dull and meaningless that even her close family would be relieved if she was dead. Drawing from Goffman's (1963a) work on behaviour in public places, Scheff puts emphasis on the tacit rules governing everyday human interaction. He thus suggests that what Goffman has described as rules of engagement (for instance, not to withdraw too much, having a purpose and so on) qualify as residual rules. In developing his theory, Scheff presents nine fundamental propositions, some quite well grounded in empirical research, some more conjectural:

1. *Residual rule-breaking arises from fundamentally diverse sources.* Scheff differentiates between four distinct types of sources: organic, psychological, external stress and volitional acts of defiance. He shows how this transgresses a limited medical model understanding of mental illness as biological pathology and instead highlights the social sources of stress and volition. For Scheff, military combat or sleep deprivation exemplifies external stress. Other known external stressors include those related to working life and school settings. As for volitional sources, Scheff refers to art movements such as the French impressionists and the Dadaists. A contemporary example of volitional rule-breaking can be seen in forms of body piercing that appear objectionable to the majority.
2. *Relative to the rate of treated mental illness, the rate of unrecorded residual rule-breaking is extremely high.* Scheff cites the then-contemporary literature from the 1960s that indicates how psychiatric symptoms are, in fact, very common in the general population. More recent research seems to affirm this. For example, a large-scale study from Switzerland found that a considerable proportion of the general public displayed 'psychotic' experiences within a four-week period, with 38 per cent reporting that 'someone else can control your thoughts' and 43 per cent 'feeling that you are watched by others' (Rössler *et al.* 2007). This leads to the next proposition.
3. *Most residual rule-breaking is 'denied' and is of transitory significance.* Here, Scheff suggests that the normal response to strange behaviours is to ignore or forget about them without reacting against the rule-breaker. This is what makes labelling theory so powerful – shifting the attention from symptoms themselves to the social responses to rule-breaking as the major determinant of when a person will be diagnosed with a mental illness. This insight can be further corroborated by studies such as Garfinkel's (1967) famous breaching experiments, where he analysed people's reactions when faced with violations of 'background expectancies' or unspoken rules of everyday interactions (such as treating friends and family overly politely as strangers, saying 'hello' at the end of a conversation, bargaining for standard-priced items in a store and so on). Garfinkel found that people typically went to great lengths to normalise and make sense of such strange behaviours, and only imposed moral rejection as a last resort.
4. *Stereotyped imagery of mental disorder is learned in early childhood.* Although Scheff admits that this proposition lacks support in empirical research, it does appear plausible and on a par with what we know about the current negative perceptions of mental illness among the public (Angermeyer and Dietrich 2006), as well as the long history of ideas on madness (Foucault 1965; Scull 2006). The taken-for-granted ideas about madness and mental illness that have been established in Western society are, then, reinforced through contemporary culture.
5. *The stereotypes of insanity are continually reaffirmed, inadvertently, in ordinary social interaction.* Scheff notices how terminology related to mental illness is incorporated in everyday language. Cultural perceptions of mental illness are reproduced through popular culture and

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the mass media as well as ordinary, everyday interactions. The point here is how stable ideas about mental illness become, and how difficult it is to change them due to the variety of ongoing reproduction mechanisms. It is against the backdrop of cultural perceptions about mental illness that people, under certain circumstances, may start to interpret a person's residual rule-breaking as a token of mental illness – the labelling process has thus been initiated. Due to the high prevalence of residual rule-breaking in society in general, there will always be a pool of earlier infractions to look back at and reinterpret in light of the new label; the recent behaviour can be seen as only part of a progress towards insanity. This process is facilitated by the fact that the labelled person, as part of the same culture, draws from the same cultural perceptions as those around her.

The next three propositions deal with how the person labelled reacts on being labelled and how she thus becomes inclined to accept the deviant role:

6. *Labelled deviants may be rewarded for playing the stereotyped deviant role.*
7. *Labelled deviants are punished when they attempt the return to conventional roles.*
8. *In the crisis occurring when a residual rule-breaker is publicly labelled, the deviant is highly suggestible and may accept the proffered role of the insane as the only alternative.*

It may make sense to the labelled person to adopt the classification that others have made. In fact, accepting and adhering to the labelled role may be rewarded. It may open possibilities to solicit help with material matters such as housing and welfare payments. Medical treatments such as tranquillisers can be attractive, and there may also be social and emotional rewards in the social engagement of professionals, family and friends in support of a person who accepts the role of being mentally ill. Conversely, the same benefits may be withdrawn if the label is taken away. Moreover, alternative interpretations and labels of her behaviour may be even more stigmatising – for instance, no one wants to be seen as being evil or stupid. In this context, Scheff highlights the role of 'insight', where a person is encouraged and rewarded when she accepts the ascribed role as being mentally ill. In fact, rejecting the label may even be seen as evidence that the person really is ill. Today, insight remains a key notion in psychiatric decision-making with regards to the involuntary commitment of patients (Diesfeld 2003; Diesfeld and Sjöström 2006; McSherry 2015). Scheff notes that, when residual rule-breaking occurs, there is likely to be some kind of crisis, both for the rule-breaker and the people around her. This will make the rule-breaker inclined to accept new definitions of who and what she is. All in all, there are strong feedback mechanisms that lead people who first might have only received subtle signals for residual rule-breaking to enter a process of labelling attachment and reinforcement. The first eight propositions outlined above form the basis for Scheff's final proposition:

9. *Among residual rule-breakers, labelling is the single most important cause of careers of residual deviance.* (In the second edition of his book, Scheff (1984) relinquished the phrase 'single most important' from this proposition). This last proposition constitutes a serious critique of the medical model and the measures psychiatry applies to treat people labelled as mentally ill. If the problem primarily rests in processes of social definition and exclusion, argues Scheff, surely the methods to resolve the problem should take this into account. This view became a critical component in the various antipsychiatry movements that flourished in the 1960s and 1970s (Cooper 1971; Crossley 1998; Nasser 1995). Within this broad movement objections were raised against the inhumane treatment at large institutions (Belknap 1956;

Goffman 1961), but also against the legitimacy of coercive treatment (Breggin 1964; Livermore *et al.* 1968). Furthermore, the validity of the notion of mental illness was questioned, with the psychiatrist Thomas Szasz (1961) famously arguing that mental illness is 'a myth'. A less radical but still critical approach to diagnosis was taken by those who argued that medical psychiatry failed to acknowledge the psychological and social aspects of mental illness (Jones 1962; Laing and Esterson 1964). Several authors have also connected criticism against biomedical psychiatry to a sociological argument that the primary function of the mental health system is to impose control over deviants rather than benevolently providing help and treatment to people who suffer mental afflictions (Foucault 1965; Horwitz 1982; Scull 1979).

Labelling and stigma

Scheff's work had a close affinity with Erving Goffman's, whose book *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961) became the major symbol for the critique against psychiatric institutions. In many respects, Goffman's ethnographic observations of life at a large mental hospital could be understood in terms of labelling. Goffman also applied a career perspective on patients, noting mechanisms that rewarded patients to remain in a sick role. Perhaps Goffman's most important conceptual contribution relevant to labelling theory is that of 'stigma' (Goffman, 1963b). As with labelling, the notion of stigma addresses general patterns of social interaction involving deviance, but it has particular ramifications with regards to mental health. To Goffman, a stigma is an attribute of an individual that causes those around her to react negatively due to existing stereotypes. There are three types of stigma that are relevant to mental illness designations: stigma based on character traits, physical stigma and group identity stigma. Goffman's main concern is not to analyse how stigma occurs or is socially constructed (in other words, how someone becomes 'labelled' with a stigma). Instead he is preoccupied with the social consequences of stigma and the *stigma management* of deviant individuals and groups. A fundamental condition for stigma management is whether the stigma is apparent to others or not; depending on specific symptoms, a person's mental illness may or may not be visible to others. If the stigma is unknown to others, the stigma-bearer has two options: she may try to 'pass' as normal or she may choose to be open and 'reveal' her stigma. Goffman also distinguishes between different strategies for passing (fabrication, concealment, discretion) and revealing (signalling, normalising, differentiating). In cases where the stigma is visible (or otherwise known) to others, the person can apply compensatory management strategies by 'acknowledgement' (the person openly admits to having a stigma), by 'individuating information' (she emphasises other aspects of herself) and by 'increased positivity' (she makes special efforts to appear friendly, helpful and in other ways socially acceptable). Some definitions of stigma come closer to labelling theory in conceptualising it as a process initiated by a majority group applying negative stereotypes to certain groups or individuals. In the next stage, stigmatised individuals are susceptible to accepting negative stereotypes and prejudices, which then may cause them to withdraw from interaction with others (Link and Phelan 2001; Rüsch *et al.* 2005). Stigmatisation may also lead to the creation of deviant subcultures. Traditionally, it has been rare for people with classic psychiatric diagnoses such as schizophrenia or depression to form positive group identities based on their mental illness label. However, with the expansion of identity politics since the turn of the millennium, the nature of stigma management may be moving more in that direction. Particularly with regards to newer diagnoses such as eating disorders, autism and attention deficit/hyperactivity disorder (ADHD), it appears that patients are becoming more inclined to form a sense of belonging and solidarity with those similarly labelled (Chamak 2008; Koski 2014). Historically,

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the development of such positive group identities has primarily been found in deviant groups outside the mental health field, where those with hearing impairments are often mentioned as the classic example (Solvang 2000).

The concept of stigma is perhaps the sociological notion that has had the most impact on other disciplines that take an interest in mental health. In recent years, the notion has become operationalised into different measurement scales which are used to chart attitudes towards mental illness in the population as well as among professional groups. There is also an increasing interest in designing mental health interventions to reduce stigma and evaluate the effects of such efforts (Rüsch *et al.* 2005; Thornicroft 2006).

Critiques of labelling theory

Scheff's original propositions on labelling did fuel criticism and a debate that intensified into the 1970s. A main protagonist in this debate was Walter Gove, who argued that it was the behaviour of the person rather than interpretive processes that had the decisive impact on whether someone would be diagnosed as mentally ill (Gove 1970, 1975, 1982). Both Scheff and Gove conducted and cited empirical studies in support of their views (Scheff 1974, 1975). Later, Link *et al.* (1989) proposed a modified labelling perspective to accommodate some of the criticisms made of Scheff's theory. They rejected the idea that labelling was a direct cause of mental disorder, but maintained that labelling could lead to negative outcomes. Faced with negative stereotypes and discrimination, claimed the researchers, individuals labelled with a mental illness might endorse strategies of secrecy and withdrawal that adds complexity to their problems.

In reviewing the Scheff–Gove controversy, Holstein (1993) has argued that the different approaches are restricted to empirical evaluation, yet they tend to agree on the same basic assumptions – even if Scheff prioritises societal reaction, he seems to agree with Gove about the existence of observable behaviours and symptoms that are specific to designations of mental illness. This is evident in the methodological design of several of Scheff's studies, where he employs independent psychiatric evaluations as a baseline for investigating the diagnostic practices of clinicians (Scheff 1964, 1966: 155–68). Holstein thus alerts us to a fundamental distinction in how labelling theory has, and can, be understood. The theory has often been interpreted as a radical critique of the very notion of mental illness and the practice of psychiatric diagnosis that shares similarities with Szasz's (1961) idea that mental illness is a myth. This 'hard' version of the theory can be contrasted against a 'softer' alternative which does not question the concept of mental illness, but rather points to the variability and social contingencies involved when some people acquire the label. This difference corresponds to a similar discussion regarding social constructivism and essentialism: when we say that something is socially constructed, do we mean that it does not 'really' exist or merely that the way we capture a phenomenon will always be mediated through social interaction and language (Berg-Sørensen *et al.* 2010)? In Holstein's assessment, Scheff's contribution was not questioning the medical model itself, but rather arguing that it was poorly applied.

The nature of residual rule-breaking is another topic that has generated critical discussion. In his book, Scheff (1966) does not expand on a definition of the nature of residual rules. In fact, his stated definition is somewhat paradoxical. Residual rule-breaking is the kind of norm violation that causes people to identify someone as mentally ill. Yet he defines residual rule-breaking as norm violations that are peculiar in the way that they are not associated to any specific label. One could also object that, in a given society, there are a number of behaviours that people in general would associate with mental illness or madness. For example, the

behaviour of a severely underweight person who starves herself while claiming that she is 'too fat' is likely to be interpreted in terms of an established social category – 'anorexic' – that is shared by professional psychiatrists and ordinary people alike. The examples given in Scheff's own work often concern the breaking of subtle and unspoken rules of everyday interaction (such as looking a conversation partner in the eyes, standing at a proper distance from people and so on). Here, Scheff takes inspiration from Goffman's (1963a) work on social interaction. In the same vein, Smith (1978) has demonstrated the subtleness in the norm violations and interpretations that can be involved when people come to redefine a person as mentally ill. Nevertheless, it seems that a large number – if not most – of acknowledged symptoms of mental illness are not about breaking unspoken rules of everyday interaction (for example, hallucinations, paranoia and suicidal thoughts). Another limitation of Scheff's version of labelling theory is that he developed it mainly by researching severe mental disorders, often in the context of involuntary commitment; within a sample of people diagnosed with schizophrenia, mania or another psychotic disorder, it is possible that the kind of residual rule-breaking Scheff conceives will be more common.

In his preface to the third edition of *Being Mentally Ill* (1999), Scheff reflects on the above criticisms, agreeing with Gove that there is no clear evidence in support of labelling theory and favouring an approach that integrates insights from different disciplines such as sociology, psychology and biology. However, he nevertheless maintains that his theory serves a useful function as part of a more complete understanding of the phenomenon known as 'mental illness'. In this edition, he increases the emphasis on the role that emotions have in the labelling process, particularly those of pride and shame.

The critical potential of labelling theory

During the last couple of decades there has been little discussion of labelling theory within the mental health field and even less empirical research built on its foundations. In a rare retrospective commentary, Scheff (2010) maintains that the theory has had little impact on disciplines other than sociology, or indeed the public at large (Scheff, 1999). However, the reduced interest in labelling theory might not be taken as a sign of empirical and conceptual failure. To some extent, some of its core ideas have been adopted and rephrased by various constructionist approaches to mental illness and psychiatric practice. The flourishing empirical research on stigma is one example: other such perspectives are medicalisation (Conrad and Slodden 2013), various forms of discourse and narrative analysis (Berring *et al.* 2015) and even, to some extent, postmodern, deconstructivist perspectives (Arrigo 1996). The virtue of such approaches lies in the analytical (if not ontological) 'bracketing' (Holstein and Gubrium 2008) of the notion of mental illness and psychiatric practice. Looking at current developments, it appears that it would be fruitful to apply labelling theory to the increased medicalisation of problems that previously were seen as everyday emotional or existential behaviour, or even entirely unproblematic (Conrad and Slodden 2013). In particular, labelling theory has a potential to contribute to understanding the substantial growth in new psychiatric diagnoses in recent years. Another phenomenon that could be analysed in terms of labelling is the increasing complexity and interaction between lay, service user and professional conceptions of mental illness (Brown *et al.* 2004). By insisting on the relevance of social structures and social interactions in defining mental illness, in the identification of individuals said to suffer from it and the measures institutions take to manage and treat them, labelling theory can guide the choice of critical research questions and the design of empirical research, as well as the critical interpretation of results.

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2

The social construction of mental illness

Kevin White

Social constructionism, as developed in the sociology of health, is a theoretical tradition which argues that concepts of disease and the body are the product of specific socio-historical periods rather than reflections of an independently existing nature or reality. The constructionist approach problematises medical reality, particularly the claim that health and ill-health can be understood through an objective natural science; it demonstrates how ‘objective’ scientific knowledge both shapes and is shaped by social relationships, and it shows how the technical realm of medical practice is a product of wider social processes. Applied to mental health, we can trace the constructionist approach in the works of Erving Goffman’s book *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (1961), which opened up the critique of medicine as a value-loaded system of social control operating under the guise of scientificity. This was part of a wider critique of psychiatry as a form of social and political oppression, particularly identified in Thomas Szasz’s text *The Manufacture of Madness: A Comparative Study of the Inquisition and the Mental Health Movement* (1962) and R. D. Laing’s book *The Divided Self: An Existential Study in Sanity and Madness* (1962). Laing was followed by what became known as the antipsychiatry movement in David Cooper’s work, *Psychiatry and Anti-psychiatry* (1967). These authors argued that the categories that medicine and psychiatry used to label a person (that is, the disease labels) do not necessarily have an underlying biological reality but instead reflect the social values and prejudices of medical professionals and the society they work in. They held that this was particularly the case when the diseases were psychiatric and no physical basis for them could be established. Furthermore, psychiatry was seen as a form of political oppression. As Laing (1964: 100) put it, ‘I do not myself believe that there is any such “condition” as “schizophrenia”. Yet the label is a social fact. Indeed this label as a social fact is a political event.’ Laing’s point is that once labels are established (that is, become social facts), they have real consequences.

The antipsychiatry movement provided the environment for the first English understandings of Michel Foucault’s work, especially *Madness and Civilization* (1965), which can be taken as the consolidation of the development of social constructionist accounts. The book is both a sociological account of the social functions of psychiatry and a historical account of the emergence of insanity as a category in the West. In particular the argument is that the late eighteenth-century reform of the asylum system under the influence of Philippe Pinel was not a breakthrough in the humane treatment of the mentally ill that progressive historians presented it as. Rather it

was the refinement of the incarceration of the mentally ill, sequestering them in asylums. So, for Foucault, the apparently naturally occurring and objective features of social life – sanity, in this instance – are cultural and historical products. In *Madness and Civilization* he documents historically the transformations in the way the ‘mad’ has been conceptualised. In the medieval period, madness was not a distinct feature of social life. In the Renaissance it starts to become an identifiable characteristic of man and, with the great confinement in the classical age (1650–1800), becomes antithetical to reason (Foucault 1965). In Foucault’s analysis, the category of insanity is a label to sort and segregate the population, administered by state-mandated professionals. Here, a whole range of ‘normal’ human problems – from sexual preferences and drug use to body shape and deportment – are seen through the prism of the ‘psy-professions’ in which ‘normalisation’ is the key, and therefore extends beyond the professionally defined ‘mental illness’ category of psychiatry. For Foucault the point is not just that mental illnesses are not real diseases, but they are the product of psychiatric classificatory systems, existing to police the population through the ‘medicalisation’ of deviant behaviour. Medicalisation is the historical process in which medicine has replaced religion and law as the dominant institution of social control. It also refers to the spread of medical definitions and processes into areas of life which have only a tangential relationship to the body and disease.

Under the influence of Szasz, especially his book *The Myth of Mental Illness* (1974), mental illness could be seen to be the effective labelling by someone in power (the psychiatrist) upon someone powerless (the patient) with a condition. These labels (for example, attention deficit disorder (ADD), bipolar disorder, oppositional defiant disorder (ODD) or schizophrenia) occur in the absence of any physical evidence or test for a disease and are based upon professional judgement. Hence, Szasz argued that labelling someone mad was accomplished in language and through professional intervention. It is these linguistic, structural and power-laden processes that then shape the reality of the situation. Once successfully labelled, said Szasz, an individual (now ‘patient’) played out their role as insane, just as in the Middle Ages when people were labelled as ‘possessed’ they played out their cultural script for demonic possession.

Originally developed in the sociology of deviance, labelling theorists pointed to the way in which deviance was the product not of an act itself, but of the reactions of others to it. The ‘primary deviance’ was less important than the ‘secondary deviance’ of the individual’s response to being labelled as, for example, ‘mentally ill’. In the sociology of health, labelling theory has been widely used to explore how the ‘master status’ of being diseased (for example, as someone who has been labelled with ‘schizophrenia’) overwhelms all other aspects of the person’s identity. Sociologists of mental illness have used the theory to highlight the contextual nature of what it is – and who it is – that gets labelled as mentally ill (Scheff 1975).

The social construction of mental illness can be demonstrated in the institutional attempts by the American Psychiatric Association (APA) to consolidate a claim to be a rigorous part of the medical profession. Before the third edition of the APA’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III, published in 1980), the focus of psychiatry was on the unconscious mechanisms which were the underlying causes of the symptoms of mental illness. Diagnosing specific conditions was secondary to understanding their dynamics. This orientation was a weak base from which to define the medical speciality. It did not differentiate the occupation from a wide range of close competitors such as counsellors, psychologists and social workers. The solution was the DSM-III, where precise definition of specific disease categories provided medical respectability and drew clear enforceable boundaries around the profession: only psychiatrists could diagnose mental disease and prescribe drugs for them.

The strategy unravelled with the publication of the DSM-5 in 2013. After extensive revision, the new *Manual* came under major attack from within the psychiatric profession itself for

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labelling social conditions as diseases and for the influence of drug companies in spurring new disease categories for which drugs were the first point of treatment. There was controversy over the exclusion of Asperger's disorder from the DSM-5, as well as the inclusion of disruptive mood dysregulation disorder (DMDD), mild neurocognitive disorder (MND), generalised anxiety disorder (GAD) and major depressive disorder (MDD) which were all seen as further attempts to medicalise normal human conditions (Frances 2012). The rise and fall of ADD and Asperger's disorder are good examples of these processes of the social construction of mental illness.

ADD was first classified as a psychiatric disorder in the DSM-III (American Psychiatric Association 1980) as a condition with two different manifestations (one 'with hyperactivity', the other 'without hyperactivity'). Revised in 1987, the DSM-III-R (American Psychiatric Association 1987) reclassified them as attention deficit/hyperactivity disorder (ADHD). The condition is one of 'developmentally inappropriate inattention and impulsivity' – that is, the classification of inappropriate behaviour as a disease. It thus represents the medicalisation of human behaviour and its changing diagnostic criteria have been analysed to demonstrate the political and social construction of the disorder. Although there are no biological tests for the condition it is treated with a prescribed drug, *Ritalin* (Conrad 1976).

Asperger's disorder is a psychiatric diagnosis for children – usually between five and nine years of age, and more commonly applied to boys than girls – of a qualitative impairment in social interactions, such as eye-to-eye gaze, facial expression and body postures. It was named after Hans Asperger, who first diagnosed it in 1944, though it was not a diagnostic category in the United States until the 1980s when his work became available in translation. Once thought to be very rare, it became widely diagnosed, though the symptoms were said to be very mild and difficult to diagnose. Because there are no clinically identifiable causes and because the diagnosis is so insecure, sociologists argue that it can be analysed as the medicalisation of socially inappropriate behaviour (Conrad and Schneider 1992). In the DSM-5 (American Psychiatric Association 2013) the condition is no longer classified and the symptoms have been subsumed into autism spectrum disorder (ASD).

Contemporary accounts of the social construction of mental illness by sociologists link the process of constructing, producing and distributing mental illness labels to specific power relationships in society. Thus, Marxist sociologists have long demonstrated the social distribution and differential diagnoses of mental illness, feminist sociologists have explained the consistent over-representation of women in psychiatric populations as a function of women's social roles as wives and mothers and of their patriarchal subordination, and ethnicity too is now understood as a major variable in the social construction and distribution of mental illness. In developing a social constructionist account of mental illness, the rest of this chapter will explore these issues of social class, gender and ethnicity in the social construction of mental illness in more detail.

Mental illness and social position

Sociologists have long demonstrated the social distribution and differential diagnosis of mental illness. For instance, Faris and Dunham showed in 1939 that while manic-depressive psychosis appeared randomly distributed across the city of Chicago the diagnosis of schizophrenia, in contrast, was more common in poorer areas. Their work was among the first to test and dismiss the 'social drift' hypothesis (Thoits 1995), showing that poverty preceded illness, rather than that sick people were downwardly mobile (Faris and Dunham 1939). The debate over whether individuals diagnosed with some mental illnesses are more likely to be part of the lower classes because they have drifted down the social system as a result of their condition or whether mental illness is caused by poverty has been with us since the early twentieth century. This is

because of the political implications of the argument – if, on the one hand, mental illness causes downward social mobility then the implication is that it is an individual and biological condition, and therefore not amenable to community-directed policy intervention. In a period of conservative economic policy characterised by the withdrawal of the state from the provision of welfare services, this is a very attractive argument. If, on the other hand, mental illness is caused by people's lower social position then this is a political issue and very amenable to policy intervention. Studies demonstrating the social production and distribution of mental illness thus become highly charged political documents that show the role of inequality, class, gender and ethnicity as causes of mental illness in themselves. Of course, the policy implication is that what is socially, politically and economically caused can and should be ameliorated by state action.

In a comprehensive review of the history of the debate, and drawing together all the large-scale studies on the topic, Hudson (2005: 16) concluded that there was 'a remarkably strong and consistent negative correlation between socioeconomic conditions and mental illness, one that supports the role of social causation in mental illness and cannot be accounted for by geographic or economic downward mobility'. In short, across all types of mental illness (and, importantly, for the most severe, such as schizophrenia), economic stress, uncertain employment, homelessness and the experience of low social status results in mental illness. However, it is not the social causation of mental illness that is at issue but the labelling of the working class as mentally ill, as discussed below.

Class position is significantly correlated to the diagnosis of mental illness and the form of treatment. The lower classes are more likely to be labelled and diagnosed with psychosis, enter treatment through the legal system and are more likely to receive biological treatments (for example, drugs and electroconvulsive therapy (ECT)) than psychotherapy (Hollingshead and Redlich 1958). In Marxian analysis, increases or decreases in those diagnosed as mentally ill are shown to be closely linked to the economy. Increases in the number of those labelled mentally ill reflect the increase in surplus unemployed people at times of economic crisis, while in times of high economic demand they diminish. Additionally, asylums are argued to 'mop up' the casualties of the labour market (Brenner 1973).

Gender and mental illness

Women are generally diagnosed as 'mad' more than men while, in contrast, men are more likely to be labelled as 'bad'. Men are criminal, violent and imprisoned, while women are depressed and have been treated more with ECT, insulin coma therapy and psychosurgical techniques such as the lobotomy (Busfield 1986). It is a well-established finding from the earliest sociological analyses of psychiatry (Brown and Harris 1978) that women are diagnosed as depressed more than men and that the pattern has gone virtually unchanged into the twenty-first century. Indeed, the statistics are quite staggering, with women having a 50 to 100 per cent higher incidence of depression than men. Research in the United States suggests that women are two-thirds more likely to be diagnosed as depressed as men (Bertakis *et al.* 2001; Kessler *et al.* 1994). Those women most at risk of being diagnosed as mad are the married, those with children and the unemployed (Ussher 2013). These findings have been explained with reference to gendered differences in stressful life events and the victimisation which women experience in patriarchal societies (Nolen-Hoeksema 2001).

There is no evidence that there are any biological explanations for the differences in depression rates between men and women (Harris *et al.* 1991). Sociologists of mental illness instead argue that the differences in the labelling rates of depression can be more accurately explained by women seeking health interventions more often than men when they experience poor

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health. Consequently, women are labelled (or self-label) as being depressed – especially on self-scaled questionnaires and in research averaging women's depression across a range of scales – which results in an over-representation of apparent depression (Bertakis *et al.* 2001; Kessler *et al.* 1994). The social construction of gender roles results in women's minds and bodies being medicalised in a framework which defines them as inherently at risk of mental illness and, physically, always in need of monitoring by the medical profession. This leads to the over-surveillance of women in ensuring conformity to social roles and policing gender roles through the psy-professions.

Ethnicity and mental illness

Ethnic groups are positively or negatively valued status-identities based on a shared culture, language or place of origin. Negatively valued low-status groups face severe economic discrimination in life, including exclusions from health care and health insurance provision, from adequate schooling and from access to the legal system. This results in the explicit outcomes of lower wages and participation in the informal sector of the economy with its increased exposure to health hazards at work (Krieger *et al.* 1993). In a vicious causal circle, the outcome is segregated residential areas, increased exposure to the hazards of industrial zones, poisoning, environmental hazards and the corollaries of addictive and violent behaviour. These political and economic inequalities are added to by a general disparagement and denigration of cultural values and health belief systems and a stereotypical representation of ethnic groups as responsible for their own problems (Krieger *et al.* 1993).

Ethnic stratification and social disadvantage are significantly linked with mental illness. For example, Australian Aboriginals receive diagnoses at two to three times the rate for mental illness as the general population (Jorm *et al.* 2012). Importantly for a social constructionist account, ethnicity (unlike social class) always precedes the onset of mental illness and thus cannot be the cause of it. It has also been established that the migrant groups are not bringing their mental illness diagnoses with them, since research has shown that these conditions are rare in the country of origin. Furthermore, the mental illness – of which schizophrenia tends to be the dominant one – is not manifest in first-generation migrants but in the second. Thus, it is not the stress of migration that induces mental illness (Eaton and Harrison 2000).

This may be overlaid by the lack of attention paid by Western psychiatrists to the ethnic background of their patients, many of whose cultural beliefs involve the presence of spirits, the power of visions and the hearing of voices (all symptoms of mental illnesses in the DSM) as part of their religious and cultural beliefs. Thus there is a likelihood of false diagnoses, but ones which, once made – as labelling theory suggests – become a master stigma and leaves these groups with the negative connotation of being prone to mental illness (Selten *et al.* 2001). What is very clear is that the onset and diagnosis of mental illness have their origins in the social, political and economic relationship of ethnically stratified Western societies and not in nature or biology.

Conclusion

This chapter has outlined the origins of the social constructionist approach to mental illness from the 1960s onwards. It showed that mental illness is socially constructed in the sense of being the successful labelling of someone, or some condition, as mentally ill. This labelling process operates inside a social system characterised by inequalities in social class, gender and ethnicity. In this social system mental illness follows the social gradient of disease: the poorer you are, the

lower your ethnic group status, and being female both produces mental illness and increases the likelihood of being labelled as ‘mentally ill’. Hence, rather than being a fact of biology, genes or nature, mental illness is socially constructed, produced and distributed.

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‘Mental health’ praxis – not the answer

A constructive antipsychiatry position

Bonnie Burstow

Upon being invited to pen a chapter for the *Routledge International Handbook of Critical Mental Health*, I was immediately beset by two opposing feelings – pleasure (I was delighted to be part of this important undertaking) and discomfort over the title. A clarification about the latter: I hold that terms like ‘mental health’ are misnomers – moreover, a form of colonisation. Herein lies a clue about the nature this chapter.

As evident in my title itself, the chapter is antipsychiatry. Now, as a descriptor, ‘antipsychiatry’ has had variable meanings. Introduced by the group that coalesced around R. D. Laing (see Cooper 1967), it initially referred to an existential and social reframing of the concept of ‘mental health’, along with a commitment to ‘treatment’ of an existential variety, as well as to social restructuring. When associated with Thomas Szasz (1961), it means rather a *total* rejection of psychiatric concepts. When employed by activists today, however (see, coalitionagainstoppsychiatricassault.wordpress.com), it generally denotes a Szaszian critique combined with a commitment to abolition.

Uncompromisingly antipsychiatry in the latter sense, while also drawing on Laing, this chapter fundamentally problematises psychiatry’s use of the concept ‘mental illness’ and, in line with that, psychiatry as a whole. What is demonstrated is that something is being depicted and treated as medical which is in no way medical and, largely as a consequence, people are being profoundly damaged. Psychiatry is likewise revealed as self-interested, reductionistic, a form of power-over. Moreover – what particularly distinguishes this piece – psychiatric reform itself emerges as problematic. The chapter culminates in an abolitionist call but also a call for a more fundamental shift – one effecting not only ‘services’ but, on a very basic level, how we live with one another.

Psychiatry as a regime of ruling

Irrespective of how credible or non-credible one finds psychiatry, it is blatantly a formidable regime of ruling (an institutional ethnography term; see Smith 2005). That is, it is a form of governance which creates ‘official knowledge’, which dictates how people are seen and what happens to them. One obvious example of the power wielded is that, via psychiatry’s authority, people who have committed no crime are ripped from their lives and deprived of their freedom, despite their urgent wishes to the contrary. Pivotal players in this ruling are psychiatrists

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themselves, their business partners (e.g. the multinational pharmaceutical corporations), the legal apparatus (which endows psychiatry with this power and facilitates it) and, not coincidentally, the state, which provides funding, legitimisation and the means by which psychiatry continues to grow. Institutionalisation itself occurs on the basis of ‘dangerousness’, albeit statistics do not indicate that the ‘mentally ill’ are any more dangerous than anyone else (see Burstow 2015). Psychiatry, correspondingly, is a growth industry with more and more falling under its auspices (for details on the exponential growth in both the number of ‘diagnoses’ and the numbers of people ‘diagnosed’ and ‘treated’, see, e.g. Whitaker 2002, 2010). All of which, in turn, increases the power and the profit of the industry.

Like all regimes of ruling, psychiatry rules by texts. If a psychiatrist activates a particular section of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), for example, the person is officially ‘schizophrenic’. Correspondingly, if s/he signs a particular form (in Ontario, Canada, a *Form One*; see Hiltz and Szigeti 2011), a person *by law* is involuntarily committed. In this respect, the words spoken or written by a psychiatrist have the power of law, they make certain processes happen. This in itself is a problem of epic proportions, as is the transparently carceral and punitive nature of the psychiatric project, so brilliantly articulated by Foucault (1980, 1988). That said, a whole new problematic level surfaces as we consider psychiatry’s pivotal concept.

The concept of mental illness: the foundations of psychiatry

While mental illness as a concept has become so hegemonic that most people use it without hesitation, stop to reflect on it and it begins to look strange, perhaps even suspect. Significantly, as Szasz (1961) points out, illnesses are conditions of the body and, as such, *only a body or one of its organs* can have an illness. The mind (thinking) is neither a body nor an organ. It is rather *an activity* of the body much like running and jumping and, as such, it can no more have a disease than running or jumping can – hence Szasz’s (1961) identification of ‘mental illness’ as a metaphor. This much the early psychiatric pioneers were well aware of, with the Austrian physician von Feuchtersleben (1955: 412, emphasis original), for example, stating that, ‘[t]he maladies of the spirit... can be called diseases of the mind only per *analogiam*’ – though we almost never see such admissions today. Now, to be clear, it is not in itself problematic to employ health-based metaphors. We habitually do with no untoward consequences. We refer, for instance, to ‘sick jokes’. The difference is we do not bring in a doctor to cure the sick joke. By contrast, we do call in a doctor to attend to these putative ‘mental illnesses’.

What has happened here? What is a figurative truth only is being taken as literal fact. In short, what we have here is the literalising of a metaphor – hardly a credible scientific foundation. The problems evident here are multiplied exponentially when you examine the ‘diagnoses’ themselves. Integral to the DSM is language manipulation, arbitrary criteria, reductionism, a de-contextualising of people’s problems, the transformation of people’s reactions to their world into inner ‘symptoms’ (see Woolfolk 2001) and, correspondingly, the projection of a disease entity which is subsequently treated as causal despite the DSM’s claim to be aetiology-free (for elucidation of this claim, see Burstow 2015). A response which I gave in an interview recently (see Spring and Burstow 2015) further elucidates the phenomenon:

[The DSM] sets practitioners up to look at distressed and/or distressing people in certain ways. So, if they go into a psychiatric interview, they’re going to be honing on questions that follow the logic of the DSM, or to use their vocabulary, the ‘symptoms’ for any given ‘disease’ they’re considering. In the process it rips people out of their lives. And so now

there's no explanation for the things people do, no way to see their words or actions as meaningful because the context has been removed. In essence, the DSM de-contextualizes people's problems, then re-contextualizes them in terms of an invented concept called a 'disorder.' Let me give you an example. 'Selective Mutism' is a diagnosis given to people who elect not to speak in certain situations. So, if I were... trying to get a handle on what's going on with somebody – I would try to figure out what situations they aren't speaking in, try to find out if there's some kind of common denominator, to ascertain whether there's something in their background or their current context that would help explain what they are doing. You know, as in: Is it safe to speak? Is this, for example, a person of color going silent at times when racists might be present? Alternatively, is this a childhood sexual abuse survivor who is being triggered? Whatever it is, I would need to do that. But this is not what the DSM, as it were, prompts. In the DSM, 'Selective Mutism' is a discrete disease. So, *according to psychiatry*, what causes these 'symptoms' of not speaking? Well, 'Selective Mutism' does.

What we have here is the invention/projection of invalidating labels which function so as to cover up the real problems that people face. Correspondingly, in what is blatantly an exercise in ideological circularity, these labels are attributed with causality. Now, to be clear, it is not that any of us who are antipsychiatry would deny that the people so diagnosed *may be* enormously confused or beset with horrendous problems and *may* indeed be in need of assistance – only that we see these as social and psychological in origin, rather than as products of a disease process, and we regard the people themselves as agential. Herein lies a paradigm difference of colossal significance.

Psychiatry's biological claims

Psychiatry's way around the 'metaphor problem' has been to be more biologically specific and name the diseased organ. The psychiatric claim, as articulated by Andreasen (1984), is that 'mental illnesses' are illnesses of the brain – moreover, that they have been conclusively proven to be such. Here, once again, we enter the realm of assertion, not fact. Note that, as demonstrated by Breggin (2008) and Burstow (2015) (despite assertions to the contrary), not a single brain illness – not any oedema, not one lesion – has ever been established for a solitary 'mental illness'.

That said, proceeding as if the brain disease hypothesis were proven has long been psychiatry's way. This modus operandi stems from a gambit made by pioneer Emil Kraepelin (1962: 151) over a century ago, who recommended that psychiatrists act *as if* these putative 'conditions' were bone fide diseases, adding:

The nature of most mental illnesses is now obscured. But no one can deny that further research will uncover new facts in so young a science as ours... It is logical to assume that many other types of insanity can be prevented even cured – though at present we haven't the slightest clue.

Psychiatrists proceeded as recommended. In the fullness of time they additionally 'progressed' from acting *as if* the brain disease hypothesis were 'established' to insisting that the hypothesis *had in fact been proven*, this despite the total lack of evidence. Herein lies the basis for psychiatric treatment of 'mental illness' – something transparently fraudulent. Correspondingly, the very fact that attempts to prove the brain disease hypothesis persist

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despite the fact that over a century of trying has led only to reasons to see it as mistaken is itself an indicator that the agenda is inherently political (for a detailed discussion of such attempts, see Burstow 2015, chapter 1).

A related claim, also without merit, is that the success of the psychopharmaceuticals proves that ‘mentally ill’ people have chemical imbalances, which, in turn, constitutes proof of brain disease. Again such claims will not hold. To put aside the dubious claim of the ‘success’ of the psychopharmaceuticals for a moment, chemical imbalances in themselves do not constitute proof of a disease. In this regard, according to the Virchow criterion (the medical gold standard), to qualify as a disease there must be real lesions, real cellular abnormality observable directly or by tests (see Ackerknecht 1953; Szasz 1988). And note, chemical imbalances do not constitute lesions or cellular abnormality. What is equally fundamental, contrary to the impression created by psychiatry, as demonstrated by numerous authors (see, e.g. Breggin 2008; Whitaker 2010) and despite the abundance of research and research funding in this area, there is not an iota of proof that a single chemical imbalance underlies even one of these putative disorders. In this regard, the so-called proof of the chemical imbalance theory of schizophrenia serves as exemplum.

For years it was *claimed* that people labelled schizophrenic had chemical imbalances. Then proof began to materialise, all based on incorrect premises, all subsequently disproved, only to be rapidly replaced by others equally problematic. A well-known example is the proof predicated on the prevalence of extra dopamine receptors. To wit, having found that neuroleptics (‘anti-psychotics’) impeded the transmission of the neurotransmitter dopamine, psychiatric researchers hypothesised that ‘schizophrenia’ is caused by excess dopamine. Searching for ‘evidence’, they soon claimed to have discovered that ‘schizophrenics’ have extra dopamine receptors – from which they concluded that ‘schizophrenics’ indeed suffer from a chemical imbalance. What was subsequently discovered? Being labelled schizophrenic was not the relevant variable but *the taking of the drug*. The point is, it is not ‘schizophrenics’ but *people ‘after treatment with the neuroleptics’* who have extra receptors – a development itself traceable to the brain’s attempt to compensate for the dopamine deficiency created by the drugs. The point? No chemical imbalance exists *until the ‘treatment’ creates one*. A similar story could be told about all the other psychiatric drugs (for details and substantiation, see Burstow 2015; Whitaker 2002). Whatever additionally follows, the treatments per se are lacking in medical validity.

The ‘treatments’ as ‘help’

It might be argued that, irrespective of medical validity, the treatments are helpful – so, minimally, they should be prescribed to those who want them. To argue this, however, is to misunderstand the coercive nature of the environment in which they are promoted and also the habitual lies told about the treatments. It is, likewise, to misunderstand the nature of the substances and processes involved.

As demonstrated by researchers like Breggin (2008), all quintessentially ‘psychiatric treatments’, whether they be electroconvulsive therapy (ECT) or one of the drugs, work by impeding and damaging the brain. Indeed, demonstrates Breggin, there is a one-to-one ratio between the ‘effectiveness’ and the degree of damage done. Correspondingly, albeit individuals may feel they have been helped by the drugs and, indeed, *on the face of it* may well fare better for a time, longitudinal studies reveal a truly bleak picture: those who come off the drugs within a few years fare better than those who stay on them. Correspondingly – and this is the ‘killer discovery’ – those who fare best in the long run are those who were *never on them in the first place*. By the same token, so-called schizophrenics living in allegedly ‘underdeveloped’ countries with

no access to the drugs fare better than those in ‘developed’ countries with access (for further details, see, respectively, Harrow 2007; Rappaport *et al.* 1978; Hopper 2000). In short, even when appearances seem to suggest otherwise, we are not helping, we are harming. Moreover, via the power of the state, we are not only authorising but paying for such harm. In the process – and as demonstrated by Whitaker (2010) – I would add, as a society, we have created a drug problem of epidemic proportions, all in the name of care.

How did we, as a society, get here?

It is beyond the scope of this chapter to articulate in any detail exactly how we arrived where we are. However, for us to make better decisions it is critical that we have some understanding of the factors involved. To begin with the most obvious: we have been routinely misled both intentionally and otherwise by an industry whose interests lie precisely in making what is not medical appear medical. What is apropos here (not just recently, but throughout the vast majority of psychiatry’s history) is that its practitioners have ever more systematically used medical trappings to bolster the claim that ‘madness’ is medical and hence the proper province of doctors, in the process driving out or marginalising all competitors for control over this turf – witness the routing of the women healers in the nineteenth century (see Burstow 2015).

Along with this, there has long been an exceptional level of manipulation both in how psychiatric research is conducted and in the reporting of it (see Whitaker and Cosgrove 2015). Other factors which come together to bring us where we are include:

- medicine proper reaching the scientific threshold and the huge credibility concomitantly given to everything considered a branch of medicine, including psychiatry (see Burstow 2015);
- mad doctors becoming agents of the state, complete with dictatorial powers;
- the state’s progressive attempts to control;
- the enormous money and power involved;
- people’s fear of those who strike them as different, and hence their willingness to entertain solutions that promise to keep the ‘othered’ person under control (see Foucault 1988);
- our tendency to see anything labelled ‘help’ as benign, even when it is blatantly incarceral (see Lewis 1970).

What is, likewise, a factor: the more our lives are in the hands of ‘expert others’, the more ‘normal’ and reasonable arrangements of this ilk seem.

What should we do about psychiatry?

On a very simple level, insofar as substances and processes such as electroshock and psychiatric drugs are not medical and, beyond that, by their very nature harmful, over time doctors should not be allowed to prescribe them – to be clear, this is not to say that I am advocating a ban on psychopharmaceuticals, any more than I would ban any other mind-altering drug which people use to cope. Correspondingly, on a more fundamental level, I am suggesting that we, as a society, admit that psychiatry has been a colossal misstep and begin moving towards abolition, preferably of the attrition (gradual erosion) variety (for elaboration on the attrition model, see Burstow 2014). A good beginning is, bit by bit, severing the relationship between psychiatry and the state.

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Herein my stance differs from the reformer, who opts for tempering psychiatry only. The question is: does such an arbitrary and coercive state power really serve us? And why would we want even a reformed psychiatry, given that psychiatry is a medical discipline and the problem being ‘treated’ *is not medical*? Correspondingly, there are lessons from history here that we can ill afford to ignore. Significantly, on two previous occasions, institutional psychiatry embraced reformism, moving seemingly decisively in a non-biological, comparatively humanistic direction. The first was called ‘moral management’ and it was dominant from the late eighteenth to the mid-nineteenth century; the second was psychoanalysis – the mainstay of mid-twentieth-century psychiatry. In both cases, these revolutions seemed irreversible yet proved to be detours only, leading to a return of biological psychiatry with a vengeance. Why? In both cases, non-medical helpers were better at it, which threatened the dominance/continuation of psychiatry. All of which culminated in a new revolution. In each case, moreover, it is not just that the ground gained was lost. The situation which materialised was far worse than what predated reform, for everything became grist for the biologising agenda (for details, see Burstow 2015) – a predictable reaction by psychiatrists, this being the one way to stop what would otherwise be an unstoppable erosion of their power. The point being made here is that a system which *includes* psychiatry but *precludes or minimises* the medical (read: pseudo-medical) will not last long precisely because psychiatry cannot afford it to, with the result being re-biologisation with a vengeance. As reasonable and promising as a non-abolitionist reform agenda may look, in the long run it is set to backfire and, in the short run – what is hardly a minor issue – it squanders the momentum for benign and lasting change.

In concluding: so where do we go in the long run?

This chapter has demonstrated that psychiatry’s tenets are unfounded, that psychiatry inherently and inevitably harms, and it calls for phased-in abolition. While it is beyond the purview of this chapter to articulate in any detail a more encompassing societal approach, I end by conveying, however scantily, a general direction: obviously disentangling ourselves from psychiatry, however necessary, hardly suffices – people will still be beset by massive problems and be in need of help. Nor, I would suggest, will providing more decent services (i.e. ones connected to the actual nature of people’s problems in living, ones provided on a voluntary basis and in line with recipients’ preferences), vital though these are. Insofar as the majority of us dwell in societies which are alienated and alienating and, as such, ones that necessarily give rise to humungous personal troubles, we need a more fundamental societal transformation.

With disempowerment and the relentless erosion of community clearly a factor in our current plight, an obvious direction would be predicated on smaller communities wherein everyone had a place, where we see ourselves as connected to every other being and where we grapple with problems together. Critical aspects could include:

- participatory environmentalism;
- participatory (not simply representative) governing;
- expansion of the commons (joint owning, co-creating, being co-responsible for; for a discussion of the commons, see Hardt and Negri 2004);
- equality/egalitarianism, with rigorous attention to systemic oppression such as racism and sexism;
- allowing everyone to contribute in their own unique way;
- respect for both collectivity and individuality;
- cherishing – not pathologising or trying to control – difference.

How children are raised is pivotal. Caring – not correction – would need to be prioritised. Correspondingly, it would be important that schools be places of freedom and creativity, while introducing children to the skills needed for life generally and community engagement in particular. Learning about feelings – one's own and others – would be crucial. In such schooling, moreover, learners should be helped to appreciate the wisdom in states once dismissed as 'mental illness'; skills such as conflict mediation should be prioritised; everyone should learn how to 'befriend' others in distress, including how to engage in active listening; moreover, everyone should acquire the skill needed to follow thinking processes radically different from their own (including acquiring what I call 'mad literacy' – that is, being able to follow thought that might initially seem irrational; for details, see Burstow 2015).

What would services look like in such a society? They would be diverse, manifold, tailored to both individual and collective needs and they would be vested in the community as a whole – as opposed to experts. People would contribute as their talents/inclinations lead them, whether it be counselling, assisting in emergencies, providing others with healthy food, witnessing, lending a supportive presence as folk retreat into themselves or any other act of befriending. Some basics would be: forced help is *not* help, people's welfare is everyone's concern and everyone befriends. Specifics would vary according to the particularity of a community's needs and inclinations – in an apartment complex, for example, on a rotational basis, resident befrienders might be on-call who could be turned to should any resident find themselves in distress or should conflict arise. By the same token, everyone would be involved in conflict mediation, with the well-being of everyone affected actively grappled with and with respect demonstrated for everyone's rights, everyone's wisdom (for a fuller articulation of this 'commoning' of services, including how *extreme* situations might be handled – for, to be clear, such will inevitably arise – see Burstow 2015, chapter 9).

In ending, two questions and some tentative answers: 1) can we integrate aspects of such services in society as it exists now? and 2) is there *any place* for 'professionals'? For the first, my sense is, yes. Correspondingly, my invitation would be for readers, as interested, to be on the alert for openings in their current lives where such 'commoning' might be introduced. For example, does your current apartment building have residents on-call? If not, how would you feel about initiating a conversation about this? For the second, while arguably there is indeed room for 'professionals' (e.g. to provide training as needed), a cautionary note: the last thing needed is yet more armies of experts – a component, alas, implicit in the solutions of most reformers. Correspondingly, given how frighteningly easy it is for slippage to occur, care should be taken that decision-making remains in the hands of the community as a whole and its members, and not in the hands of the 'experts'.

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Foucauldian theory

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This chapter moves beyond the social construction of mental health and illness, to engage with poststructuralist debates that emphasise how power works through discourse to shape knowledge and subjectivity. It explores the significant influence that French philosopher Michel Foucault (1988a) has had on understanding how ‘madness’ or ‘mental disorder’ has been problematised and made thinkable as an historical category within particular regimes of truth that are configured through power-knowledge relations. As an anti-humanist, Foucault was not interested in excavating the interiority of subjectivity to locate the source of mental disorder; rather he questioned or ‘problematised’ the very way in which truths produced about disorder also sustain ‘normality’ and dominant forms of morality. Power, for Foucault, was not a zero-sum game nor was it a matter of ideology; rather power was understood as relational and material-discursive in its operation and truth effects. Hence, power relations are implicated in the production of certain ways of knowing and being that could be both regulatory and normalising, as well as resistant and subversive (Foucault 1980).

In his historical analyses of madness during the Renaissance, the seventeenth and eighteenth centuries and in the modern era, Foucault (1988a) sought to show how madness was shaped within the available discourses of the time and was not always considered to be the opposite of reason or a source of negative social judgement. He argued that the ‘age of reason’ created the economic, political and social conditions that justified a clearer spatial division of people associated with ‘unreason’ and immorality (for example, the mad, prostitutes and vagrants). This mid-seventeenth-century period of ‘the great confinement’ led to the establishment of institutions such as hospitals, prisons and workhouses (for example, the *Hopital General* in Paris, founded in 1656) across Europe and with it the creation of populations who were confined to protect society. With the emergence of psychiatric expertise during the eighteenth century, ‘unreason’ became subject to medical expertise in the desire for a cure. The psychiatric gaze played a significant role in the manifestation of madness through particular theories and techniques that acted upon the body and hence unreason (for example, heat and cold were connected to energetic states, flows of blood and bile). Visualisation techniques – such as observing behaviours, taking photographs of bodily posture, comportment and facial expressions – were particularly important in rendering madness ‘knowable’. As Rose and Abi-Rached (2013: 58) note, the moral shift to more ‘humane’ treatment in asylums involved a different way of seeing the mad that was,

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part of a fundamental individualization that rendered madness into a possible object for a clinical medicine... The image was fused to the biography in the form of the case, and inscribed at the heart of psychiatric epistemology and diagnostic practice.

Despite the significant shift in nineteenth-century clinical medicine from observing the body to seeing what was beneath the skin, the mad doctors remained focused on the surface as it 'reflected' the interior world of the subject. The significance of this scientific and cultural imaginary, evident in visual techniques, also manifests in new ways within contemporary practices of brain-imaging that seek to reveal a biological origin of mental illness (Rose and Abi-Rached 2013).

Despite the contemporary biomedical quest in science to locate the cause of mental illness within an individual's biology, there remain no identifiable biomarkers and hence the classification of human distress is a highly contested area (Ehrenberg 2009; Moncrieff 2010). Disciplinary perspectives informed by Foucault's work (for example, critical psychiatry and psychology, sociology, feminist theory, postcolonial studies, geography and mad studies) have importantly explored how various categorisations of emotional or mental distress in Western cultures have been historically underpinned by oppositional power relations where the former term is privileged over and defines the latter – including sane/insane, normal/abnormal, healthy/ill, mind/body, masculine/feminine, white/black and expert/patient (Metzl 2010; Ussher 2011). One example that reveals the historical power-knowledge relations of classifications of mental illness is the removal by the American Psychiatric Association (APA) of homosexuality as a disorder from its official *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973.

Foucault's insights remain highly relevant today for thinking critically about how mental health and illness are constituted as problems with certain 'solutions'. OECD (Organisation for Economic Co-operation and Development) countries often purport to follow a biopsychosocial model of mental illness, yet their policies largely reiterate a medicalised approach, with crisis care provided in hospital settings. While longer-term care has shifted to community settings, the management of symptoms and behaviours via psychopharmacological expertise is still privileged and often exists in tension with the desires of service users or survivors to define the parameters of their own recovery process. In the United Kingdom, mental health promotion and early intervention programmes urge individuals to access brief counselling sessions or take up digital technologies so as to improve their well-being and combat the rise of common mental health disorders such as depression and anxiety. Social movements have also formed through resistance to the psychiatrisation of distress or unreason via expert diagnoses such as 'schizophrenia'. Individuals may identify themselves as 'survivors' of the psychiatric system or through alternative (and less pathologised) identities such as the 'hearing voices' network (Blackman 2012). Recently, the global mental health movement (led by psychiatrists) has celebrated the inclusion of mental health in the post-millennium 2015 goals (United Nations General Assembly 2015), while critics have argued against the colonising effects of this rolling out of a 'one size fits all' Western model of intervention (Mills 2014). In addition, Foucault's work has informed growing intersectional critiques such as the racialisation of mental health knowledge in terms of diagnostic practices that constitute black men as mentally ill (Metzl 2010) and therapeutic subjects of incarceration (Hejtmanek 2015) in particular ways. Analysis of gendered prescribing practices within the clinic and marketing campaigns have also identified how women are positioned as consumers of pharmacological solutions (Fullagar and O'Brien 2013; Metzl 2003; Stoppard 2000). Analysing the under-representation in mental health services of migrant and diasporic communities that identify as Muslim, Rondelez *et al.* (2016) have also explored the power relations that work to 'other' particular categories of subjectivity with respect to mental illness in Europe.

In the contemporary context mental disorders are not problems that exist outside social relations or beyond the epistemological and ontological claims of the researchers, policy-makers or professionals who seek to know them. Moving beyond a focus on either the agency of individuals or the ideological operation of social structures, Foucauldian scholars have engaged in the ‘process of problematisation’ in order to understand ‘how and why certain things (behaviour, phenomena, processes) became a problem’ (Foucault 1984: 17). Foucault’s (1988a) analysis explored how madness could be understood in terms of a history of the present that identified the discursive fields through which categories of humanness were rendered culturally intelligible as objects/subjects of knowledge. This means exploring the ‘ensemble of discursive and non-discursive practices that make something enter into the play of true and false and constitute it as an object of thought, whether in the form of moral reflection, scientific knowledge or political analysis’ (Foucault, cited in Rabinow and Rose 2003: xviii–xix). In this way, Foucault’s (1984) writing opens up a discursive space for critical mental health scholars to act upon the normalised assumptions defining human subjectivity in order to ‘refuse’ the question of who we are and, rather, to think ‘otherwise’ (see, e.g. Bracken and Thomas 2001; Busfield 2001; Fullagar and O’Brien 2013; LeFrançois *et al.* 2013; Mills 2014; Rose 1996; Teghtsoonian 2009; Ussher 2011).

Biopower and the rise of the neurochemical subject

Foucauldian scholars have approached the question of how we understand (and speak of) mental ‘disorders’ by asking how specific subject positions (the abnormal, the schizophrenic, the neurochemically unbalanced, depressed self) have been produced through human and biomedical sciences and practices. The discursive fields of medicine, psychiatry, psychology, epidemiology and neuroscience work to classify, organise and divide individuals and populations (as they, in turn, act upon a host of related areas such as public policy, law, welfare, health, social work, health promotion, urban planning and education) (Rose and Abi-Rached 2013). Categories of mental disorder are produced in historically contingent ways through a range of professional practices that seek to identify and ‘know’ abnormal behaviour via the clinical gaze (for instance, observations of behaviour and assessments of personality and symptomology), epidemiological surveillance of populations (for example, government health surveys and big data collated by insurance companies) and research evidence (including clinical trials funded by pharmaceutical companies and psychological intervention evaluations). These discursive fields not only invent ‘mad subjects’, they also contribute to the broader apparatus of mental health care that is bound up with particular social, political, juridical and economic relations and rationalities that underpin the organisation of care and intervention in particular contexts (such as institutional confinement, psychopharmacology, electroconvulsive therapy (ECT) and community living).

Within critical mental health studies, Foucault’s work on biopower has been especially useful for thinking about the multiple forms of power that act upon both individuals and populations in the name of improving health, well-being and ‘life itself’ (Foucault 1991; Frandsen and Triantafillou 2011; Rabinow and Rose 2006). Biopower works to shape the ‘conduct of conduct’ – that is, the professional techniques (measuring, prescribing, talking therapies and confinement) that act upon the subjectivities of people classified as mentally ill (who, in turn, act upon their thoughts, feelings and actions through the process of subjectification, becoming mad subjects) (Foucault 1997). Foucault’s later work on biopower has been taken up by a range of scholars who are interested in understanding the ‘conditions of possibility’ that have produced particular discursive formations of ‘neuroselfhood’ in relation to the rise of molecular science, pharmacology and neurocapitalism (Fullagar 2008; Pickersgill 2011; Pykett 2013; Rose and Abi-Rached 2013).

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Contemporary biocitizens are increasingly urged to think about their physical and mental health/illness not in terms of the whole person but via the molecular discourses of medicine and life sciences (such as biochemistry, genetics and neuroscience). Biopolitics has reconfigured the brain-body as the focus of a clinical gaze to produce a different somatic conception of subjectivity that visualises life at the molecular level (and located in brain spheres and chemistry). The neurochemically deficient subject has become a recognisable identity for a range of mental illnesses and is obliged to engage in expert treatment as an exercise of responsibility and self-control that will restore and maximise life potential. In this sense, 'patients' are no longer passive recipients of expertise; they are urged to become active, responsible consumers of medical services, expertise, products and pharmaceuticals (Rose and Abi-Rached 2013). These products have emerged out of the broader transformation of knowledge within biocapitalism, science and the clinical encounter to profoundly change the way we imagine and relate to our biological selves at the molecular level. Biocapitalism works through global circuits of exchange that bring together a range of government, research and corporate institutions, which, in turn, generate profit from the creation of particular disorders that require drug treatments (Pykett 2013).

With the rise of neuroscientific research and its translation into popular and policy vocabularies, the mentally ill subject is reconfigured via new practices of diagnosis (including brain scans through magnetic resonance imaging (MRIs)) that render the molecular substance of the biomedical body more visible than issues of social injustice underpinning the social conditions of distress. Hence, the contemporary exercise of biopower is less 'disciplinary' than Foucault previously identified in relation to the regulation of populations and bodies via the expansion of public health administration in the eighteenth century (Rose and Abi-Rached 2013). Importantly, these shifting power-knowledge relations of biomedicine significantly shape the thinking and practices of mental health services in ways that also forge alliances with, and contestation by, patient, survivor and consumer groups, as well as antipsychiatry and mad movements (LeFrançois *et al.* 2013).

In my own research into women's accounts of recovery from depression, biochemical discourses were a dominant source of authority that informed how antidepressant medication was experienced as 'positive' (Fullagar 2009). Foucault's work was useful for understanding how expert and self-knowledge become entangled, thus moving us beyond previous sociological notions of medical dominance that imply false consciousness about expert ideology (Lupton 1997). The consumption of antidepressants is bound up with the process of subjectification as the feminine subject negotiates competing discourses about the biopsychosocial causes of depression. She interprets her own responses ('symptoms') in relation to cultural norms about gender (and race/class/sexuality/age) identity, successful self-management and neurochemical notions of balance, cure, normality and so on. The impossibility of separating the biopsychosocial dimensions of medication raises questions about how placebo effects are shaped discursively as well as materially (Blackman 2007). Women in my study exercised agency through performing the subject position of the biomedical consumer as they engaged with the expertise generated by neuroscience and psy-expertise. Rather than being positioned as passive recipients of expert knowledge, the position of consumer obliges women to align the desire to recover their lives and reduce the risk of depression recurring with biochemical management. Antidepressants act as a 'bio' technology of the self that shapes the depressed subject's relationship to her mind-body-emotions in the quest for recovery. However, the truth claims of psy-expertise were also questioned in my study when the promise to alleviate suffering was unfulfilled, symptoms were exacerbated or women identified the personal and social circumstances in their lives that contributed to distress (for instance, child abuse, male violence, unemployment, racism/sexism/homophobia and inequitable care responsibilities) (Fullagar and O'Brien 2013).

Recovery as empowering or normalising?

Foucault's work has also usefully informed debates about the discursive shift within mental health policy, research and services towards a 'recovery' orientation (Fullagar and O'Brien 2014; Lafrance 2009; Smith-Merry *et al.* 2011; Vandekinderen *et al.* 2014). While the intent of the shift towards recovery is articulated in terms of personal rather than professional meaning and control, 'recovery' is a problematic term that also refers to some kind of return to 'normality' or the discovery of a real or true self that exists beneath depression (Keane 2000). By examining the discursive formation of recovery we can see how assumptions about empowerment are articulated in different ways by both service users and professional models. The former emphasise the personal meanings of recovery that exist 'beyond' cure and expert treatment, while the latter tend to emphasise individual choices 'within' the medical system of expert diagnosis and treatment. The normalising rationalities of individual choice articulate desirable subjectivities in advanced liberal societies (as autonomous, self-improving and entrepreneurial selves) and minimise market forces that shape service provision (Vandekinderen *et al.* 2014). As Poole (2011) has also argued in the Canadian context, the recovery model narrowly defines the discursive parameters of how an individual subject must recover from mental illness in ways that silence psychiatric survivors who seek to critically engage with the recovery movement.

Hence, recovery can be understood through technologies of the self that are deployed to transform the individual's ethical conduct in relation to the discursive and material conditions of everyday life (within and beyond the implicit moralities of mental health services). Foucault (1988b: 18) describes technologies of the self as permitting,

individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection or immortality.

Foucault's (1990) later work explored the productive exercise of power via ethical relations of the self and provides a useful way to think about how individuals engage in diverse experiences of recovery that are contextual, embodied and, hence, forms of 'subjugated knowledge'. Exercises of the self 'on the self' can be disciplinary practices that produce 'normalisation', or conversely they may enable one to engage in care of the self as an ethical practice of freedom, refusing who we have been told we should be (and hence contesting shame and stigma) (Foucault 1990, 1997). Thus, ethical relations of the self can reposition individuals, groups and communities as having expertise in their own lives, rather than assuming a deficit understanding of human subjectivity that requires a cure or therapeutic expertise derived from a biochemical illness model (Fullagar and O'Brien 2014).

Critical discussions on the changing power-knowledge relations of expertise are also particularly important with the rise of digital mental health promotion (for example, apps, social media, website information, vlogs, blogs, self-diagnostic tools and gamefied interventions). Traditional notions of mental health literacy (as compliant with expert diagnostic criteria) fail to identify how mental illness is constituted in normative and contested ways; hence, there is a risk that educational programmes will reiterate discourses about normality/abnormality that render social forces such as gender invisible (Fullagar 2008). For example, Gagen (2015) argues that the rising popularity of emotional literacy programmes in UK schools can be highly problematic in producing vocabularies about mental health that draw upon neuroscience discourses of brain dysfunction. Extending their Foucauldian insights to youth suicide prevention programmes in

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Canadian schools, White *et al.* (2011) argue for a critical sensibility that does not assume coherence, knowledge hierarchies or stable understandings about distress or help-seeking practices. These examples provide ways to 'think otherwise' about the diverse and complex terrain of mental health policy, practice and promotion domains, as well as the possibilities for alternative forms of support or recovery orientation.

Conclusion

This chapter has discussed the considerable contribution of Michel Foucault's scholarship to the growing area of critical mental health studies. Foucault's work has significantly shaped how mental illness (and the assemblage of related concepts from diagnosis to recovery) has been problematised and made thinkable as an historical category. This body of work continues to inform contemporary debates about the effects of neuroscience, psy-discourses and pharmacology in classification systems, education and treatment contexts. Foucault's work has also been subject to critique and development by scholars who seek a deeper understanding of the dynamics of intersectional injustice (including race, gender, sexuality, age and disability) (Mills 2014), as well as those who wish to move beyond the primary emphasis on discursive formation. For example, drawing upon cultural theories of affect, Blackman (2012) explores how affective relations are entangled with the materiality of the body and hence shape the experiences of those who hear voices. Others drawing upon Deleuzian notions of assemblage (Duff 2014; McLeod 2014) examine the affective flows and intensities of mental health and illness that continually reshape embodied human and non-human relations through particular spaces and objects (such as medication). Foucauldian scholarship means that we can never return to naive assumptions about expert truth, nor as a society can we afford to ignore the effects of power on those who are discursively positioned as 'mentally ill'.

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5

Marxist theory

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While Marxist theory often draws on the critical work of labelling, social constructionist, antipsychiatry and Foucauldian scholars, it is clearly distinct from these positions in prioritising the structural dynamics of capitalism – particularly the material (economic) conditions – above all other variables in understanding mental illness and the mental health system. Capitalism is a system of societal relations based on the private ownership of the means of production and the systematic exploitation of the working-class population so as to maximise profit for the ruling classes. This dominant societal structure that we currently live with in the West is therefore marked by a fundamental disparity in the distribution of economic resources between the majority of the population and the ruling elite. The first half of this chapter outlines the main directions of argumentation in the area of mental health which have been offered by Marxist-influenced writers – namely, an understanding of the mental health system as a source of direct and indirect profit generation, and as an institution of social and ideological control. In the second half of the chapter I update the latter arguments so as to theorise the contemporary expansion of mental illness discourse under neoliberal ideology as a form of ‘psychiatric hegemony’. In the first section that follows, however, I briefly outline a third line of Marxist argumentation which focuses less on the mental health system as an instrument of capitalism, and more on the wider alienating conditions of that society which can determine poor mental health within the population.

Alienation

Although Marx never wrote explicitly on the subject of health or mental illness, Roberts (2015: 9) notes that he did see the increasing rates of lunacy in the nineteenth century ‘as a direct consequence of capitalism’. Indeed, the number of those diagnosed with a mental illness continued to grow throughout the twentieth century and is currently estimated to effect one in four people in countries such as the United States and the United Kingdom (Davies 2013: 1). Such afflictions are heavily mediated by social class position, with Rogers and Pilgrim (2003: 18) noting that the available research ‘suggests that a strong inverse relationship with social class exists for those with diagnoses of “schizophrenia”, “depression” (in women), “antisocial personality disorder”, “alcoholism”, “substance abuse”, and “non-specific distress”’

(for a recent summation of the evidence, see Cockerham 2017: 149–66). Thus, some Marxist scholars have theorised the growing rates of mental illness as an inevitable consequence of the oppressive conditions and alienating tendencies of capitalism which especially impact the working classes. Rosenthal and Campbell (2016: 34), for instance, state that '[c]apitalism is a sick social arrangement which damages physical and mental health'. Similarly, Robinson (1997: 75) argues that capitalism is a 'breeding ground' for mental illnesses because it creates the social conditions in which people require such a label as a coping strategy (1997: 24). The acceptance of a mental illness label under these circumstances, he forwards, is totally understandable (Robinson 1997: 2). For such writers, mental illness is fundamentally a product of capitalism and one which can only be eradicated with the overthrow of this class-based society. Taking the notion of being 'driven crazy by a crazy world' (Parker 2007: 214) one step further, Rosenthal and Campbell (2016: 58) conclude that, in fact, '[i]t is impossible to be mentally healthy under capitalism'.

In such circumstances, we are all implicated as alienated from a state of mental well-being by current economic conditions. As Laing (1967: 11) questioned of the human psyche in this environment,

What is to be done? We who are still half alive, living in the often fibrillating heartland of a senescent capitalism – can we do more than reflect the decay around and within us? Can we do more than sing our sad and bitter songs of disillusion and defeat?

This focus on the alienated individual in capitalist society, perhaps inevitably, has influenced some forms of therapy within the mental health system itself. Fromm (1991) famously argued that it was not people who were mad but society. However, he believed that a form of 'moral change' within individuals was still required to bring about a better society (Nahem 1981: 32), suggesting therapeutic interventions were inevitable. Similarly, Laing and his antipsychiatry colleagues worked with their patients as transcendental guides to understand and give meaning to their states of madness (Sedgwick 1982: 102–24). As a result, critical and left-leaning therapeutic interventions have aimed to 'emancipate' people from capitalist alienation. Following Fromm and Laing, for example, the US-based Radical Psychiatry Center in the 1970s declared of their self-proclaimed method for working with people that,

The radical psychiatrist sees anyone who presents himself with a psychiatric problem as being alienated; that is, as being oppressed and deceived about his oppression, for otherwise he would not seek psychiatric succor. All other theoretical considerations are secondary to this one.

Steiner 1975: 14, emphasis original

There is, however, a significant problem with this narrow focus on the alienating factors of capitalism as the explanatory variable for mental illness, in that it largely ignores any critical theorising of the mental health system itself. The practices, priorities and knowledge claims of mental health professionals are exempt from blame and, whether intentional or not, such an approach actually supports the *expansion* of mental health services aimed at the working classes and other oppressed populations. If Marxist scholars only focus their critical gaze outwards – on the victims of capitalism that have been labelled as 'mentally ill' – they risk ignoring the more salient dynamics of the mental health system which follow the prerogatives of capitalism to maximise profits and control the working classes. This will be demonstrated in the two sections that follow, beginning with scholarship which has theorised the economic dimensions of the mental health system.

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Profit accumulation

The most often cited example of capitalism profiteering from the business of mental health in contemporary society is the dominance of drug treatments. Despite the ineffectiveness of such interventions (see, e.g. Breggin and Cohen 1999; Burstow 2015; Davies 2013; Kirsch 2009; Moncrieff 2009; Whitaker 2010), the sales of psychopharmaceutical agents have recently exceeded US\$40 billion (Whitaker 2010: 320). As critical scholars have noted, the introduction of a plethora of new mental illness categories over the past few decades (such as attention deficit/hyperactivity disorder (ADHD), borderline personality disorder (BPD), generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD), premenstrual dysphoric disorder (PMDD) and social anxiety disorder (SAD)) alongside a psychiatric discourse that has falsely claimed mental disease as a biological reality, has served to exponentially increase the profits of pharmaceutical corporations as well as the credibility of mental health experts (see Whitaker and Cosgrove 2015). However, this is only the most recent example of capitalism extracting profit from a mental health system that has, since its beginnings, facilitated what the critical historian of madness Andrew Scull (1989, 1993, 2015) describes as an ongoing ‘trade in lunacy’.

Scull’s (1993: 29) analysis of the formation and growth of the public asylum system across Europe and America in the nineteenth century demonstrates that,

the main driving force behind the rise of a segregative response to madness (and to other forms of deviance) can... be asserted to lie in the effects of a mature capitalist market economy and the associated ever more thoroughgoing commercialization of existence.

Psychiatric institutions, he argues, became an economically efficient means of both separating the able from the non-able bodied (e.g. the sick, disabled, poor, alcoholic, vagrant and elderly) and keeping them under close surveillance by new professional authorities (Scull 1993: 33). The asylum offered an institutional base for the emerging psychiatric profession who, over time, could sell an increasing range of services to the marketplace (Scull *et al.* 1996: 5). While asylums sought to institute work regimes which could – at least in theory – return patients to the workforce (Cohen 2016: 99–101), private practice offered therapeutic services to the middle-classes, including the management of ‘disobedient’ daughters and wives (Cohen 2016: 149). Similarly, the introduction of psychiatric ‘treatments’ such as electroconvulsive therapy (ECT), psychosurgery and drugs can be understood as profitable services which have been useful in modifying the behaviour of the patient, in turn aiding capitalist prerogatives for increased productivity in the family, school and the workplace (Cohen 2016: 41–52).

As a number of medicalisation scholars have detailed (see, e.g. Conrad 2007), subsequent to the de-institutionalisation of patient populations across Europe and America in the 1960s and 1970s, we have witnessed an increasing de-regulation of the market, leading to the rapid expansion of private mental health services and products. Not only are enormous profits being made for the multitude of therapeutic services, drug treatments, research agencies, third sector organisations and insurance companies which surround the mental health industry, but also, notes Scull (2015: 376), from ‘the growth of nursing homes and board and care homes in which large numbers [of former patients have come]... to be confined’. This is the new trade in lunacy, he argues (2015: 376), in which ‘[a]n entrepreneurial industry [has] emerged, one which profits from this form of human misery, and is almost wholly unregulated by state authorities’.

Social control

Alongside profit accumulation, Marxist scholars most often theorise the mental health system as a key institution of social control. That is, they argue it is an authority responsible for reinforcing the dominant moral codes of capitalist society and punishing deviations from these (through, for example, the application of a mental illness label). As a branch of medicine mental health experts can claim a scientific neutrality and objectivity to their work, yet, in reality, their role is to sanction the behaviour and emotions of people which run contrary to the prevailing social order. As Scull (1993: 392–3) reminds us, psychiatry's claims to 'scientific practice' means it has 'great potential value in legitimizing and depoliticizing efforts to regulate social life and to keep the recalcitrant and socially disruptive in line'. With the continuing lack of evidence for their area of expertise (for a recent summation, see Cohen 2016: 9–17), it is generally agreed by critical scholars that psy-professionals (including psychiatrists, psychologists, therapists and counsellors) can only ever make historically and culturally bound judgements on the 'correct' and 'appropriate' behaviour of society's members. Ingleby (1980: 55), for example, makes the point that,

what one thinks psychiatrists are up to depends crucially on what one thinks their patients are up to; and the latter question cannot be answered without taking an essentially political stand on what constitutes a 'reasonable' response to a social situation.

In the same manner, the British psychiatrist Joanna Moncrieff (2010: 371) agrees that a 'psychiatric diagnosis can be understood as functioning as a political device, in the sense that it legitimates a particular social response to aberrant behaviour of various sorts, but protects that response from any democratic challenge'. Even the highly respected and staunch supporter of psychiatric medicine, Edward Shorter (1997: viii), admits that the profession is responsible for policing social deviance when he remarks that '[p]sychiatry is, to be sure, the ultimate rulemaker of acceptable behaviour through its ability to specify what counts as "crazy"'.

The social control function within psy-professional work practices and knowledge claims is reasonably easy to identify and has been a major focus of labelling, social constructionist and medicalisation scholarship since the 1960s (see, e.g. Conrad 1975; Goffman 1961; Rosenhan 1973; Scheff 1966). For example, considering the mental health system as a moral and political enterprise helps to explain the nineteenth-century labelling of runaway slaves in the Deep South of the US with 'drapetomania' (Breggin and Breggin 1998: 144–5) and early feminists and suffragettes with 'hysteria' (Showalter 1980). Likewise, it can help us understand the psychiatric labelling of young civil rights activists in the US as 'schizophrenic' in the 1960s (Metzl 2009), the inclusion of homosexuality as a mental illness in the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM) until 1973 (Kutchins and Kirk 1997: 55–99) and the more recent labelling of unruly young people with 'ADHD' (Conrad 2006).

While there is general agreement among critical scholars that the mental health system is a source of moral policing, there is less agreement as to what specific ends it serves. As a libertarian, Szasz (2010: xxii), argues that psychiatrists are fundamentally self-serving in seeking to 'enlarge the scope and power of the therapeutic state'; their aiding of government authorities in managing groups of deviants is useful only insofar as it aids their own professional expansion. In contrast, the neo-Foucauldian Nikolas Rose (1999) suggests that the psy-professionals in fact carry out a positive role as moral arbiters of our behaviour and emotions under advanced liberal conditions; the mental health system aids the self-surveillance of the subject and informs the limits of our conduct in contemporary society. Marxist scholars, however,

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theorise the moral entrepreneurship of the mental health system as ultimately tied to the requirements of the market, whether they be through the pathologisation of potential threats to capital, the profiteering from individual treatments, the expansion of professional services or the reinforcement of ‘normal’ and ‘acceptable’ behaviour in the name of ‘successful’ treatment outcomes. Through a Marxist analysis we can then understand the pathologisation of runaway slaves as an example of psychiatry supporting the (agrarian) economic system of the Deep South, the labelling of civil rights activists as the de-politicisation of threats to a US system of apartheid which exploited low-paid working-class black labour and the stigmatisation of suffragettes as ‘hysterical’ as the mental health system’s attempt to reinforce gender roles and the division of labour which so effectively serves capitalism (Cohen 2016: 169–204). Historically, as well as in the contemporary environment, the working classes are the primary target for the mental health system, with lower socio-economic groups being labelled, incarcerated and ‘treated’ for ‘mental illnesses’ at much higher rates than other groups, in turn de-politicising and neutralising threats to ruling-class authority.

Neoliberalism, risk and psychiatric hegemony

In my recent book *Psychiatric Hegemony: A Marxist Theory of Mental Illness* (2016), I argue that the social control function described above has taken on increased significance as neoliberalism has progressed. Primarily, the mental health system can now be considered as an ideological tool of capitalism which normalises the ongoing oppression of the majority of the population through a psychiatric discourse which has become totalising – or ‘hegemonic’. This section briefly outlines my rationale for this argument.

Despite the dubious knowledge base upon which psy-professionals rest their continuing claims to expertise on the mind, there is no doubt as to the contemporary proliferation of the psychiatric discourse into areas of public and private life previously untouched by the mental health industry. In day-to-day conversation, for example, when we make assessments of character or behaviour, we often articulate these using the language of the DSM – ‘your kid’s a bit hyperactive’, ‘those guys in the IT department are all on the [autistic] spectrum’, ‘she’s obviously experiencing mental health issues today’, ‘I’ve just got a compulsive personality’, ‘he’s totally addicted to gaming’, ‘you sound clinically depressed’ and so on. This is a seismic transformation in the way people talk about and make sense of themselves and others in contemporary society compared to some 40 years ago when the mental health system was viewed with a large amount of suspicion, their profession was experiencing an epistemological crisis and few people wished to align their personal behaviour with stigmatising psychiatric labels (Cohen 2016: 11–13). This change signifies the increasing ideological power of the psy-professionals to the point where their discourse has become ‘hegemonic’ – that is, an all-encompassing form of knowledge which works to naturalise and reinforce the norms and values of capital through professional claims-making. Our behaviour, our personalities, our lifestyles, our relationships and even our shopping trips are now closely observed and judged under the ‘science’ of the psy-professions, and we have, in turn, come to monitor and understand ourselves through a dominant psy-discourse. The reasons why we are in this current moment of psychiatric hegemony can be better understood with reference to Gramsci’s ideas on civil society and changes which occurred across Western societies, beginning in the 1970s.

In analysing the survival of capitalism in the twentieth century, the Italian Marxist Antonio Gramsci (1971) argued that the coercive powers of the state (e.g. the army, police and the judicial system) were comparatively ineffective in ultimately halting the revolution; instead, the ruling classes had secured a greater chance of survival through hegemonic power – the rule of the

bourgeoisie by *consent*. This consent for ruling-class authority is achieved through an intellectual and moral leadership which resides in civil society – public and legal institutions such as the school, the church, the media and the criminal justice system, as well as the health system (see, e.g. Navarro 1986; Waitzkin 2000). Civic institutions are much more effective than direct, repressive organs of the state in manipulating the masses due to their perceived detachment from elite control. Hegemonic power is conducted under the guise of objective and neutral institutional practice, though it is in reality nothing of the sort. Instead, intellectuals and professionals are responsible for legitimatising ruling-class ideas within the public sphere, articulating such values as seemingly natural and taken-for-granted knowledge about the world. What we understand as ‘normal’ and common sense is, in fact, dominant, capitalist ideas imparted through professional discourse. Thus, the mental health system can be understood as an institution of civil society with the potential to impart a hegemonic, ruling-class ideology through its practices, priorities and discourse. This, I argue, has come to fore with the development of neoliberalism.

The post-war period of social welfarism and popular state intervention in many spheres of social and economic activity (including state provision of health and welfare services, public housing, nationalised industries and a highly regulated labour market) effectively came to an end in the 1970s with high levels of inflation and unemployment (Schrecker and Bamba 2015: 13). In this climate there was a popular response from the economic elites – and then the electorates – to the ‘neoliberal’ ideas of economic philosophers such as Hayek (1976) and Friedman (1982), who argued that the well-being of the individual was predicated on the autonomy and freedom of the market in capitalist societies. As with the ‘freeing’ of capital from state intervention, neoliberal philosophy argued that the individual must also be ‘freed’ from the state. The withdrawal of the state from many areas of social and community activity and the refocusing on the individual as the site of responsibility and transformation begins to explain how the psy-disciplines came to expand their areas of jurisdiction. Rose (1996: 150–1) eloquently refers to the populace in this new set of political and social relations as ‘enterprising individuals’ – that is, subjects imbued with the core values of neoliberalism. This includes the very language we now use to speak of and understand ourselves – as autonomous individuals seemingly free to choose, yet personally responsible for our ‘failures’. As Harvey (2005: 65–6) has suggested of the neoliberal self,

While personal and individual freedom in the marketplace is guaranteed, each individual is held responsible and accountable for his or her own actions and well-being... Individual success or failure are interpreted in terms of entrepreneurial virtues or personal failings (such as not investing significantly enough in one’s own human capital through education) rather than being attributed to any systemic property (such as the class exclusions usually attributed to capitalism).

How we understand ourselves and the world is both shaped by and relies on the dominant language of this ‘enterprise culture’. In other words, the discourse traditionally associated with business and economics (e.g. ‘efficiency’, ‘productivity’ and so on) is now also used to refer to our own experiences, emotions and behaviour. In neoliberal ideology, the self has replaced the group, the community or wider society as the site for reform and change. This emphasis on the individual has seen the de-politicisation of social and economic inequalities to the point where, in the words of Ulrich Beck (1992: 100, emphasis original), they have been redefined ‘in terms of an *individualization of social risks*’. Most pertinent to understanding the role of the psy-professions in neoliberal society is that ‘social problems are increasingly perceived in terms of psychological dispositions: as personal inadequacies, guilt feelings, anxieties, conflicts, and neuroses’ (Beck 1992: 100). In this ‘risk society’, ‘expert’ groups such as psychiatrists and psychologists have become

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increasingly important to capitalism in their attempts to scientifically speak to the 'risky' behaviour of the individual. This rise of 'expert knowledge and expert opinion' in neoliberal society, remarks Turner (1995: 221), means that such discourse is 'highly politicised'. Thus, as the social state has fallen away with the expansion of neoliberal ideology, the psy-disciplines have come to play a key role in promoting and perpetuating the focus on the risky subject. They have progressed their moral authority into new areas of jurisdiction, with every individual within a population redefined under a hegemonic psychiatric discourse as 'in a permanent condition of vulnerability' to mental illness (Furedi 2004: 130). For Rose (1999: vii), the psy-professions have played 'a very significant role in contemporary forms of political power', so much so that the disciplines 'make it possible to govern human beings in ways that are compatible with the principles of liberalism and democracy'. This is due to their professional focus on character reform and self-realisation – values which have a high degree of symmetry with the neoliberal project.

As the priorities of capitalism changed, so did psychiatric discourse. It was, for example, with the publication of the third edition of the DSM in 1980 (the DSM-III, see American Psychiatric Association 1980) that the APA significantly increased the range of mental disorders, as well as making them more user-friendly (Cohen 2016: 75–81). The DSM began to speak the language of neoliberalism, highlighting everyday issues in settings beyond the institution. Rather than only disability and illness, recovery and growth were now also promoted as possible. Previously dominated by the negative institutional classifications of schizophrenia and manic depression, the expanding range of personality, identity and anxiety disorders from the DSM-III onwards has initiated a more 'positive' discourse of day-to-day concerns, inadequacies and traumas. In the post-institutional climate, acute and severe mental disorders have been replaced with the now 'common disorders' of ADHD, autism, BPD, GAD, PTSD and SAD, for which the prescribed treatment is much more likely to be drugs or therapy rather than committal. The impressive results of this neoliberal shift in the psychiatric discourse towards the idea of 'positive' mental health can be seen in the countless 'awareness campaigns' invoking the risk of mental illness within the general population ('it's everyone's problem'), as well as the mass screenings and 'early intervention' programmes in schools to 'catch' the early phases of mental illness in children and thereby 'prevent' a more serious disorder in adulthood. Further examples include the expanding number of epidemiological studies which claim to highlight yet more cases of mental pathology which have gone undetected and/or untreated in the community, the grassroots movements campaigning for further aspects of behaviour or personality to also be classified as an official mental disorder and the general high levels of self-labelling within the population.

What is also evident here is that the APA's turn to the biomedical model of mental disease with the DSM-III (Whitaker and Cosgrove 2015: 9–25) has been crucial to promoting neoliberal solutions focused on the individual. This has successfully de-politicised the non-conformity of the individual through suggesting that 'chemical imbalances' in the brain are the root of the problem. As Moncrieff (2008: 243) has recognised, the rise of biomedical psychiatry and neoliberalism are intrinsically linked – 'the chemical imbalance idea of psychiatric problems facilitates the neoliberal project', she argues, and 'features of neoliberalism in turn strengthen the chemical balance theory and biopsychiatry more generally'. The increasing social and economic disparities in neoliberal society are individualised through biomedical ideology. Moncrieff (2008: 248–9) states that this represents:

a clear instance of the medicalization of political discontent. But this situation is not overtly coercive. This view has not been imposed on people by direct force. People themselves have come to see their problems as individual problems, emanating from their brain chemistry.

Thus, biomedical ideology as a part of psychiatric hegemony has become the dominant ‘solution’ to what are social and economic conditions of late capitalism. Biomedicine promises a range of corrections in line with neoliberal conduct, such as improved productivity and marketability as well as ‘recovery’ and the ‘normalisation’ of mental disorders for those who are at risk of deviating from their expected roles as workers, consumers, students, homemakers and reproducers of the future workforce. Yet psychiatric hegemony encompasses more than the dominant biomedical rhetoric and can also be detected in social models of the psy-professions. Feminist therapists, for example, argue that a legitimate response to a climate of antifeminism is now to work on the self-esteem of their clients. ‘Hence,’ remarks Dubrofsky (2007: 266), ‘social, political, and economic problems are turned into personal problems that can be solved by an individual who is willing to work on him- or herself.’ It is but one example of an all-encompassing psychiatric discourse that denies the social and political realities of late capitalism and has successfully placed the focus back on the individual as the site of change.

Conclusion

This chapter has outlined a number of Marxist approaches with which to understand both the rise of mental disease in capitalist society as well as the growth in professional power and profiteering from the business of mental health. While theorising mental illness as a result of the alienating conditions of capitalism may appear to have merit, I have suggested that it is necessary for Marxists to focus their energies more on analysing the ways in which the mental health system supports the economic and political prerogatives of the ruling classes. This allows us to make sense of the ‘trade in lunacy’ – from the birth of the psychiatric profession with the asylum system to the current market for psychopharmaceuticals – as well as the medicalisation of groups of deviants with various mental illness labels. Ultimately, the business of mental health supports profit accumulation alongside the social control of problematic populations. As neoliberal ideology has developed over the past four decades, so psychiatric discourse has infected more and more areas of economic and social life; we are now living with what I refer to as a ‘psychiatric hegemony’, a totalising form of professional claims-making, imbued with neoliberal values but appearing as an objective and neutral discourse on mental disease. As such, mental health ‘experts’ have probably never been as powerful as they are now. Under such circumstances, it is more urgent than ever that critical scholars of mental health are encouraged to engage with and utilise Marxist approaches so as to be able to more thoroughly analyse the structural determinants of the psychiatric expansion we are currently witnessing.

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6

Critical cultural theory

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This chapter argues that in the developed West we live in societies where neoliberal values encourage individuals to compete with each other, resulting in ‘winners’ and ‘losers’, and where the ever-present anxiety of losing has been subject to market forces resulting in the growth of a profitable mental health industry that locates causes and solutions of failure and other struggles as residing within the individual. Due to my focus on the broader social, political and cultural contexts, there is, of course, a danger of losing sight of the intentional person making sense of their reality. The arguments forwarded here, however, should not be seen as deterministic and able to explain the specific struggles of any individual or family, merely a broader set of tendencies within which such conflict and distress are situated. Nonetheless, this position also understands that children are socialised by belonging to a particular culture at a certain moment in that culture’s history, so that certain aspects of young people’s behaviour can be seen as influenced by broader tendencies involving beliefs and practices around child development, family functioning and institutional and socialisation processes, all of which are influenced by the economic and political realities that govern our material lives.

Competition

Competition is a key economic driver in neoliberal economies and hence a widely held social and cultural value. In neoliberal capitalism market forces are freed to govern all aspects of societal functioning, including institutions previously owned, regulated or managed by the state. Thus, from transport to schools, the dominant ideology is that competition will improve ‘standards’ and is preferred to cooperation and/or social responsibility as a vehicle for improving well-being (Braedley and Luxton 2010).

Neoliberalism sees competition as one of the defining characteristics of humanity. Citizens are viewed primarily as consumers, who exercise their rights to ‘freedom’ through buying and selling whatever they want in a process that extols the virtues of success (often measured in material wealth) at the same time as making people anxious about failing in whatever arena they have found themselves competing. Inequality is viewed as inevitable and being on the ‘failure’ side of inequality is regarded as due to personal deficiency and/or inefficiency in competition. In this type of cultural milieu the importance of social solidarity gives way to a preoccupation with

individual performance. The social unit and concept of the 'self' in neoliberal societies, therefore, is the individual in competition, with those around her involved a never-ending struggle to be 'better' (smarter, stronger, wealthier, more famous and so on) than their peers. Of course, very few will achieve such neoliberal-style 'self-actualisation'. Most are then subject to the ongoing fear of falling behind and becoming defined (and/or self-defined) as being a member of a class of 'losers'. To live in a social context where you perceive that you are in the loser class and where this is individualised (as evidence of weakness, dysfunction, undeserving, or – to soothe the guilt of the winner – 'vulnerable') is obviously painful. Neoliberalism, however, has commodities to sell to help you deal with this, which I will return to later.

According to McKenzie (2001), 'performance' has replaced 'discipline' as a way of regulating power and knowledge in neoliberal cultures. He argues that the pressure to perform underlies, in a variety of ways, widely divergent domains of contemporary life. From corporate management to academic practices, performance has become central. Knowledge in neoliberal ideology is produced through a system's (and by extension an individual's) performance, be it organisational, cultural or technological. Systems, organisations and individuals are subject to ongoing surveillance and monitoring of their performance using surrogate measures of efficiency (from exam results and school league tables to work appraisals and stock market share values). Knowledge and power are thus produced less through hierarchical imposition (though plenty of this still exists, see Cohen 2016), but more subtly through production of competitive performance-related information.

The effect of absorbing this ideology on individuals in society is to atomise the individual and insulate their private spaces to the degree where obligations to others and harmony with the wider community can become obstacles rather than objectives. In this 'look after number one' value system, other individuals are there to be competed against as they too chase after their personal desires across a variety of performative areas. Figuring out who is the 'top dog' in what and, once achieved, how to stay there is more defining of personhood than how we support each other and our communities.

Children are cultured into the virtues of competition and consumerism through competitive performance across a variety of arenas and by virtue of living within societal institutions (such as schools) that embody these values, as well as being exposed daily to its discourses (such as through the media). The emotional correlates of 'failure' such as misery, fear and demoralisation are naturalised, individualised – and so de-politicised. In this cultural milieu, feelings of insecurity, anxiety and stress and epidemics of self-harm, eating disorders, depression, loneliness, performance anxiety and social phobia/shyness have increased (Verhaeghe 2014).

The impact of competition starts young. An analysis of the academic performance of the entire state school population of England in 2013 replicates a common finding that the fortunes of the youngest in the class, compared to the eldest in their class, are dramatically different over the course of a lifetime. August-born children (the youngest in the class) get consistently lower results in school exams, are more likely to leave education at 16 years old, are more likely to report feeling 'unhappy' and have a lower chance of getting into a high-performing university (Henry 2013). Similarly, an 11-year study of 938,000 Canadian children (that confirmed the results of two earlier large-scale American studies) found that children born in the last months of a school year are far more likely to be diagnosed and receive medication for attention deficit/hyperactivity disorder (ADHD) than their older classmates (Morrow *et al.* 2012). Performative competition, it seems, starts young and its impact continues for years. The effects go across the childhood population and are not just confined to various sub-groups. Thus, surveys on various aspects of childhood well-being consistently find that children in those countries that pursue the most aggressive neoliberal policies (such as the

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UK and the US) are ranked as the worst off among countries in the developed world (e.g. United Nations International Children's Emergency Fund 2007; United Nations International Children's Emergency Fund and Mori 2011).

Commodification

Commodification refers to the process by which goods, ideas – indeed, anything – can become a 'thing' with a commercial value that can be bought and sold, and subject to the influence of the market (Appadurai 2005). Once a market industry grows around a commodified 'thing' and it becomes available for making monetary profits, this 'thing' becomes vulnerable to the manipulation of consumers by the money-makers (with promises of a better life if they 'buy' or have this 'thing'). Childhood, parenting, children's distress and professional approaches to intervening in this have all become subjects of commodification. Human suffering that follows from the pressures inequalities within the economy put on people are turned into opportunities to create individualised explanations and therefore 'treatments'. The growth of this consumerism contributes to both an increase in certain behavioural problems and the continual expansion of the repertoire of behaviours and emotional states found in children that are considered to be 'abnormal' (and therefore in need of correcting and treating with this or that product). Neoliberal political economy has successfully commodified most domains of contemporary life, moving from goods to services, and in recent decades this has included the commodification of subjective states – from those considered 'disorders' (such as ADHD, autism and depression) to enhancing well-being, emotional intelligence and self-esteem.

Commodification distances people from a more considered and involved understanding of the problems being experienced. It also disconnects people from the possibility that they already possess the knowledge to know how to deal with their subjective states (positive or negative), at the same time as reinforcing the idea that any perceived failing or suffering is the result of personal and internal factors that need experts who have the technical know-how in order to manipulate and 'cure' these internal 'dysfunctions'. Individuals 'buy' expert/technically developed commodities (such as particular diagnoses, medications and psychotherapies) which they are led to believe will enhance their quality of life with little adverse effect.

In a culture that is driven by the social arrangement in which the buying and selling of goods and services is not only the predominant activity of everyday life, but is also an important arbiter of social organisation, the commodification of distress and perceived deviance should come as no surprise. Thus diagnostic categories relegate markers of individual differences to ones of lesser significance and instead promote a more uniform and standardised set of 'types', which are easier to 'package', promote and sell.

Childhood distress was once the remit of parents and families to deal with and, in most parts of the world, this remains the case. However, once this responsibility begins to migrate into being the remit of a professional class whose livelihood is based on an 'expertise' in alleviating childhood distress and preventing behavioural deviance, and when this occurs in a free market context, then the commodification of distress/deviance in children and families is just around the corner. Once we have categorised states of emotional and behavioural difference or deviance and these categories enter the market, they become subject to the process of 'branding'. Each brand (such as autism, ADHD, bipolar disorder and so on) will develop a market that includes a variety of products and services such as professionals (with expertise in the brand), books, courses and, of course, particular treatments (such as a particular medication or a particular form of psychotherapy). Potential consumers for these brands will include teenagers worried about their state of mind and their perceived futures, as well as other adults in caring relationships with these

young people (such as their parents and teachers) who, partly as a result of the dynamics mentioned above, have come to be concerned that their child has a problem and that this problem is beyond their capability to resolve.

However, it is not just parents, but a host of other social actors who have been influenced by these neoliberally inspired cultural beliefs (for example, politicians, social workers and teachers); these actors play important roles directly as consumers for children under their authority or as consumer advocates encouraging parents to become consumers. These consumers now seek out a brand or a product (a diagnosis, an expert, books, a treatment) based on the information they receive (from advocates, media and a variety of other marketing sources) in the hope that the product will offer a form of 'validation' (of the struggles and anxieties being experienced) and/or a sense of 'promise' (having the 'product' or brand – such as a diagnosis – will lead to an improvement in their or the child's life). Like all commodities, the appeal is more at the emotional/desire level rather than the rational one.

Once this system is set in motion we can predict a number of things will happen. Commodities tend to give only temporary experiences of satisfaction as markets must keep selling to keep the monetary flow going and so must keep convincing consumers that there is a better product available or that if they stop consuming the brand (for instance, renounce a diagnosis or stop a medicine) their life would deteriorate. In other words, once an area of life has been subject to market commodification, we can predict that the market will grow in volume as the pressure to make profit continues and new products and competitors enter the arena. Thus, the number of available psychiatric diagnostic categories has continued to expand, both in the 'official' manuals and in everyday practice (Davies 2013). Not only do new categories emerge, but also new sub-categories, the number of professionals providing services, the number of specialisations and sub-specialisations, the number of treatment models (for example, there are now well over 400 systematised models of psychotherapy, see Duncan *et al.* 2010) and so on. There is now a bewildering array of commodities out there for the concerned parent or teenager to access.

Unlike the rest of medicine, where diagnostic categories have largely developed around an aetiological basis and where treatments have demonstrated sustained improvements in outcomes for patients, there is little encouraging news for long-term mental health outcomes and some potentially discouraging ones (Whitaker 2010). Like any market, there are periods of high consumption resulting in a pruning off of some competitors. Likewise, commodities can be subject to the changing whims of the producers and consumers as certain products go in and out of 'fashion' (such as 'autism' becoming more popular and 'learning difficulties' becoming less popular). As a relatively young market, this 'McDonaldisation' of children's mental health has only just started. The owners of these new products (for example, institutional psychiatry and psychology based in the West, in partnership with the financial and marketing prowess of the pharmaceutical industry) are only just beginning the mass export and globalisation of this market with all the ideological implications this contains (Timimi 2010). Similar to the relationship between the dieting and food industries, our consumer culture contributes to creating mental stress and, as it spreads, this distress now presents itself as a new and growing market for exploitation and profit.

Scientism

'Scientism' is the belief in the universal applicability of the scientific method and approach, and the view that empirical science constitutes the most 'authoritative' worldview. Scientism reflects a tendency of putting too high a value on natural science in comparison with other branches of learning or culture (Sorell 1994). I use the term 'scientism' to describe the inappropriate usage of science and the deferential lack of critical questioning of claims made by those in the

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mental health industries who call themselves ‘scientists’ or maintain that their arguments, results or practices are ‘scientific’ – based on the belief that their findings are scientific because they do ‘science’, rather than because of what the actual findings show (Whitaker and Cosgrove 2015).

In order to gain a market in a culture where the cosmology uses a narrative of science for authoritative positioning, using the language of ‘science’ is more valuable than the actual research findings if what is discovered is unhelpful for selling the product. Thus ‘evidence-based’ becomes a phrase liberally attached to products (whether pharmaceutical or psychotherapeutic) as the narrative of advancement in health is associated with technology and the rhetoric of ‘scientific progress’. Mental health is now an arena dominated by the language of scientism, where the use of brain scans, discussions about genetics and the concept of ‘evidence-based’ treatments fits into the image of a scientific technology that offers hopes and remedies to the problems of living. This scientism has enabled the hiding of the actual evidence which finds that the outcomes and prognosis for mental illnesses have been declining and that none of the psychotherapeutic or pharmaceutical technologies have proven themselves to be that much better than placebo treatments, particularly in the long term, and many may also be harmful (Timimi 2014). Instead, the ‘evidence-base’ tells us that to work effectively with those presenting with what we call mental health problems we must foreground the non-technical aspects of our work (Bracken *et al.* 2012).

The professionalisation of growing up

Maintaining the concept of ‘freedom’ in neoliberal societies means that control is often maintained through mechanisms that encourage populations to internalise, self-monitor and self-censor, rather than through more overt mechanisms of direct military/police state control (although the ‘war on terror’ has provided opportunities for greatly expanding these overt controls as well). Young people and their carers are now invited, through the ubiquity of discourses on young peoples’ mental health, to monitor their internal states, behaviours and their approaches to child-rearing. This process is encouraged by the large amount of surveillance to which parents and their children are subjected, with an army of professionals tasked with this monitoring and an array of commodities made available that are promised to enhance lives by ‘treating’ or otherwise ‘improving’ their wellness. When the young person is not reaching the expected high-level efficiency or shows what are considered deviations from the expected pre-destiny inscribed for successful neoliberal subjects (such as having fun at the same time as achieving academic success), introspection on personal failures and the search for an individualised solution is deepened. If they cannot be returned to being successful neoliberal subjects, then they may be categorised as vulnerable (to failure) and a part of the growing numbers assumed to be chronically unwell (current concepts of mental illness, influenced by neoliberal understandings, locate the individual/body as the site of pathology) who may need to become long-term consumers of mental illness-related products (from diagnoses to pharmaceuticals, therapies and various social supports).

The increase in levels of anxiety among parents, teachers and others who care for children means that many fear the consequences of their actions to the point where they may consider that any influence that is discernible (such as placing boundaries or influencing their belief system) could be viewed as undue influence. This increases the likelihood that parents will leave essential socialising and guidance to the expertise of professionals as, surrounded by a discourse that paints childhood and child-rearing as loaded with risk, they lose confidence in their own abilities (Maitra 2006). The increased use of medicalised and technicalised (scientism) explanations for behaviour and its attendant problems have far-reaching effects, changing our ideas and expectations of what we consider to be normal, acceptable and desirable, as well as influencing

beliefs about free will, personal responsibility and the nature and meanings attached to what might be considered as suffering. For example, if impulsive and aggressive behaviour by a child is viewed as being *caused* by a brain disorder called ADHD, then it is considered to be behaviour that a child or their parent cannot consciously influence and one that requires medical assistance to remedy, thus shifting activities previously considered pedagogic (and the remit of parents and teachers) into the medical arena (Tait 2006).

In this anxiety-loaded, narcissistically predetermined vision of childhood and practices of child-rearing, diagnoses such as childhood depression, ADHD and autism appear to provide a temporary relief to the beleaguered, intensely monitored child carers. Viewing children's difficult behaviour and distressed emotional state as being caused by an 'illness' apparently spares all from further painful scrutiny and confronting the fear that you are one of the failures as an individual, a parent or a teacher and so on.

Implication for practitioners

I have argued in this chapter that the principles that structure the economy of neoliberal societies also influences its value system, which in turn affects the narratives that people absorb and the nature of the societal institutions they interact with. I have focused on the effects on young people (and those in various caring roles for them) of growing up in societies that promote competition, commodification and a discourse of 'scientism'. Pressures to compete and then deal with perceiving oneself (or being perceived by others) as a 'loser', the individualisation of identity and ambition, the internalisation of anxieties of failing, the mass surveillance of parents/teachers and young people, and the commodification of potential solutions (such as through the offer of pharmacological and psychological therapies) all contribute to the rapid growth in numbers of psychiatric diagnoses given to the young, and the increasing prevalence of services and products for these diagnoses.

The current diagnostic systems used in psychiatry have failed to establish themselves as scientifically credible or clinically useful. The available evidence does not support the notion that formal psychiatric diagnostic systems like the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the mental health section of the *International Classification of Diseases* (ICD) have credibility as scientifically based or clinically useful manuals (Timimi 2014). Based on currently available evidence, manuals like the ICD and the DSM cannot be used to advance research or practice, therefore real-life services should abandon designing services around their diagnostic concepts. Paradigms that draw on the existing evidence for what improves outcomes and that incorporates the views of those who matter most – namely, service users – can improve outcomes, efficiency and the humanity of services. The message from outcome-based research is that services can improve by concentrating on the contextual and real-life experiences of patients and developing meaningful relationships with them that fully include them in decision-making processes (Bracken *et al.* 2012). Incorporating service-user feedback will help deliver flexible treatment models where there is regular testing of whether or not a particular intervention is improving outcomes for that particular service user (Duncan *et al.*, forthcoming). We should campaign for reorganising our approaches to mental health locally, nationally and internationally to develop services that use such evidence-based paradigms to improve outcomes and reduce the amount of harm that diagnostic systems like the DSM and the ICD have caused.

One of the problems for practitioners wishing to take this service-user focus is that, just like any other members of society, patients will be influenced by the dominant discourses of that society. Those living in neoliberal cultures may already be influenced into expecting the delivery of an easy to consume commodity to solve whatever difficulty they perceive they

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are experiencing. In particular, the success of the pharmaceutical industry in promoting such medicalisation of all forms of suffering is well recognised – the challenge for the compassionate practitioner is how to respond to this ethically. A challenging stance may fatally damage the therapeutic alliance, while a stance of passive acceptance may expose the patient to unnecessary harm. There are no easy answers to such dilemmas, with each therapeutic encounter having to be negotiated on its own merit and with an awareness of the dynamics described in this chapter.

While, as academics and practitioners, we can confront and challenge the problem of scientism in psychiatry, addressing the wider cultural and societal dynamic of competition and consumerism requires organised politics. This chapter reminds us, therefore, that, in the arena of mental health, politics – both macro (economic, political and societal structures) and micro (within organisations and professions tasked with delivering mental health services) – cannot be escaped. The healthy development and thriving of children and young people may ultimately depend on a kinder and more cooperative form of economy and politics. In the meantime, those of us working in the mental health field must do all we can to avoid falling into the trap of promoting the vicious neoliberal system by passively accepting the roles handed out to us of commodity peddlers, increasing the market share for a corrupting McDonaldised and pharmaceuticalised mental health industry.

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Critical realism and mental health research

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This chapter proposes that all social scientists studying mental health, implicitly or explicitly, adhere to philosophical assumptions about being, knowing and values. In formal terms we all adopt, consciously or unconsciously, some position about ontology, epistemology and ethics. Moreover, I argue below that, for those interested in exploring the complexities of mental health, the philosophical premises of critical realism (CR) strike the best balance in relation to these interweaving forms of enquiry (I provide a fuller account of this in my monograph *Understanding Mental Health: A Critical Realist Exploration* (Pilgrim 2015b)). The chapter is divided into three sections that: introduce basic CR; contrast the philosophy with positivism, on one side, and strong social constructivism, on the other; and offer case studies about psychiatric diagnosis and child sexual abuse to illustrate these differences.

Some relevant aspects of basic critical realism

The formal origins of basic CR are in the work of Roy Bhaskar (Bhaskar 1997). This was then elaborated in social science by, among others, Margaret Archer (Archer 1995) and Andrew Sayer (Sayer 1997). For the purposes of this chapter, some major elements of CR will be introduced, to offer its defining aspects and to introduce the advantages of it for non-philosophers, in both the natural and social sciences.

Those elemental aspects of CR are 1) ontological realism, 2) epistemological relativism and 3) judgemental rationality. Ontological realism is the axiomatic position in CR that the world exists independent of the way we describe it. It is not only mind independent but species independent. (If humans were wiped out, reality would still be there.) For CR, reality has intransitive and transitive aspects. The first are durable but the second are transient and fluid and are inflected by our descriptions and perspectives, which cues the next and second CR element.

Epistemological relativism is the assumption that we construe the world individually and collectively (for example, in religious and political ideologies). If we *act* upon the way we construe the world, then this means altering it in some way, large or small, and in that way the transitive domain enters the intransitive domain. For example, if I think the world is oppressing me and my peers and then I act to change the world as a result, then my thought becomes action and thereby my inner reality transforms my outer reality by intention and possibly successfully. Praxis

thereby links thought and action in human agency; we hold transformative powers but these are constrained by the real material conditions of possibility linked to our bodies, our time and place and our position within them.

Because human action entails meaning-laden motivations and post hoc evaluations, then we cannot readily separate facts from values. However, in taking into consideration those values and discerning particular aspects of reality, we can weigh up what is true. This means that we operate judgemental rationality not judgemental relativism – our judgement about what is likely to be fair and true (after weighing up evidence and applying logic) is non-arbitrary. Reality is not merely a matter of opinion or epistemological privilege and all perspectives are not of equal value.

We can err during our attempts at judgemental rationality in a variety of ways. One is to over-value our descriptions of the world, when we confuse the map with the territory (this is called the ‘epistemic fallacy’). In a closely related error, we can be acculturated into reading reality as being self-evident in some way, when we may be wrong. For example, if a person is not intelligible in their actions to us they are deemed to be ‘obviously’ mentally ill (this is called the ‘ontic fallacy’). Reality is complex and we must approach it cautiously, sceptically or critically (hence *critical* realism). Reality is multilayered (‘laminated’) and contains within it a range of generative mechanisms. These may occur alone or together (‘synergistically’) to create the emergence of actual events. But some mechanisms may interrupt or cancel out the emergence of events from other mechanisms. Moreover, we cannot reduce one level of reality to another (logical and empirical reductionism). Recurring attacks within mental health research on bio-determinism point up the error of the latter.

Thus, for CR we have three domains of being. The real is the totality of everything that exists and does not exist. The actual is what actually emerges into events in the world. The empirical is what we then observe about some of the actual. This triple conceptualisation of the real, the actual and the empirical means that there is more to reality than the empirical – much happens that we are unaware of (the unobserved actual). Accordingly, empiricism is a limited defining philosophy for science and its legitimacy in society. The wider domain of reality also contains *potential* powers, whereby events are not actualised. For this reason we also should be wary of reducing all reality to what emerges as events (‘actualism’).

The implications of all the above are as follows for researchers in human science: first, we expect reality to be there and to be complex. It is not just about the way we see the world and neither will there be simple answers to complex questions (such as ‘what is the cause of schizophrenia?’). Although epistemology is important, it does not exhaust our task in social science – we must address ontological claims but not do so naively. To rely only upon epistemology leads to linguistic reductionism and this fails to address questions of causality. Second, if we address causality then it is likely that multifactorial explanations will be required and that context-specific formulations are implicated, especially in open living systems. Third, we are part of what we study and so there is no disinterested value-free position. Fourth, if our research efforts are in the service of a better world, then the notion of ‘critical’ will refer not just to caution and scepticism about methodological certainty, but also about the values that drive our research questions (or fail to do so) and inform our interpretive procedures in the face of data. Research always has a moral and political dimension.

Between naive realism and strong social constructivism

The above section has already intimated that CR is not aligned wholly with positivism or with the radical constructivism associated with philosophical idealism (which would now include social phenomenology, symbolic interactionism and French poststructuralism). The fundamental distinction between CR and positivism (and its closely associated form of naive realism – empiricism) can be traced to the difference of view from two pre-Socratic philosophers, Heraclitus and Parmenides.

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The first of these upheld an axiom that informs CR: ‘a man cannot step into the same river twice as fresh waters ever emerge around him’. By contrast Parmenides upheld the view the world was not just real, but that reality was given in a constant fixed state by the gods. Our approach to reality can either approach it as being in flux and context-bound, or as a fixed and permanent set of events and processes than can be revealed in lawful relationships. (Hence the preoccupation of positivist natural and social science with discovering universal and abiding laws from an observer position of disinterested objectivity.) This, then, is at the heart of the difference between naive and critical realism today.

On the other side from positivism is idealism and its legacy of strong social constructivism. This is focused singularly, or overwhelmingly, on epistemology and has been modish in the social sciences, arts and humanities since the postmodern or linguistic ‘turn’ of the 1980s. It culminates in a distrust of reality (seeing it as an unstable and contestable epiphenomenon of discursive activity). The focus in the tradition is the elaboration and discussion of narratives and discourses. These are situation-specific, infused with power and open to change across time and place.

CR accepts some of these points in some circumstances (and so can be described fairly as a form of ‘weak constructivism’), but it also insists on ontological realism. This means that epistemological concerns in social science do not exhaust our task: we must explore ontology and give it due respect. Everything is *not* ‘socially constructed’. We construe reality (individually and collectively across time and space), but we do not construct it (in the sense of making it).

Moreover, whereas strong constructivism culminates in historical, cultural and judgemental relativism, CR considers that we should replace the last of these with judgemental rationalism instead. Relativism is a feature of human societies, but there are abiding and recurrent concerns about progress, justice and the recognition of what it is to be human. Moreover, there are some aspects of human existence that are demi-regularities. For example, misery, unintelligibility and incorrigibility are abiding concerns of all societies, even if there is variation in how they are codified within shifting societal norms.

Thus, CR shares the ontological concerns of positivism and the context-bound and meaning-laden concerns of idealism but it does not embrace other aspects of the two philosophical currents. Table 7.1 indicates ways in which CR sits between these two positions for the reader

Table 7.1 Comparison of features of naive realism, strong constructivism and critical realism

	<i>Naive realism (form of positivism)</i>	<i>Strong constructivism (form of idealism)</i>	<i>Critical realism</i>
Importance of context	No	Yes	Yes
Ontological realism	Yes – and governed by universal laws discovered or awaiting discovery	No – arbitrary, contingent, ephemeral or even scorned. ‘Everything is socially constructed’	Yes – primary focus. Reality is governed by emergence in flux. Accepts real demi-regularities
Epistemological relativism	No – avoids subjectivity and aspires to objectivity	Yes – and is the primary focus	Yes – but the degree is case contingent
Judgemental rationalism	Yes – but limited to empiricism or actualism. Falsifiability is guide. Facts and truth simply accepted once proved	No – favours judgemental relativism instead. Facts and truth are constantly queried. Facts and values are not separated	Yes – but case contingent. Facts and truth accepted sceptically. Facts and values not separated. Falsifiability accepted in principle

to consider (and accept or reject). It is evident that CR accepts some elements of positivism and idealism but rejects others.

I now move to illustrate the above points in mental health research by setting CR first against positivism (by examining psychiatric diagnosis) and then against idealism and its legacy of strong social constructivism (by examining child sexual abuse as a putative moral panic).

Critical realism and mental health research

Critical realism is a philosophy. It is not a theory or model or methodology but it does have implications for all of these three. Because its premises are broad, about blending ontological realism, epistemological relativism and judgemental rationality, then any theory, model or methodology which conforms to that blend can be aligned with, and be informed by, CR. For example, in health research, the biopsychosocial model is compatible with CR (but has some limitations) (Pilgrim 2015a). General systems theory (GST) is more fully aligned with CR (Mingers 2011). Also mixed methods are implied, with both quantitative and qualitative methods having their role, depending on the research question.

Critical realism, as its name implies, is about reality, but it is also about scepticism and critique. Three versions of the latter are important and have relevance to the investigation of mental health: immanent critique, omissive critique and explanatory critique. In the first we ask: 'does a claim make sense in terms of its own fundamental or axiomatic premises?' The second asks: 'why are we asking this question and not another one?' The third asks: 'how and why has this claim emerged?'

In any particular investigation all three forms of critique might be relevant. The research approach of CR in many ways is like good journalism or detective work. How do we make sense of what we observe in the light of the facts that we can, in good faith and with reasonable certainty, agree on? This does require interpretive procedures (in common with the idealist tradition in social science), but it also requires a confidence in truth claims about reality (fact-claiming in common with positivism). To give a sense of the concurrent application of these three forms of critique, I now provide two case studies about psychiatric diagnosis and child sexual abuse. The first reflects the tradition of positivism and the second has been problematised by social constructivists as a moral panic.

Critical realism and psychiatric diagnosis

An immanent critique of psychiatric diagnosis reveals the following shortcomings, which undermine its credibility as a form of medical science in practice (Bentall 2010; Johnstone and Dallos 2006; Pilgrim 2015b):

1. *Measurement/empirical validity.* A valid medical diagnosis should have measurable phenotypes that reflect a proven natural disease entity. The disease becomes empirically manifest in an embodied form. However, the bulk of psychiatric diagnoses have no measurable signs. They simply reflect judgements based upon social norms, which are then medically codified by psychiatrists. Diagnosis adds no scientific value to common sense judgements about psychological deviance.
2. *Construct validity.* A category must be coherent and clear and separate from other categories. Clear conceptual boundaries should exist between one disease and another. However, there is a large symptom overlap between psychiatric categories.
3. *Prognosis/predictive validity.* A diagnosis should deliver a predictive advantage beyond guesswork. However, functional psychiatric diagnoses have poor predictive validity.

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4. *Inter-rater reliability.* Psychiatrists should agree with one another about a diagnosis in a particular case. However, in practice, psychiatrists often put forward different diagnoses in the same case.
5. *Test-retest reliability.* A diagnosis should reflect a stable clinical state. However, patients not only have periods of being symptom-free, they also often accrue several diagnoses over time.
6. *Aetiology and pathogenesis.* A valid medical diagnosis should manifest aetiological specificity. However, functional diagnoses are functional *because* causal antecedents are unknown or are contested. In modern psychiatry, with the exception of post-traumatic stress disorder (PTSD), there is no specified antecedent.
7. *Treatment specificity.* A particular treatment should be aligned with a particular diagnostic state and not others. However, it is common for treatments for one diagnosis to be used in another.
8. *Acceptability.* A good diagnosis should be experienced as being helpful by its recipient. However, patients often experience it as being unhelpful and stigmatising.

Thus, applying the method of immanent critique from CR to psychiatric diagnosis, we find the latter seriously lacking in credibility. But this begs a question about why poor science has survived (Pilgrim 2007). So, turning to an explanatory critique, we find that since the nineteenth century there has been a confluence of medical dominance (within an insecure medical speciality) culminating in the seeming certainties of bio-reductionism, the convenience for health service planners of diagnostic related groups (DRGs – groupings of patients with the same diagnosis, often a favoured analytical unit utilised in the planning of services by health managers and politicians) and commercial advantages to the pharmaceutical industry. The latter's marketing rhetoric relies upon the spurious notion that DRGs are scientifically legitimate (when in truth they are not) and that their wares offer a corrective to neurochemical abnormalities (when the latter are still completely unproven).

An omissive critique about this topic reveals that what is *silenced* includes the disaffection of diagnosed patients and the complex web of psycho-social factors that both generate symptoms and provide the norms for their social (dis)valuation. Psychiatric diagnosis survives because it provides these conservative advantages to interest groups, including the psychiatric profession, big pharma and those of us who are sane by common consent. In particular, the perseverance of psychiatric diagnosis obscures our view of the intersecting, generative mechanisms of class, race, gender, age and sexuality, which deflect the probability of the symptom emergence subsumed in DRGs.

Critical realism and the study of sexually traumatised children

In recent years it has been recognised increasingly that trauma in childhood, including sexual trauma, predicts mental health status, both at the time and later in life. This statement is incontrovertible and can be confirmed by innumerable studies (e.g. Cutajar *et al.* 2010; Finkelhor *et al.* 2008; Ogata *et al.* 1990; Radford *et al.* 2011; Read *et al.* 2003). Put differently, child sexual abuse (CSA) is not merely a social construct, but also reflects real events having real impacts on the mental health of victims. Given that realists now adhere to a traumagenic model of mental health problems, a critical realist appraisal of the counter view – that CSA is a moral panic and has a trivial impact on children – is important. The analysis below is an example of how CR allows us to pursue greater clarity about the emergence of mental health problems by critiquing strong constructivist approaches in social science.

This, then, is my CR appraisal of CSA. I do not say that CSA causes mental illnesses like 'schizophrenia' (because those under the sway of naive realism commit both epistemic and ontic

fallacies in relation to that concept), merely that CSA is a proven risk factor in a range of forms or symptoms of distress, unintelligibility and dysfunction. But, more importantly, I do not say that CSA is a moral panic. Many strong constructivists in social science *do* make such an assertion (e.g. Clapton *et al.* 2012; Furedi 2013; Jenkins 2004). From a CR perspective they are wrong and this can be demonstrated at once by an immanent critique (Pilgrim, 2017).

If true to its own defining features, a moral panic should be manifest in the following ways: there is widespread public feeling of disgust and fear. That reaction is disproportionate in scale to the transgression under consideration. The feared transgression is not harmful or its harm is heavily exaggerated or is an artefact of social stigma. The panic is ephemeral. The panic operates as a conservative homeostatic process in society. All of these criteria should be fulfilled for a moral panic to be fairly claimed (Cohen 2002).

With the exception of the first of these, CSA does *not* conform to our expectations of an ideal-type moral panic. Rather than being disproportionate, CSA goes largely under-reported and, in legal cases, false negatives are inflated by historical investigations, meaning that dead perpetrators on record remain innocent until proven guilty (yet they may have committed actual offences, illustrating the gap between the actual and the empirical at times). Two-thirds of cases of CSA are not reported to the police and only a proportion of these cases culminate in prosecutions (Finkelhor *et al.* 2008; Radford *et al.* 2011). Several early claims in social science that adult-child sexual contact was harmless or the harm done emerged from the social censure and the distress linked to legal proceedings have now proved to be unfounded (West 1981).

Moreover, CSA is not an ephemeral public policy matter. Child protection has been an abiding concern in developed countries since the late nineteenth century. In developing countries today, the United Nations (UN) has defined child brides as the most important future challenge in relation to sexual violence against children, and the European Union (EU) has issued a clear statement of intent about reducing the incidence of CSA (Council of Europe 2007).

As for the point about conservative interest work, the rich and the powerful have sought to suppress (rather than whip up) a moral panic about CSA. Indeed, the doyen of moral panic theory Stanley Cohen, in the third and final edition of his book *Folk Devils and Moral Panics* (2002), pointed out that maybe our biggest problem about CSA was not moral panic but 'moral stupor' and 'chilling denial' (Cohen 2002). He also cautioned against claiming a moral panic without empirical checking, case by case, that criteria were being met.

Put simply, an immanent critique disconfirms the claim that CSA is a moral panic. This raises the next question pertinent to an explanatory critique: how and why has such a discreditable claim been sustained in social science? There are two main explanations which are not mutually exclusive. First, some social scientists have been paedophiles or have supported pro-paedophile groups. They have co-opted the legitimacy of their academic credibility to argue that adult-child sexual contact is harmless and that paedophiles are an unfairly stigmatised sexual minority (e.g. Fraser 1981; Righton 1981).

The second explanation is about disciplinary interests. As Craib (1997) pointed out, sociologists have few claims of legitimacy or practical relevance compared to other disciplines. However, if their expertise is to recurrently argue that 'everything is socially constructed' then this provides them with a dominant identity in public policy deliberations. Moral panic claim-makers operate in this domain of inflated authority from some sociologists (but are found also in forensic psychology, law and social work).

The relevance of an omni-critique in this case is to ask why there is widespread denial of the ubiquity of CSA in modern societies: how do we account for what Cohen called 'chilling denial' and 'moral stupor'? Why do cases *not* get reported? Why do onlookers fail to report cases when perpetrators are 'hiding in plain sight'? Why are children disbelieved when they speak out?

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Why have the police been complicit at times in CSA when not pursuing prosecutions? Why have so many responsible adults been bystanders not guardians of children?

Cohen's own later work on 'states of denial' in relation to social oppression (Cohen 2001) has been used to explore this matter in the case of the British Broadcasting Corporation (BBC) and its failure to deal with former television and radio personality Jimmy Savile, posthumously described by the police as the most prolific sex offender in British criminal history (Greer and McLaughlin 2015). We need to account at times for silences in social relations and, in this case, that silence is in relation to protecting children from the sexual attention of adults.

Conclusion

This chapter has outlined the key features of critical realism and compared and contrasted them with other traditions in social science from positivism and idealism. A case has been made that CR takes the advantages offered by the latter traditions and helpfully rejects their disadvantages. Immanent, explanatory and omissive critiques deployed by CR have been applied to two illustrative case studies in the field of mental health. CR provides support for an approach to mental health research that is truly scientific without being politically naive.

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8

A critical feminist analysis of madness

Pathologising femininity through psychiatric discourse

Jane M. Ussher

For centuries, women have occupied a unique place in the annals of insanity. Women outnumber men in diagnoses of madness, from the ‘hysteria’ of the eighteenth and nineteenth centuries, to ‘neurotic’ and mood disorders in the twenty and twenty-first centuries. Women are also more likely to receive psychiatric ‘treatment’, ranging from hospitalisation in an asylum, accompanied by restraint, electroconvulsive therapy (ECT) and psychosurgery, to psychological therapy and psychotropic drug treatments today (Ussher 2011). Why is this so? Some would say that women *are* more mad than men, with psychiatric treatment a beneficent force that sets out to cure the disordered female mind. In this chapter I will proffer an alternative explanation – that women are subjected to misdiagnosis and mistreatment by experts whose own pecuniary interests can be questioned, as can their use (or abuse) of power. This is not to deny the reality of women’s experience of prolonged misery or distress, which undoubtedly exists. However, if we examine the roots of this distress, in the context of women’s lives, it can be conceptualised as a reasonable response, not a reflection of pathology within (Ussher 2011).

The pathologisation of femininity and regulation of unhappy or ‘difficult’ women through patriarchal psychiatric nosology has a long history. In the nineteenth century, hysteria was described as a woman’s ‘natural state’ (Smith-Rosenberg 1986: 206), with Otto Weininger asserting in 1903 that ‘hysteria is the organic crisis of the organic mendacity of woman’ (cited in Bronfen 1998: 115). The contemporary diagnostic category of anorexia nervosa has been described as the successor to hysteria, the modern manifestation of a ‘female malady’ (Showalter 1985). This is a persuasive argument: hysteria and anorexia nervosa are diagnoses predominantly ascribed to women – the ‘typical patient’ is often described as wilful or immature in both contexts, and each has been conceptualised as a feminine ‘disorder’, tied to the enactment of archetypal femininity (Malson 1998). Anorexia nervosa is not, however, the only female malady to afflict women today, nor is it the only diagnostic category to be contested or located in cultural constructions of femininity. Depression is presently the diagnostic category widely accepted as a ‘woman’s problem’, described as a ‘menace to mood and national productivity’ (Gardner 2003: 109) and the most common diagnosis applied to women’s distress. The diagnosis of depression is primarily the reason why women significantly outnumber men in first admission rates for psychiatric treatment, and in register studies where the

incidence of madness is calculated by contact with services (Ussher 2011). The fact that women are twice as likely as men to be prescribed psychotropic medication – in particular, selective serotonin reuptake inhibitors (SSRIs) (Currie 2005) – and twice as likely to be given ECT (Burstow 2006) is also largely attributable to diagnoses of depression. These are the material consequences of patriarchal psychiatric discourse which defines errant women as ‘mad’.

Much attention has been paid to research conducted by Broverman and colleagues in the late 1960s, where it was argued that women who conform to the feminine role and, paradoxically, also those who reject it, were likely to receive a psychiatric diagnosis (Broverman *et al.* 1970). At the same time, definitions of mental health were found to coincide with definitions of masculinity, whereas femininity was seen as psychologically unhealthy. Standardised questionnaires which measure depression have been described as gender biased, as many categorise experiences that are normative for women, or part of the feminine role (such as crying, sadness or loss of interest in sex), as ‘symptoms’ (Salokangas *et al.* 2002). Thus, instruments such as the Beck Depression Inventory (BDI), which are often used in large-scale epidemiological surveys, may simply be over-estimating depression in women (Salokangas *et al.* 2002) and distorting conclusions about gender differences in psychopathology.

Women in specific demographic groups – in particular, working class women (Caplan and Cosgrove 2004), black women (Loring and Powell 1988), older women (Siegal 2004) and lesbians (Metcalf and Caplan 2004) – are at the highest risk of over diagnosis of psychiatric problems. Older women are also vulnerable to both over- and under-diagnosis of depression (Siegal 2004): the tendency to pathologise everything about older people often leads to misery being seen as mental illness when it is not, while invisibility leads to a lack of recognition of symptoms and the withholding of necessary services (Ginter 1995). While homosexuality has officially been removed from the American Psychiatric Association’s (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM), many clinicians still view it as a pathology and will pathologise lesbians who are seeking help for problems with relationships or work, seeing their sexuality as an issue of concern (Metcalf and Caplan 2004). From the perspective of intersectionality (see Davis 2008), where it is recognised that we all have multiple cultural and social identities, being a member of multiple marginalised or minority groups can exacerbate vulnerability to misdiagnosis. For example, differences in identity development have been reported between white and African American or Latina lesbians (Parks *et al.* 2004), which has implications for mental health and well-being, while it has also been reported that older women who are poor face the double discrimination of class and age (Siegal 2004).

Hysterical and borderline personality disorders: pathologising exaggerated femininity

Depression is not the only diagnosis to be critically examined for being more readily applied to women. Similar arguments have been made about women’s greater propensity to be diagnosed with hysterical personality disorder, the modern incarnation of hysteria. Hysterical personality disorder’s depiction in the second edition of the DSM (DSM-II, published in 1968) has been described as ‘essentially a caricature of exaggerated femininity’ (Jimenez 1997: 158) as the ‘symptoms’ included excitability, emotional instability, over-reactivity and self-dramatisation. Indeed, the description in DSM-II of hysterics as ‘attention seeking, seductive, immature, self-centred, vain... and dependent on others’ (American Psychiatric Association 1968: 251) is almost identical to the nineteenth-century description of hysterics (Showalter 1985). It is also close to the archetypal version of femininity women were expected to follow in the 1950s and 1960s, parodied (or perhaps celebrated) in the twenty-first-century television series *Mad Men*. In the

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DSM-III (American Psychiatric Association 1980), published in 1980, hysterical personality disorder was renamed 'histrionic personality disorder' (HPD) to avoid the negative connotations that were associated with 'hysteria' (Jimenez 1997). However, the descriptors of the typical patient still depicted an exaggerated femininity: '[s]uch individuals are typically attractive and seductive. They attempt to control the opposite sex or enter into a dependent relationship. Flights into romantic fantasy are common; in both sexes overt behavior often is a caricature of femininity' (American Psychiatric Association 1980: 314). Is this not how we are taught to 'do girl' (Ussher 1997) through teenage magazines, romantic fiction and 'chick flicks'? But we should be careful. Enacting this particular version of 'seductive' femininity may attract more than a man – it can clearly attract a psychiatric diagnosis. This was evidenced in a study where psychiatrists were asked to judge a range of case descriptions, wherein a diagnosis of HPD was given to women, even though the case studies gave little indication of any disturbance (Loring and Powell 1988).

Changes in gender roles after the 1960s and 1970s, which saw Western women enter the workforce in unprecedented numbers and reshaped sexual and family relations, resulted in the marginalisation of hysteria as a diagnostic category. However, as Mary Ann Jimenez has argued, this did not mean that exaggerated femininity was no longer pathologised, as borderline personality disorder (BPD) simply took the place of hysteria, capturing 'contemporary values about the behaviour of women' (Jimenez 1997: 161). Described as a 'feminised' psychiatric diagnosis because it is applied more often to women than men (at a rate of between three and seven times more likely to receive the diagnosis) (Becker 2000), the criteria for BPD consists of symptoms that characterise 'feminine qualities' (Jimenez 1997: 163). These include depression and emotional lability, as well as 'impulsivity or unpredictability' that is 'potentially self-damaging', such as 'spending, sex, gambling, substance use, shoplifting, overeating, physically self-damaging acts' and 'identity disturbance' manifested by uncertainty about 'self-image, gender identity, long-term goals or career choice, friendship patterns, values, and loyalties' (American Psychiatric Association 1980: 322–3). However, where BPD differs from hysteria (or HPD) is the inclusion of the more masculine characteristic of 'inappropriate intense anger' as a criteria for diagnosis (Jimenez 1997). So while both diagnostic categories adopt gender stereotypes in positioning particular women as 'mad,' Jimenez comments, 'if the hysteric was a damaged woman, the borderline woman is a dangerous one' (1997: 163). As almost half of the women who qualify for a histrionic or borderline diagnosis meet the criteria for both disorders (Becker 2000), many women are clearly seen as both damaged and dangerous.

Jimenez has described the typical borderline patient as a 'demanding, angry, aggressive woman', who is labelled as 'mentally disordered' (Jimenez 1997: 162, 163) for behaving in a way that is perfectly acceptable in men. Evidence that there is clear gender difference in the pathologisation of emotions (in particular, anger) is supported by research by Lisa Feldman Barrett and Eliza Bliss-Moreau, examining judgements made about emotions expressed by men and women. They found that men's sadness and anger was considered to be related to situational factors – such as 'having a bad day' – whereas sad or angry women were judged as 'emotional' (Barrett and Bliss-Moreau 2009). Thus, women's emotions are deemed a sign of pathology, whereas men's are understandable. Two well-known women posthumously 'diagnosed' with BPD in the media were Diana, Princess of Wales (Bedell Smith 1999) and Marilyn Monroe (Hall-Flavin 2009), with their 'symptoms' including anger, supposed sexual promiscuity and discontent with their partner (or lover). Both experienced relationship conflict and breakdown, both had a troubled early life. Would men who behaved in a similar manner have been diagnosed as 'mad'? I suspect not.

While depression is a 'symptom' of BPD, the latter is a diagnostic category considered to be more a 'character pathology' than a disturbance of mood (Akema 1981). Janet Wirth-Cauchon (2001: 87) has argued that the borderline diagnosis is typically applied to 'certain women patients'

who are 'difficult, who resist the work of therapy, or who are socially marginal'. Similarly, Dana Becker has described BPD as 'the most pejorative of personality labels' which is 'little more than a short-hand for a difficult, angry, female client certain to give the therapist countertransferential headaches' (Becker 2000: 423). As many women diagnosed as 'borderline' have been sexually abused in childhood (Bryer *et al.* 1987), their anger is understandable, as is their 'difficulty' with men in positions of power over them – including the therapists who give out diagnoses. These women are pathologised, occupying the space of the abject – that which is 'other' to all that is desired in the feminine subject (Wirth-Cauchon 2001).

The construction and lived experience of women's distress: positioning premenstrual change as psychiatric illness

Premenstrual dysphoric disorder (PMDD) or premenstrual syndrome (PMS) stands as a further example of normal female behaviour being discursively constructed as mad, resulting in women taking up (or being given) a psychiatric diagnosis, with consequences for how their behaviour is subsequently judged. As I have described elsewhere (Ussher 2006), premenstrual change was first categorised as a 'disorder' in 1931, described as 'premenstrual tension' (PMT) (Frank 1931). It was renamed 'premenstrual syndrome' in 1956 (Dalton 1959) and now sits in the DSM-5 (American Psychiatric Association 2013) as PMDD, officially categorising premenstrual mood or behaviour change as a psychiatric disorder (see Cosgrove and Caplan 2004). Women who report a range of psychological and physical symptoms premenstrually (including anxiety, tearfulness, irritability, anger, depression, aches and pains or bloating) can be diagnosed as having PMDD. It is estimated that around 8 to 13 per cent of women meet a PMDD diagnosis each month, with around 75 per cent meeting the lesser diagnosis of PMS (the same conglomeration of symptoms, just experienced to a lesser degree) (Steiner and Born 2000). It also means that the majority of the female population of reproductive age could be deemed 'mad' once a month, as PMS and PMDD are both widely accepted as a pathological condition.

However, PMDD was included in the DSM-IV in the face of widespread feminist opposition, on the basis that there is no validity to PMDD as a distinct 'mental illness' (Cosgrove and Caplan 2004). Feminist critics have dismissed this process of pathologisation, arguing that premenstrual change is a normal part of women's experience, which is only positioned as 'PMDD' or 'PMS' because of Western cultural constructions of the premenstrual phase of the cycle as a time of psychological disturbance and debilitation. In Eastern cultures, such as Hong Kong or China, where change is accepted as a normal part of daily existence, women report premenstrual water retention, pain, fatigue and increased sensitivity to cold, but rarely report negative premenstrual moods (Chaturvedi and Chandra 1991; Yu *et al.* 1996). This has led to the conclusion that PMS is a culture-bound syndrome (Chrisler and Johnston-Robledo 2002) which follows unprecedented changes in the status and roles of women in the West, with the belief that women are erratic and unreliable premenstrually, serving to restrict women's access to equal opportunities (Chrisler and Caplan 2002). Indeed, belief in the negative influence of premenstrual 'raging hormones' has been used to prevent women being employed as pilots, physicians and presidents (Figert 2005), which, by extension, casts doubt on the reliability of *all* women occupying positions of responsibility.

It is the regimes of truth within Western medicine, which position premenstrual change as pathology, that provide the discursive context wherein women learn to define themselves as a 'PMS sufferer' (Ussher 2006). Medical textbooks and academic journals convey the message that raging hormones are the cause of women's higher rates of reported depression. At the same time 'Dr Google' ensures that this message is taken up by the masses, warning of the dangers and difficulties of a woman who is 'PMSing' (Ussher 2011). Current medical advice is that PMDD and

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PMS should be treated with hormones or SSRIs (O'Brien *et al.* 2011). Medical marketers are quick to take up the baton, persuading us to use their particular products. In 2001, Eli Lilly re-patented the SSRI *Prozac* as *Sarafem*, repackaging it in pink and lavender capsules, accompanied by an aggressive marketing campaign which told women 'PMDD affects millions of women... but the good news is that your doctor can treat PMDD symptoms with a new treatment called *Sarafem*' (Cosgrove and Riddle 2003: 39). The success of such marketing is reflected in reports that in the first six months after the US Food and Drug Administration (FDA) approved SSRIs for PMDD, 2.5 million prescriptions were written (Caplan and Profit 2004). The medical marketing for such drugs has the potential to include the significant proportion of women of reproductive age who experience premenstrual mood or behavioural change – categorising these changes as 'symptoms' of a 'disorder' that need to be medically managed. A similar process has been enacted with another 'disorder' that has the potential to be diagnosed in a significant proportion of adult women, 'female sexual dysfunction' (FSD), with drug companies avidly vying to develop a pill to increase women's sexual arousal and desire (Tiefer 2006). Described as a classic case of 'disease mongering by those in the medicalization industry' (Tiefer 2006: 178) evidence for the effectiveness of a 'female *Viagra*' is minimal, with the diagnostic category 'hypoactive sexual desire disorder' (HSDD) described as an invented disease to sell low libido (Meixel *et al.* 2015).

PMDD is open to a similar criticism: the placebo response for SSRIs is very high (Medawar and Hardon 2004), as is the case for all medication given for PMS and PMDD (Hunter *et al.* 1995). Indeed, there is a significant 'revolving door' problem with treatments for premenstrual distress, particularly those of a biomedical nature, with many women trying treatment after treatment and finding that while they may 'work' for a short time, over a longer period the 'symptoms' return (Hunter *et al.* 1995). Equally, the prescription of SSRIs for PMDD is not without material consequences, as is evidenced by the acknowledged side effects. Women have reported problems with vision (Moody Mommy 2009), bleeding to the fingertips and substantial weight gain after taking SSRIs for PMDD (Ussher 2006). The fact that many women continue to take psychotropic drugs to alleviate 'PMDD' despite these side effects is testimony to the level of distress associated with premenstrual change, and to the influence of the medicalised message that the problem is solely within and that it must be eradicated. However, women's premenstrual distress is more likely to be associated with difficulties in their relationships, over-responsibility and an ongoing practice of self-silencing, than their 'raging hormones' or dysfunctional bodies that need to be medically managed (Ussher and Perz 2013a, 2013b).

Conclusion

As the outspoken, difficult woman of the sixteenth century was castigated as a witch and the same woman in the nineteenth century a hysteric, in the late twentieth and twenty-first century she is described within patriarchal psychiatric discourse as 'borderline', or having PMDD. All are potentially stigmatising labels. All are irrevocably tied to what it means to be a 'woman' at a particular point in history. The nineteenth-century hysteric was deemed labile and irresponsible, as a justification for subjecting her to the bed rest cure or incarceration in an asylum (Ussher 2011). Women diagnosed as borderline today are often considered to be mentally disabled and subjected to involuntary institutionalisation or medication, as well as being stripped of child custody or parental rights (Becker 2000: 429), and women diagnosed with PMDD are medicated with SSRIs (Steiner and Born 2000). At the same time, a diagnosis of borderline can be used as a justification for denying women access to mental health care because of their supposed 'resistance' to treatment (Morrow 2008). However, if we examine the negative consequences of contemporary biopsychiatric 'treatment' for many women (Currie 2005; Ussher 2011), this may not be such a bad thing.

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Critical race theory and mental health

Roy Moodley, Falak Mujtaba and Sela Kleiman

Critical Race Theory (CRT) states that ‘racism and discrimination are matters of thinking, mental categorization, attitude and discourse’ (Stefancic and Delgado 2012: 21) and it challenges the ‘ontological and epistemological biases subtly inculcated in the law, policies, or in empirical research that would otherwise hinder contextualization of harm and dysfunction resulting from racial stratification’ (Brown 2003: 294). CRT has evolved over time to offer a framework of analysis in the relations of power in a multicultural and postcolonial space. Race as a variable in mental health theory and practice is not only unclear and problematic, but also confusing and confounding. Part of the problem lies in the definition of race, since race is understood as both a biological and sociological entity. However, race, as Appiah (1989) notes, is not a ‘natural’ category, having a biological or genetic base, but one that is socially and culturally constructed.

In the nineteenth century, W. E. B. Du Bois suggested in ‘The Conversation of Races’ (1970) that race was not biological but rather sociological, a notion that has become generally accepted among social scientists. For example, Appiah (1986: 35, emphasis original) argues that race is a socio-historical concept which,

bears the weight, metaphorically, of other kinds of difference... Even if the concept of race is a structure of oppositions – white opposed to black (but also to yellow), Jew opposed to Gentile (but also to Arab) – it is a structure whose realisation is, at best, problematic and, worst, impossible.

The evolution of a structure of opposition is deeply ingrained historically in the European imagination and its socio-cultural and political institutions. Mental health institutions themselves have not been immune to this way of structuring power relations. As Fernando (2014: 13–14) states, ‘[h]istorically, both Western psychology and psychiatry emerged from Western thinking after the (European) Enlightenment of the 18th century... In the 19th century, Western psychology became biological under the influence of Darwinism’, with the work of Morel and Kraepelin leading ‘psychiatry in Europe into a genetic mode... [which is now] no longer confined to geographical locations in the West’. Western thinking, then, became the foundation for a racist ideology that permeated the globe through Western colonialism, orientalism and imperialism. In *Orientalism*, Edward Said (1978: 3) forwards that, ‘European culture gained in strength and

identity by setting itself off against the orient as a surrogate and underground self'. Said's analysis of this socio-cultural process was that the Orient was created – or as he calls it 'Orientalised' – to establish 'a relationship of power, of domination, of varying degrees of a complex hegemony' (1978: 5). Similarly, in a psycho-political analysis of otherness, Frantz Fanon's *Black Skins, White Masks* (1967: 109, 110) explores the contradictions of race and colonialism when he says that while 'there is the moment of being for others', ontology 'does not permit us to understand the being of the black man. For not only must the black man be black; he must be black in relation to the white man.' Both Said and Fanon strongly articulate that racism and white privilege exist within societal power structures, including social, health and psychiatric institutions. Western biomedical psychiatry and other mental health professions such as psychology, psychotherapy and counselling not only have the potential to systemically discriminate, but also, according to Fernando (2010), can be considered institutionally racist in their past and present practices and underlying philosophies on states of mental illness. The specific mental illness labels, diagnoses and treatments applied to racialised and minoritised people and their over-representations in mental institutions are clear indications of a racist and pervasive culture that permeates Western biomedical psychiatry and psychology. Through the disavowing of the sociology of race and the emphasis on pseudo-scientific racist theories (Thomas and Sillen 1972), a Eurocentric, ethno-centric and individualistic mental health psychiatry, psychology and psychotherapy is defining the future of mental health care and the cultures of people who access them.

In this chapter, we will discuss CRT with a particular focus on its relationship to mental health care and the consequences for the healing project. Through a critical analysis of a case vignette we discuss how CRT can become a clinical tool in an ethical, anti-oppressive and social justice practice.

Critical race theory

CRT examines the interconnected relationship between race, power and the law. CRT emerged out of critical legal studies in the mid-1970s as a response to the liberal and positivist views in law and the unrealised promise of civil rights legislation. Crenshaw *et al.* (1995: xiv) explain that in the 1960s and 1970s,

racial justice was embraced in the American mainstream in terms that excluded radical or fundamental challenges to status quo institutional practices in American society by treating the exercise of racial power as rare and aberrational rather than as systemic and ingrained.

In this light, scholars such as Derrick Bell, Kimberlé Crenshaw and Richard Delgado recognised the importance of creating new theories, strategies and methodologies to counter the absence and/or negation of the role of race in the socio-political landscape. These scholars emphasised the importance of examining the socio-cultural forces that shape how we and others perceive, experience and respond to racism, along with approaching literature, legal documents and cases and other cultural works as evidence of a culture's collective values and beliefs (Delgado 1995a). Since its inception, CRT has served as a powerful and emancipatory framework to capture the social reality of racialised groups (Crenshaw 2011). As a distinct theoretical perspective offering its own intellectual and methodological foundations (Delgado and Stefancic 2001; Graham 2007; Ladson-Billings 2011), CRT has advanced and expanded beyond critical legal studies, where other disciplines have adopted and utilised CRT to analyse how African Americans, Native Americans, Asian Americans, Pacific Islanders, Chicanas/os and Latinas/os continue to

experience, respond to and resist racism and other forms of oppression (e.g. Caldwell 1991; Solorzano 1998; Wing 1997).

Racism, according to CRT, is engrained in the fabric of existing power structures and the societal landscape. CRT identifies that these power structures are based on white privilege and white supremacy, which perpetuates the marginalisation of people of colour (Godsey 1995). White privilege refers to the various unearned social, political and economic advantages conferred to white individuals based on their race relative to their racialised counterparts. These advantages may include overt and covert differences in access to power, social status, experiences of prejudice and educational opportunities (Gillborn 2006; Lipsitz 1998). CRT challenges the traditional ideas of 'natural history' and social Darwinism that put forth taxonomies of racial groups. In CRT, race is framed as a product of social thought and material relations, where the white race is viewed as the 'normal' race and, in contrast, all other races are seen to be deviant and abnormal (Haney-Lopez 2000). The process of racialisation for a critical race theorist is situated within a social, economic and historical context that is underscored by the changing nature of racial ideology and the lived experiences of racialised people. For instance, the colonisation of the North American, African and Asiatic world by European powers set the foundation for contemporary racial inequality, in which the colonial process divided the world between colonised/coloniser, master/slave and white/non-white through the development of racial ideologies (Crenshaw *et al.* 1995). CRT aims to examine and critique the social production of such racial hierarchies that have culturally and epistemologically fragmented individuals and the collective into whites and non-whites, where the former represents itself as a superior form of human, while the latter is relegated to the margins (Williams 1998).

Although race and racism are the central foci for CRT, it also integrates an intersectionality approach to point to the multidimensionality and complexity of oppressions and to address how multiple forms of inequality and identity interrelate in different contexts. Intersectionality can be thought of as 'the examination of race, sex, class, national origin, and sexual orientation, and how their combination plays out in various settings' (Delgado and Stefancic 2001: 51). In other words, an individual's identity and experiences are not limited to one aspect of their social location such as race, but rather categories like race, gender, sexuality, nationality and religion, traverse and influence their social reality. Crenshaw *et al.* (1995) emphasise the importance of analysing social problems fully to comprehensively understand the nature of social inequities and the process that creates and sustains them. In doing so, it helps discern how lived realities are shaped by different factors and how social dynamics operate together. In CRT, intersectionality helps build coalitions across marginalised groups to enhance the social justice project (Delgado 1995b).

CRT encourages the production of counter-narratives of racialised peoples as a strategy to counter dominate discourses. Solorzano and Yosso (2002: 26) define counter-storytelling as 'a method of telling the stories of those people whose experiences are not often told', including people of colour, women, sexual minorities and the poor. Expanding the traditional notions of scholarship by advocating for less objectivity as defined and promoted by the normative culture in research (Lynn *et al.* 2013), and incorporating the lived stories of the oppressed, narratives in CRT are a critical tool to undermine dominant discourses. In opposition to dominant narratives, such counter-narratives speak to the intersections of different forms of oppression (Delgado and Stefancic 2001). The notion of counter-narrative exists 'in relation to master narratives, but they are not necessarily dichotomous entities' (Andrews 2004: 2); they are inherently situated in the lived experiences of one's individual stories of resistance, which can be expressed implicitly or explicitly in relation to the master narrative (Andrews 2004). This is viewed as important to preserving the history of marginalised groups whose experiences often are delegitimised within the master narrative (Johnson 2017). In essence, through a multidisciplinary and

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interdisciplinary framework, CRT interrogates, challenges and highlights the need for understanding racial dominance.

A trans-historical overview of race and mental health

The cultural history of mental health practices has been infused with negative racial ideologies since its very inception (Fernando 1988). Pseudo-scientific racist theories have been the foundation from which newer theories and clinical practices have evolved (Moodley and Ocampo 2014; Thomas and Sillen 1972). The context for these ideas was a burgeoning colonial and capitalist Europe set on dehumanising, enslaving and exploiting non-European peoples and their lands. Racist ideologies were used to justify this European imperialism and colonialism. As discussed earlier, eighteenth-century thinking on ‘race’, with its genetic and racial differentiation, created the biomedical psychiatric model. By the end of the nineteenth century, as Brantlinger (1985: 205–17) notes, ‘eugenicists and social Darwinists were offering “scientific” justifications for genocide as well as for imperialism... through which Europeans projected many of their darkest impulses onto Africans’. Clearly many of these racist theories – including scriptural authority (the racist interpretation of the biblical narrative of Noah and his son Ham), the issue of primal difference (skull measurements and claims to white superiority by leading scientists and physicians), the phylogenetic concept of ‘race’, the superficial readings of Darwin, genetic fallacy and the mark of oppression – have been the building blocks for current ideas in mental health care (Thomas and Sillen 1972).

The trans-historical context of race and racism, with its negative ideologies, fantasies and projections of racial difference, becomes a primary site within which the human is defined. Since the origins of mental health practice are replete with racial stereotypes, it becomes problematic for mental health practitioners to purport to be non-oppressive and a guarantor of social justice. For example, it has been suggested by some scholars that the psychiatrist and psychoanalyst Carl Jung’s tacit support for the Nazis during the Third Reich was based on his own racial prejudices (see, e.g. Dalal 1988; Masson 1994). Even Freud has been critiqued on this issue – his contention that the unconscious was a place below, different, timeless, primordial, libidinal, separated from consciousness, unmapped, dark and without light was said to be ‘discovered’ at the same time that Africa was being explored. This insistence on understanding the unconscious as a dark, negative region seems to have resulted in the perception by psychotherapists that black and ethnic minority patients had failed as a result of ‘race’ in the integration of ego elements in the process of individuation. Clearly, Freud, Jung and the other ‘founding fathers’ were crucial in establishing the basic theories and practices of contemporary therapeutic care. For example, clinicians such as Kennedy (1952) and Waite (1968) emphasised racial differences as causes for black and ethnic minority patients’ psychopathology (see Carter 1995: 38). Others, such as Carothers (1953) and Carstairs and Kapur (1976), argued that black and ethnic minority patients were not psychologically sophisticated, that they represented their illnesses in physical and somatic ways and that they found it difficult to express themselves verbally in a way that was consistent with the psychotherapeutic model.

Following 9/11, race and psychology have become even more inextricably mixed with governments, social institutions and mental health professions collaborating together to redefine the theory and practice of mental health care. Surveillance of individuals and groups under the auspices of prevention and wellness are instituted in complex ways. For example, through the introduction of the UK’s Counter-Terrorism and Security Act (Home Office 2015), mental health professionals are now obliged to identify (through a mental illness diagnosis) people from particular groups or communities whom they believe are prone to acts of terrorism (Christmann

2012; Loza 2015). Clearly, these and many other programmes are indications that psychiatrists and other mental health professionals are now becoming intertwined in a new wave of mental health discourse globally. Indeed, now more than ever, a CRT approach is needed to critique this process by asking ethical questions about the role of psychologists who collaborate with state institutions to construct policy and practices that may erode civil liberties, religious rights, cultural rights and human rights.

Race and mental health

Racialised clients still appear to be,

categorised and labelled in a singular 'strait-jacket' way, often exclusively in terms of a particular continent of origin, or religious affiliation, or racial skin tone where race is seen to be equated to skin colour, particularly the colour black which then becomes a privileged site for the interpretations of psychopathology of African and African-Caribbean clients.

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The liberal humanistic ethic that is underpinned by social pluralism and cultural diversity, with its politically loaded meanings, become powerful tools for the transcultural psychiatrist or psychotherapist (Sashidharan 1986). Race then becomes a marker of difference which is presented as complex, ambiguous, contradictory and confusing, leading many professionals to avoid or dismiss race altogether in psychotherapy. Generally, therapists who are not familiar with race or take race for granted tend to avoid any discussion of it. Carter (1995) points out that, in counselling and psychotherapy, majority white therapists experience difficulties when working with black clients, especially around issues of race, racism, antisemitism and Islamophobia. This fear of working with the other can result, on the one hand, in race becoming either absent or marginalised in psychotherapy (Fernando 1988). Moreover, Carter (1995: 4) points out that '[r]ace has become less salient because mental health clinicians, scholars and researchers are more comfortable examining presumed cultural and ethnic issues than addressing racial issues'. On the other hand, if race becomes the singular focus, then therapists are accused of reifying race (albeit unwittingly) and giving it a legitimacy and potency, thus naturalising it as a socio-biological idea. Mason (1996) suggests that, in recent years, race, culture and ethnicity seem to be constructed into a theoretical principle by invoking the idea of racialisation, thereby naturalising ethnic and other differences. This racialisation of the dynamic experiences of ethnic and cultural difference is shaped into stable, negative constructs which are then attributed to the whole of the ethnic minority group. Clearly, mental health practitioners need to 'explore the social construction of race, and the centrality of racism and misogyny to this construction' (Ferber 1998: 60), while at the same time be aware that 'an individual's identity is a mixture of his or her gender, race, as well as ethnic, class, sexual orientation, and no one identity takes precedence over the other in an individual's inner world' (Moodley 2011: 93).

This dynamic is illustrated in the case vignette below – we see how the subjectivity of the client and the therapist, the relational field generated through their interactions and the time and place of their meetings all converge to make healing possible. CRT affords a broad analysis of contextual factors that may impact interracial interactions (Abrams and Moio 2009). Critical to bridging CRT and the mental health context is knowing the time and place as well as the broader institutional factors that may impinge on any given interaction (Abrams and Moio 2009). No doubt, our attempt to bridge CRT and the mental health context is characterised by many assumptions and important omissions, including an in-depth critical analysis of how

sexual orientation, physical (dis)ability, religion and socio-economic status intersect with the race, gender and age of the client.

Given that race is a fundamental consideration within CRT, it is important to have a basic understanding of how racism is typically enacted in the context of where the treatment occurs, namely the present day in a predominantly white college town. Like the majority of predominantly white cities in the US, many white people in the town where this case takes place consciously reject and disavow overt expressions of racism (Sue *et al.* 2007). Instead, more subtle racial enactments have surfaced in the form of microaggressions (Sue *et al.* 2009). According to Sue *et al.* (2009), the harm of microaggressions come from their cumulative effects over time. They serve to negate one's experiences and afford narrower possibilities for engaging with the self and others.

Case study: Hannah's story

Hannah's story is a composite of several unpublished cases of one of the authors.

The client

Hannah (not her real name) is 23 years of age and an undergraduate student in her third year at an American university. Hannah's parents emigrated from China; she was born in the US and self-identifies as Asian American. She currently lives at home with her parents.

Presenting issues and challenges

Hannah was recently diagnosed with ADHD and a learning disability. She is struggling to come to terms with her diagnoses. Hannah recalls a common narrative refrain in her family: 'James [her older brother] is the smart and personable one'. After the diagnosis, she feels especially inadequate; university studies do not come easy to her, nor does getting along with others. Hannah's relationship with her mother has gone from bad to worse since being diagnosed. While her parents support her financially by paying for extra academic support, she feels their acceptance is conditional. Indeed, she is preoccupied with the idea that her mother is disappointed in her and feels like she is 'not a good daughter'. Hannah feels overwhelmed, trapped and frustrated living at home. She seeks counselling to help manage her troubled relationships and negative self-talk.

Case history and developmental background

Hannah presented to the university counselling centre to address her difficulty coming to terms with her diagnoses, as well as the relational strain with her mother. She was assigned to Jason, a 35-year-old white man. Jason has some understanding of the importance of being a culturally sensitive practitioner but, nevertheless, does not give race and diversity more than cursory attention in this case.

Hannah is used to people asking about her Asian heritage. It is not uncommon for strangers to greet her in Mandarin, assume English is her second language and ask her where she is from (i.e. assuming that she was not born in the US). On many occasions, Hannah has a heightened sense that she is under the white male gaze because of her race. Hannah recognises a conspicuous absence of Asian American representation in US popular culture and is sensitive to the caricatured representations often perpetuated within the media. She has grown up living in mostly

white towns and has associated mostly with white peers. Her experience of herself in relation to white people is that she is different.

The therapy

Although Jason may not have consciously registered his reaction to Hannah, his automatic assumption upon meeting Hannah for the first time is that she is demure and family-oriented. During the assessment session, without realising it, Jason makes many assumptions regarding Hannah's internal experiences based on very limited information that includes her initially quiet demeanour and averted gaze. After the first session, Jason conceptualises that much of Hannah's distress is caused by cultural factors that may be inhibiting her growth. For example, he conceptualises that her cultural values regarding her academic identity constrain her ability to individuate and develop interests beyond what her culture dictates. This, he believes, limits her opportunities to cultivate interests that provide intrinsic satisfaction, instead leaving her to acquiesce to cultural values internalised and perpetuated through the family unit. Although it is established that Hannah was born and raised in America, Jason finds himself speaking to Hannah in a way that is reminiscent of how he would speak to an immigrant with language difficulties – namely, more slowly and louder than usual. In this case, Jason perceives that it is Chinese culture which is the point of pathology, rather than assessing its intersection with gender and the relationships within the family that contributes to Hannah's subjective distress and pain. After several sessions Hannah is not sure if counselling is the best way forward in helping her understand her predicament and her diagnosis. She is contemplating terminating counselling.

Discussion and analysis

CRT helps focus our attention on the recursive interactions between institutionalised and interpersonal discrimination. In this case, Hannah, by virtue of her age as well as her racial, gender and disability identities, proved to be a complex client for the counsellor. Jason made many assumptions of Hannah's internal and external experiences and made his appraisal of her behaviour through a filter that only served to confirm his expectations. For instance, Jason was not inclined to devise alternative plausible hypotheses for Hannah's 'demure' presentation beyond it being rooted in her Chinese identity. However, given the social stigma associated with seeking mental health services in North America, Hannah's averted gaze may have signalled a sense of shame derived from cultural forces that extended beyond racial background. Moreover, as CRT explicates, Jason's tendency to pathologise Asian culture forgets that individuals from racialised groups sometimes internalise a sense of inferiority in relation to standards established by dominant white culture and institutions (Speight 2007), and also that Western models of therapy have a tendency to pathologise minorities more generally. As such, a culture and system of whiteness within wider society – as well as within the counselling profession – must be investigated as a contributing factor to Hannah's mental health challenges. As previously discussed, CRT also incorporates an intersectional perspective through recognition of other social locations (e.g. sexual orientation, socio-economic status, religion, age and disability) where inequity and discrimination exists and interacts with race to influence a person's sense of themselves, others and the world around them. In Jason's conceptualisation, gender, class and other identities were omitted, as was the possible influence on Hannah's behaviour of his own socio-economic position. Indeed, Jason's power as a white man of upper middle-class status (in addition to the power associated with his position as the helper) reinforced a dynamic whereby Hannah felt disempowered. Given Hannah's social location and the regularity with which she interacted

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with white men throughout her life, she was likely familiar with feeling disempowered in this context. However, the lack of explicit mention of this feeling suggests that she was either not aware of it, did not feel safe enough to label it or did not think it was possible to feel differently. A white male counsellor aware of this dynamic would have been in a better position to disrupt it and empower Hannah. Jason's oversight was significant because the counselling became a place where power was reinforced and the status quo maintained. With CRT, however, counsellors have a lens with which to see how larger social and institutional forces impinge on clinical interactions.

Conclusion

Through the application of CRT to counselling and psychotherapy it is possible to interrogate the Eurocentric, ethnocentric and individualistic ways in which mental health practices are undertaken. Clients in need of psychological support can then be given a safe space for them to explore (in their own vernacular if necessary) their experiences of living in a capitalistic, racist and misogynistic world. Moreover, utilising CRT within the field of mental health can potentially facilitate greater understanding of the client through knowledge of the context, time and place within which counselling occurs. CRT provides another lens from which to contextualise, organise and analyse information revealed during the practice of mental health care. To be sure, issues of institutional and structural racism within the mental health system and society in general may continue to vitiate therapeutic progress and complicate practice despite the best intentions of critically engaged therapists. Thus, fundamental to addressing the needs of racialised clients are the systemic attempts to dismantle institutional and structural racism on all levels.

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Trapped in change

Using queer theory to examine the progress of psy-theories and interventions with sexuality and gender

Shaindl Diamond

The most common narrative about the status of sexual and gender minorities in the psy-disciplines is one of progress, and understandably so. Major changes have occurred over the past century in terms of theoretical understandings of and interventions with queer and trans people that have arguably created a better situation for many. This chapter will provide an overview of some of the changes that have occurred and examine current conceptualisations and treatment of queer and trans people. Using a queer theory lens, it will attempt to more deeply probe this progress to see what it has done to the self-determination of trans and queer people and what impact it has had on underlying binaries that historically have led to heteronormative understandings of sexuality and gender. It will look at the impact of psychiatry and related disciplines, which have been made custodians to the pathway of support for many living outside dominant gender norms, and will conclude by reflecting on implications for practitioners who work with queer and trans persons who seek support in coping with emotional distress, often generated by living outside of dominant gender norms. The analysis offered in this chapter builds on the important works of feminist, queer, trans, mad, disability, antipsychiatry and anti-racist activists and scholars who have likewise critiqued dominant progress narratives about the psy-complex (Burstow and LeFrançois 2014; Diamond 2014; Kirby 2014).

As a brief note about terminology, queer and trans are used in this chapter to refer to a range of identities including but not limited to lesbian, gay, bisexual, pansexual, two-spirited, genderqueer, transsexual, transgender and gender independent. These terms do not sufficiently represent the diversity of all people who identify as other than heterosexual or cis-gendered (that is, those who identify with the gender they were assigned at birth), but are used here as a short form to facilitate one contribution to a larger conversation about experiences of and resistance against sexist, heterosexist, racist, classist, ageist and ableist theories and practices related to sexuality and gender.

Challenges to heteronormative, transphobic and sexist understandings of sexuality and gender

The evolution of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), from the original 1952 edition to the DSM-5 (2013) demonstrates how changing cultural climates and pressure

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from social movements can have an immense impact on how the medical establishment conceptualises sexuality and gender. There has been a definitive shift over the past 60 years in how sexual and gender minorities are viewed within the psy-complex. From its inception, the DSM has included categories pertaining to non-dominant expressions of sexuality and gender, beginning with the diagnosis of 'homosexuality' as a mental disorder in the original 1952 edition (American Psychiatric Association 1952). The inclusion of this diagnosis mirrored the then dominant view of same-sex relationships and validated already existing theories about the pathological nature of same-sex attractions and reparative therapies. The American Psychiatric Association's (APA) endorsement of a pathological view of homosexuality, echoed by other professional organisations, supported the development of further treatment interventions aimed at changing sexual orientation (Haldeman 1991, 2012). Conversion treatments included aversive conditioning (involving electric shock and nausea-inducing drugs during the presentation of same-sex erotic images), covert sensitisation (which asked people to imagine vomiting or receiving electric shocks to decrease feelings of same-sex attractions), social skills training (which required people to learn 'heterosexual behaviours' through practising normative gender roles) and psychoanalytic therapy (which was aimed at resolving unconscious childhood conflicts that were theorised as responsible for causing homosexuality) (respectively, Burke 1996; Lev 2013; Haldeman 1991, 2012; Shelley 2008). The harm caused by these various forms of conversion therapy is well documented; anecdotal accounts and research studies have demonstrated that conversion therapy increases difficulties with self-esteem, depression, anxiety and risk of suicide (Burke 1996; Haldeman 1991).

As attitudes changed towards gay and lesbian identities, professionals and advocates became increasingly critical of the DSM for its pathologisation of homosexuality and the damage caused by reparative therapies. Facing mounting political pressures, the APA eliminated the diagnosis of homosexuality from the DSM-II (American Psychiatric Association 1968) in 1973, and in 1975 issued a resolution stating that 'homosexuality per se implies no impairment in judgement, stability, reliability, or general social or vocational capabilities' (Conger 1975: 633). Although these changes meant that the APA and the American Psychological Association no longer conceptualised homosexuality as intrinsically pathological, the DSM-III (published in 1980) still included the diagnosis of 'ego-dystonic homosexuality' (EDH), a term used to describe a mental disorder related to the distress experienced by many queer people in relation to their sexual identities. The manual specified that the diagnosis only applied to people with unwanted homosexual feelings, and that 'distress resulting from a conflict between a homosexual and society should not be classified' (American Psychiatric Association 1980: 282). However, given that queer people continued to live in the context of heterosexism and homophobia, and that people generally experience distress when associated with a socially despised identity, the diagnostic category of EDH continued to pathologise the experiences of many. The DSM-IV (American Psychiatric Association 1994) included a residual, lesser-known category for EDH under the category of 'sexual disorders not otherwise specified' (SDNOS). Among three potential criteria, this category included 'persistent and marked distress about sexual orientation' (American Psychiatric Association 1994: 538) to account for experiences presumably related to the distress experienced by queer people in the context of homophobia and heterosexism, again pathologising understandable responses to oppression. This last diagnostic category was not included in the most recent edition of the manual, the DSM-5 (American Psychiatric Association 2013).

Changes to the DSM relating to what is and what is not pathological in sexuality led to a dramatic alteration of best practices in psy-interventions with queer people. In the past 20 years, mainstream medical and psychological bodies have denounced conversion therapy as harmful,

recognising that treatment is based on the exploitation of guilt and anxiety, thereby risking damage to self-esteem, rendering individuals further vulnerable to depression and suicide (Just the Facts Coalition 2008). Professional organisations in the psy-disciplines recognise that interventions purporting to cure people with non-heterosexual orientations are based on the notion that homosexuality is an illness and present a significant threat to the health and well-being of sexual minorities (Just the Facts Coalition 2008). The current stance within mainstream professional organisations is that non-heterosexual orientations are normal, natural variations of human sexuality that cannot accurately be regarded as pathological (Just the Facts Coalition 2008). Interestingly, when homosexuality was removed from the DSM, diagnostic categories pertaining to gender identity were first introduced (Lev 2013). In the DSM-III, two diagnoses were included for the first time: 'gender identity disorder of childhood' and 'transsexualism', a diagnosis reserved for adolescents and adults. In the revised version of the DSM-III (the DSM-III-R, American Psychiatric Association 1987), an additional diagnosis was included: 'gender identity disorder of adolescence and adulthood, non-transsexual type'. The latter diagnosis was removed in the DSM-IV (American Psychiatric Association 1994) and, instead, the adolescent/adult and childhood categories were combined into one new category, known as simply 'gender identity disorder' (GID), with two different criteria sets, one for children and one for adolescents and adults (Lev 2013). Conversion therapy became a choice treatment for children who met the criteria for GID, aimed at teaching them how to conform to traditional gender roles associated with the gender that they were assigned at birth. Only recently, in 2016, did the Centre for Addiction and Mental Health (CAMH) close the Gender Identity Clinic for Children, a well-established conversion therapy service in Toronto, Canada, which was run by a psychologist who for decades was a leader in the theorising and treatment of gender variant children within the psy-disciplines (Ubelacker 2016).

Among the advocates for the inclusion of gender identity diagnoses were those who believed that the inclusion of mental disorders pertaining to gender identity would allow greater access to treatment for marginalised people, particularly for transition, including access to hormones and sex-reassignment surgery (Lev 2013). As predicted, support for transition became deeply intertwined with the psychiatric system, and eligibility criteria for services most often required the person to have a diagnosis of GID. A professional protocol for working with trans people, entitled the Standards of Care (SOC), was introduced by the Harry Benjamin International Gender Dysphoria Association (later renamed the World Professional Association for Transgender Health (WPATH)) in 1979 and was adopted by many professionals who worked with trans people as a rigid policy guideline.

The SOC have gone through seven revisions since their initial publication, each edition reflecting contemporary theorising of gender identity issues within the mainstream psy-complex. Increasingly, over the years, the SOC have been criticised by members of trans communities for contributing to the pathologisation of trans people and putting professionals in the position of gatekeepers who judge who can gain access to interventions in support of transition (Kirby 2014; Namaste 2000). For example, the sixth revision of the SOC, released during the era of the DSM-IV, required a certain amount of psychotherapy and/or full-time living in one's desired gender prior to starting hormone therapy. In some jurisdictions, specific health care professionals or clinics were designated as the only options available to trans people seeking treatment subsidised by government-funded health care (Kirby 2014; Namaste 2000). This led to numerous chronicled encounters with some very harsh gatekeepers (Namaste 2000). Due, in part, to limitations set by funding bodies, in many cases, trans people have had (and currently have) few options in terms of professionals whom they can see for an assessment that will lead to funding for surgery (Kirby 2014; Namaste 2000).

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It appears that the trajectory of diagnoses related to gender identity is following a similar historical path to that related to sexual orientation. Most recently, the DSM-5 has replaced GID with the term 'gender dysphoria' (GD), which, similar to EDH, places emphasis on experiences of distress and dysphoria rather than on gender diversity per se. The diagnosis is applied when there is a marked incongruence between the person's expressed or experienced gender and the gender assigned to the person at birth.

The nomenclature change from GID to GD attempts to straddle the desire to de-pathologise transgender identities and the demand to secure medical resources and funding to support individuals in need of transition. The changes represented in the seventh edition of the SOC similarly reflect community pressure to de-pathologise transgender identities, providing more choice in professional support and in control over one's own body. The document clearly states that 'the expression of gender characteristics, including identities, that are not stereotypically associated with one's assigned sex at birth is a common and culturally diverse human phenomenon [that] should not be judged as inherently pathological or negative' (World Professional Association for Transgender Health 2012: 4). While psychotherapy is still suggested prior to authorising hormones and surgery, it is no longer a requirement. Access is more open and acknowledges that care can be and is available in community settings and requirements for surgery have changed so that more decision-making can occur based on informed consent rather than assessment (with the exception of genital surgeries). While there are clinics that operate with the same gatekeeper mentality outlined in the previous SOC, there has been a positive shift towards an informed consent model – respecting people's right to make decisions about their lives and their bodies, as long as they are being comprehensively informed about the risks and consequences attending to transition (Kirby 2014).

Another diagnosis pertaining to gender diversity is that of 'transvestic fetishism' (TF) which has similarly undergone numerous changes in nomenclature and criteria in the various editions of the DSM. In the DSM-IV, the diagnosis was applied only to heterosexual males who, over a period of at least six months, have 'recurrent, intense, sexually arousing fantasies, sexual urges, or behaviours involving cross-dressing', which in turn caused them 'significant distress or impairment in social, occupational or other important areas of functioning' (American Psychiatric Association 1994: 531). This diagnosis applied only to heterosexual males, exempting women and queer men even if they exhibited the same 'symptoms', clearly exposing the sexist and heterosexist beliefs underlying the construction of the category. In the DSM-5, a new diagnosis, 'transvestic disorder' (TD), is meant to reflect the difference between non-pathological cross-dressing behaviour and crossdressing behaviour that 'causes distress to the person or harm to others' (Blanchard 2010). The diagnosis can be applied to a person of any sexual orientation, but it continues to rely on the notion that dressing in ways that challenge normative gender roles is in itself harmful behaviour. This line of thinking clearly defends a binary and sexist notion of gender and continues to pathologise some people's expression of gender. As before, it ignores the natural symptoms of distress that arise from repudiation when one challenges deeply ingrained gender roles.

'Queer'ing and 'trans'forming how we approach sexuality and gender in the psy-disciplines

Queer theory offers an important lens to consider concepts related to mental health or mental illness and queer and trans people. Queer theory problematises naturalised discourses on sex, gender and sexuality and examines the historic and cultural construction of these concepts, ultimately demonstrating how binaries such as 'normal heterosexuality' versus 'deviant

homosexuality' work. This theoretical perspective first emerged in the early 1990s from feminist and lesbian, gay, bisexual and transgender (LGBT) studies and draws on the work of a number of poststructural theorists, including Jacques Derrida (1976, 1988), Michel Foucault (1966, 1975, 1978) and Judith Butler (1990, 1993). In the context of understanding sexuality and gender, queer theory demonstrates the importance of 'the theoretical power of difference', questioning assumptions about community consensus, uncovering metanarratives and deconstructing absolutes, compelling us to break apart deeply ingrained dualisms such as good/evil, straight/gay and male/female (Shelley 2008).

Queer theory questions the very nature and function of language itself. Derrida reveals that language is used to organise the world strategically to keep in place hegemonic relations. The result is that non-normative experiences are either excluded from language or available only in defamatory description (Wilchins 2004). According to Derrida, language works through a process of exclusion, rooted in dualistic relationships such as good/evil, natural/unnatural, superior/inferior or normal/pathological. The 'normal' subject always occupies the centre, while all other subjects deviate from this ideal and are considered to some degree as 'inferior' or 'unnatural'. The 'normal' is left unquestioned, while its derivative subjects are constantly subject to judgement as people progress towards new knowledge. In this way, language fails to adequately reflect the plurality of human experience, refuses to capture the complexities of the self, body, gender and desire, disallowing new understandings from any source that challenges the existing framework (Wilchins 2004).

Like Derrida, Foucault undermines the notion of the self as transcendent and questions how our subjectivities act as a form of politics and resistance. In *The History of Sexuality* (1978), Foucault demonstrates how identity categories are created and maintained through discourse perpetuated by various cultural institutions, including medicine, the state and the church. This history illustrates how the science of sexuality shifted the discourse of homosexuality away from acts perpetrated by people to the homosexual as a person – a permanent identity that defines who one is. According to Foucault, discourse acts as a power that produces individuals as certain kinds of social actors and culture regulates behaviour both internally and externally. Foucault examines the history of prisons to demonstrate how control through the fear of punishment has largely been traded for control through the fear of being abnormal. In other words, the fear of being labelled as evil, unnatural or inferior forces individuals to police themselves, even when they are not under the direct gaze of authority. Foucault (1978) views this as the creation of what he terms 'docile bodies' or conforming individuals with an internalised sense of social norms and self-consciousness.

Queer theory moves towards an understanding of gendered subjectivity that incorporates the complexities and instabilities of desire that cannot be captured within established binaries. It resists essentialised understandings of relationships among sex, sexual behaviour, identity and desire and disrupts the stability of identity, including gay and lesbian identities. Central to this understanding is Butler's (1997) understanding of gender performativity, adapted from Derrida's (1982) and Austin's (1962) theorising of performative utterances. Butler illustrates that even though gender constructs are naturalised and commonly accepted as truth, there is, in fact, no stable reference point for defining what constitutes real gender. Rather, gender is constantly evolving and changing. As people attempt to meet the ideals of normative gender, it is actually their performance of gender itself that produces, reproduces and maintains gender constructs.

While queer theory literature has primarily focused on interrogating gender, desire and sexuality, some queer theorists, including Anzaldúa (1998), Smith (2010), McRuer (2006) and Nyong'o (2005), have used queer theory in their explorations of identity and practices

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related to race, disability, indigeneity and other sites of power. In a 2014 article, LeFrançois and I (2014: 39) introduced the potential application of queer theory in mad studies to 'help foster a deeper understanding of how psychiatric discourse creates and perpetuates theory and practice which pathologizes, punishes, and erases... human diversity and ultimately threatens the hegemonic order'. In exploring a broader understanding of 'queer', we examined how various identities and bodies that are considered 'odd' within dominant discourses disrupt behavioural norms, whether or not those norms are directly related to sexuality or gender, and are viewed as sick within psychiatric discourse and dominant culture.

The arguments that have been used to advocate for the removal of homosexuality and GID from the DSM have admitted some queer people into the realm of normal, have brought some trans people closer to normal as well, but, ultimately, have done nothing to disrupt the binaries underlying dominant psy-discourses. These binaries are based on, and reinforce, the pathological/normal dichotomy. Professional authorities within the psy-disciplines have declared that homosexuality is a natural variation of human sexuality and that transgender people are no longer sick after they gain access to hormones and surgeries and transition to the other sex, as long as they do not meet any other diagnostic criteria for a category of mental illness. In other words, what is determined to be 'normal' and 'pathological' has shifted, but the 'normal' and 'pathological' constructs themselves have remained intact. Meanwhile, queer and trans people continue to live in contexts where they experience homophobia, heterosexism, racism, ableism, ageism, classism, sexism and colonisation. They experience distress in relation to the oppression they experience, and their responses, means of survival and forms of resistance to oppression continue to be viewed as pathological. Advocates have fought to have queer and trans people viewed as 'normal', respectable members of society; however, many queer and trans people who behave in ways that disrupt expectations of behavioural norms continue to be defined as pathological according to dominant narratives. For example, queer youth who are kicked out of their family homes, those trying to support themselves as sex workers and those who cope by using strategies viewed as deviant (such as drug use or cutting) remain marginalised and vulnerable to being labelled as mentally ill. Their behaviours are rarely recognised as responses to abjection based on dominant views of poverty, racism, homophobia, ageism, ableism, adultism, heterosexism and sexism. Psychotherapist and trans activist, Ambrose Kirby (2014: 163), eloquently and very powerfully describes this in an interview. He states:

while our identities are being normalized, our resistance to transphobia is increasingly being separated out from our identities and pathologized. Instead of being trans people who creatively survive transphobia, we are trans people with anxiety disorders, anger disorders, bipolar [disorder], schizophrenia. Our basic identities are less and less considered a 'mental illness,' but our strategies for surviving are being taken out of context and individualized as 'mental illnesses'.

As Kirby notes, when we fail to unpack the notion of 'pathological' human experience, queer and trans people – as with all oppressed people – will continue to be relegated to categories of mental illness, in even more insidious ways than when their identities themselves were being categorised as mental illness.

It is also important to note that the pathologisation of queer and trans people's diverse responses to oppression creates increased vulnerability to marginalisation in the psy-complex. Even as the dominant narrative moves towards informed consent and power to make choices about their own bodies, queer and trans people who continue to be diagnosed as mentally ill remain at risk of being declared as too sick to make decisions for themselves. Further in the same

interview, Kirby (2014) gives two examples of how this blocking of access to transition at the CAMH gender clinic for adults occurs:

someone had struggled with anxiety, and really struggled to leave their house and got a family member to do most of the things that they needed to do outside of the house so that they wouldn't have to leave the house. This is an example of someone they [psy-professionals at the clinic] would try to block from transitioning until they got their so-called 'anxiety' under control.

2014: 164–5

someone who's suicidal, really desperately wants to transition but can't because they're depending on CAMH, and CAMH is saying, 'Until you have one year when you haven't tried to kill yourself, we won't consider allowing you to have surgery.'

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The implications of what Kirby is describing are astounding. The anxiety stemming from living as a trans person who is not able to access resources to transition and the deep pain that flows from this situation are not given priority at the gender clinic. Instead, people's distress and desperation is treated as a pathological problem, unrelated to the issue of transitioning. The psy-professionals require management of this problem prior to the person making a decision to change their bodies – a change that would surely lessen their pain and may even be a life-saver.

Conclusion

A queer theory analysis demonstrates that, just as there is no stable reference point for defining what constitutes real gender, there is no real state of mental health or mental illness. This assertion is corroborated by an examination of the fluid nature of psychiatric diagnoses. An individual socially situated in one cultural and historical setting acting in one way will be declared mentally ill, while another person acting in the exact same way but situated in a different cultural and historical setting will not be diagnosed as such (LeFrançois and Diamond 2014). There are many illustrations of how mental illness is conceptualised differently across cultural and historical contexts and applied differently depending on the individual's social location (LeFrançois and Diamond 2014; Watters 2010). It is through the citation of an inaugurating authority and the subsequent repetition of claims that the notion of mental health and mental illness becomes solidified as 'truth', and the questioning of such notions is removed to the fringes (LeFrançois and Diamond 2014).

As long as these binaries are not challenged, more vulnerable people will be delivered de-contextualised and subjected to biological interpretations of their distress. In working towards creating queer and trans positive theories and services, it is imperative that critical professionals in the psy-disciplines be conscious of how differences in subjective experience and bodily functions are socially constructed as 'sick', 'mentally ill' or 'in need of correction'. This is not to deny the very real suffering that people experience – emotional distress, anxiety and pain in the body – but to recognise how medical discourses are designed to support hegemonic power relations and largely define psy-theorising about these experiences. Choosing to eliminate specific categories of mental illness, while treating emotional and perceptual experiences of the very people who would have been labelled within such categories, separates marginalised people from one another and obscures how systems of power and domination act on our psyches. Contextualising all human experience is a critical step in challenging the pathologisation of queer and trans people.

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Yet, the current reality is that, in many jurisdictions, trans people are reliant on receiving a diagnosis of GD in order to access funding for surgery. Queer and trans people who experience financial struggles due to their marginalised positions often require social assistance. Many struggle within the current organisation of the world and are unable to find or maintain employment and therefore may require disability support. In these cases, people may require a diagnosis to prove that they are disabled and in need of such support, and are therefore forced into a system that reinforces their marginalised status. Additionally, some people may feel that diagnosis validates the struggles they have been through (Health Talk 2015). This is understandable given the lack of alternative narratives within dominant culture to understand problems that arise from living in cultural and economic contexts that fail to meet their basic human needs.

Helping professionals need to be aware of and help people gain access to the material supports they require, whether that is financial assistance, housing supports, hormones or surgery. However, a change in diagnosis without a change in the flawed foundational organisation of psy-theories and services does not move us closer to better serving queer and trans people. As a matter of fact, it may slow progress towards genuine inclusion of those who challenge the dominant organisation of sexuality and gender in society. As long as professionals continue to decontextualise experiences within medicalised discourses, the dominant dialogue within society will also decontextualise and ultimately misunderstand the experiences and challenges faced by queer and trans persons. Critical helping professionals occupy a difficult position, navigating the very real constraints of a system that simultaneously hurts people while offering them life-saving supports. It is a challenge to remain aware of the foundational flaws of a system that perpetuates the oppression of marginalised people and support people to navigate this system to get the resources that they require, while working towards a better, more holistic and inclusive system that does not pathologise queer and trans people who creatively survive oppression.

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Reflections on critical psychiatry

Pat Bracken and Phil Thomas

Over the past 20 years a good deal of our work has been concerned with imagining what a psychiatric practice that embraced critical reflection might look like. We were both involved in the initial meetings that led to the formation in Bradford of the UK-based Critical Psychiatry Network (CPN) in 1999 (see criticalpsychiatry.co.uk). However, we are clear that we do not speak ‘on behalf’ of the CPN: no one does really. The CPN is a network, an alliance, not a party with a manifesto. The views expressed here about the nature of critical thinking and psychiatry are ours alone.

In this chapter we will begin by offering some ideas about the nature of ‘critical reflection’. By necessity, these are brief in nature – we do not, for example, explore the various dimensions of critical theory. For us, critical thought in any domain is essentially about questioning what is currently understood to be the common sense in that domain. We will argue that our current common sense about mental health is informed by a modernist agenda. This is what we, and others, have called the ‘technological paradigm’. While we do not have the space to explore the complex economic, political and cultural forces that work to keep it in place (Bracken and Thomas 2005; Thomas 2014), we spend the first half of this chapter outlining the nature of this paradigm. In the second half of the chapter we sketch out what we see as the five dimensions of critical psychiatry. We understand critical psychiatry as an attempt to get beyond the dominant modernist agenda. In the last section of this chapter, we make the case for the recovery approach. We are aware of how this concept has been abused (see recoveryinthebin.org). However, we argue that it still has the potential to be a vehicle for revolutionary change within the field of mental health. Our case is that critical psychiatry is essentially an argument in favour of such a revolution.

Critical thought

In philosophy, the tradition of critical thinking goes back 2,500 years to Socrates, one of the main philosophers of ancient Greece. Socrates engaged his students in dialogues and refused to simply present them with theories and dogmas. The goal of his dialogical method was to promote doubt and to challenge the accepted, common sense way of looking at the world. For Socrates, true wisdom involved an appreciation of the *limitations* of one’s knowledge and a mind-set that put a value on doubt, questioning and critique. The practice of philosophy has been

based on dialogue and questioning ever since. Peter Singer (2016: 536) puts critical thinking at the heart of philosophy. He argues that '[p]hilosophy ought to question the basic assumptions of the age. Thinking through, critically and carefully, what most of us take for granted is, I believe, the chief task of philosophy, and the task that makes philosophy a worthwhile activity'.

In education, there has also been a long tradition of valuing critical thought. For example, the Brazilian educationalist Paulo Freire critiqued a great deal of educational practice and spoke about a 'banking approach' dominating the way we think about teaching. In this, the job of the teacher is not to promote questioning but to fill the student with facts. While learning facts about the world is, of course, an important function of education, the 'banking' approach treats reality as something static and unchanging, not something that can be questioned and transformed. It is thus inherently conservative and serves the functioning of the political and social status quo. Education equates with training and the priority of the educational system is the supply of skilled workers that will suit the needs of the economy.

What Freire calls 'critical pedagogy' involves a very different understanding of education practice. It is an educational practice with civic, political and moral dimensions. It sees the chief job of education as the nurturing of citizens who are able to reflect critically and imaginatively on the status quo and to see their role not as passive receivers of 'facts' but as people involved in a creative dialogue through which reality, in all its dimensions, is explored, illuminated and understood. Consequently, Freire (1996: 62) comments on the results of this pedagogy that, '[t]he students – no longer docile listeners – are now critical co-investigators in dialogue with the teacher'. Freire promoted this overtly critical form of pedagogy in his own country and his ideas have been taken up in various ways across the world by educationalists who want education to involve the questioning of assumptions, the questioning of facts and theories, and the promotion of hope through a culture that increasingly values change and expectation.

Some common themes can be identified as emerging across the various approaches to critical thought, namely,

- a concern with the idea that the current status quo (how we understand ourselves) is not fixed and is based on assumptions that have been generated over time. Critical thought starts from an appreciation that our 'common sense' about the world can and should be questioned;
- a respect for 'dialogue'. Critical theorists argue that we are challenged to produce the conditions wherein real dialogue can take place. This is not simple as power differentials often serve to privilege one view over the others. When assumptions are challenged, then sources of authority and power are challenged. This is what creates the conditions for real dialogue;
- an ultimate aim to promote genuine citizenship. Those who argue for critical thinking refuse the current equation of citizenship with consumerism and work, instead, with the idea that the citizen is someone who is able to engage with and change the political dynamics of their society. This is an active version of citizenship. The citizen is not someone happy to be defined by someone else, to be accounted for in the terms of a knowledge system that they have not been involved in creating. Promoting critical reflection is about promoting citizenship.

The technological paradigm

We will now turn to mental health and our current common sense, our current status quo. We often talk about the 'medical model' being dominant in mental health but there is a growing

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appreciation that the medical model is just one instance of a more deep-seated, pervasive paradigm or way of understanding states of mental illness. This is what we and other colleagues have called ‘the technological paradigm’ (Bracken *et al.* 2012). This involves the following assumptions:

- that the mental health problems to be addressed are due to faulty mechanisms or processes of some sort, located in an individual person. These are most often understood as being biological in nature, yet technological versions of psychology also provide, for example, descriptions of mental illness as due to ‘faulty cognitive or emotional processing’;
- that the ‘faulty’ mechanism or process can be modelled in causal terms – that is, described in a way that is universal and works regardless of the context;
- that technological interventions are instrumental. They have nothing to do with opinions, values, relationships, or priorities.

The technological way of understanding mental illness is usually seen as the only scientific way to approach states of madness and distress. As such, it is understood as being superior to spiritual and folk psychologies and is presented as promoting a liberation from ‘myths’ about mental illness that led to stigma and oppression in the past (Shorter 1997). Many anti-stigma campaigns are actually premised on a strong presentation of this orientation (Angermeyer *et al.* 2011); mental illness is not a spiritual or moral issue but a technical one, it is due to a faulty biological or psychological mechanism. States of mental distress are thus characterised in terms of ‘symptoms’ and it is generally assumed that a medical framework and vocabulary (or a specialised psychological vocabulary) can capture the essential nature of such problems.

The technological approach works to separate our discourse about mental distress from background contextual issues. This move promotes the gaze of the expert professional who is trained in the language and idiom of his/her profession. In media discussions of mental health issues, in government determinations of research and service priorities, in the shaping of mental health policies and laws the technological approach has universal dominance. While service users are increasingly spoken about as ‘partners’, the pronouncements of experts of one sort or another in all these domains are, in the end, what counts.

One important point is that in the technological paradigm the non-technological aspects of mental health (such as values, meanings and relationships) are not ignored or dismissed but, rather, of secondary importance only. If we look at psychiatry’s institutional priorities over the past 30 years, we have witnessed a huge amount of energy being spent on:

- classification systems such as the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the mental health section of the *International Classification of Diseases* (ICD);
- the search for biological causal factors such as genes, neurotransmitters and hormones;
- evidence-based medicine (EBM) – that is, the search to identify the therapeutic effects of discrete interventions such as drugs, electroconvulsive therapy (ECT) and technicalised forms of psychotherapy such as cognitive behavioural therapy (CBT). The fundamental assumption of the application of EBM is that mental health conditions are discrete, measurable entities and that our treatments are best understood as interventions that fix specific faults in our neurochemistry or our psychological processes.

Occasionally, there will be discussion about our values as mental health professionals, and likewise some researchers are interested in investigating relationships and meanings in health care settings, but this work is seen as adjunctive only to the main stuff of mental health, which is essentially about diagnosing and fixing faulty brains or minds, or both.

The recovery approach

We believe that, in its original meaning, the recovery approach involved a direct challenge to the technological paradigm. This approach emerged directly from the growing international movement of users and survivors. A number of people who had been informed that they were suffering from life-long psychiatric conditions (such as schizophrenia) managed to find paths that led them to a reality of personal recovery. They then wrote about their journeys in an attempt to provide inspiration for others. While some of these paths involved mental health services, most did not. Some found that traditional mental health services had worked to impede their personal recovery, others reported that they had been damaged by the way psychiatry framed their problems and intervened in their lives.

A large literature centred on these personal accounts of recovery from serious mental health problems has now emerged (see, e.g. Brown 2008; Carless and Douglas 2008; Cohen 2015; Foster 2007; Karp and Sisson 2010; Ridge 2009; Ridgway 2001). This literature moves the discussion about mental problems away from the clinical and technical focus on issues such as diagnosis, assessment, classification, prognosis and treatment, and instead focuses on the importance of seeing and understanding mental health problems within a context of social roles, relationships, values and meanings. However we define 'recovery', this approach involves the profound realisation that these issues are not secondary but rather the most important, central issues facing people with mental health problems.

The recovery approach does not dismiss questions to do with classification and the nature and relevance of technical interventions, but *these* become of secondary importance and, crucially, research, training and service priorities and discussions about drugs and therapy are now shaped by this more fundamental discourse. When we talk about services 'moving to a recovery orientation' we are talking about services that seek to make the non-technical aspects of mental health of primary importance. When we move to a recovery orientation the problems show up differently and the nature of mental health work also starts to shift. The recovery approach is about reversing the order of priorities.

Critical psychiatry: why we need to move beyond the dominant paradigm

We believe that there are five dimensions to the current project of critical psychiatry: ontological, epistemological, empirical, ethical and political. We shall examine each of these in turn. The first three relate to the fundamental assumptions of the technological paradigm that we have referred to above.

Ontological

Ontology deals with questions about what sort of entities exist and how they can be classified and understood. When it comes to mental health we are talking about questions such as: Where does mental suffering come from? What sort of entities are mental illnesses? Are they entities at all? How should we begin to classify them? Are mental illnesses of the same basic nature as physical illnesses?

The technological paradigm involves, at its heart, a commitment to what we might call 'ontological reductionism'. When it comes to mental illness, reductionism involves the belief that while social factors and relationship issues may be involved, ultimately mental illnesses are the result of faulty neurological or psychological processes, full stop. This is where we should focus

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our research efforts. Ultimately, our social interactions and our different psychologies can be explained by way of reference to the brain and neurology. One of the clearest statements of this position is at the heart of the National Institute of Mental Health (NIMH) Research Domain Criteria (RDoC) project which aims to develop a classification system to replace the DSM-5 (see American Psychiatric Association 2013). Thomas Insel (2013), who was head of the NIMH when the RDoC project was launched, maintained that '[m]ental disorders are biological disorders involving brain circuits that implicate specific domains of cognition, emotion, or behavior'. Simple as that. Everything can be accounted for by the biology of the brain. Critical psychiatry involves a challenge to this 'ontological reductionism', to the idea that mental illnesses can be understood in the very same way that we understand diseases of the body. This is not a reiteration of antipsychiatry which argued that there was no such thing as mental illness (Szasz 1974). Rather, the critical psychiatry position is a more nuanced one. It is a challenge not to the notion of mental illness per se, but to the ontological reductionism that is involved in the current way of understanding and framing states of madness and distress.

Critical psychiatry has challenged the assumption that the mind is simply another organ of the body, or that it can be equated with the brain. It asserts that when we put the word 'mental' in front of the word 'illness' we are demarcating a territory of human suffering in which *meanings* are central and cannot be ignored. And meanings cannot be explored without involving contexts. Such contexts change over time and, thus, the very nature of mental health problems – indeed, what we regard as a mental health problem in the first place – is not fixed but changeable.

Epistemological

Related to the issue of ontology is the epistemological question of what kind of knowledge is appropriate in the field of mental health. As a reminder, the second assumption of the technological paradigm is that the faulty mechanism or process can be modelled in causal terms (that is, described in a way that is universal and works regardless of the context). This is what is known as *positivism*, the idea that the human sciences such as sociology, anthropology and psychology are only being properly scientific when they involve themselves in a search to identify universal causal laws underlying social, cultural and psychological phenomena. In other words, they are only valid if they use the same approach to knowledge that is used in the sciences of the natural world such as physics, chemistry and biology.

Psychiatric research has therefore been, in its essence, a quest to produce causal, universal models of mental disorders. It has virtually ignored contextual aspects of mental health and minimised the contribution of research strategies that are based on non-positivist approaches to knowledge. We argue that this has got us precisely nowhere. Allan Frances (2014), lead author of the DSM-IV (see American Psychiatric Association 1994) and now a prominent critic of the whole DSM process, wrote recently that,

The neuroscience and genetic revolutions have been astounding in their technical virtuosity and fascinating in their findings – but to date have not helped a single patient. We have learned a great deal in basic science, but nothing at all that translates to better care.

Another senior psychiatrist, Arthur Kleinman (2012: 421), has similarly reflected that, '[a]cademic psychiatry has become more or less irrelevant to clinical practice'.

Reductionism and positivism have dominated mental health research for the past 30 years. They provide the guiding ontological and epistemological assumptions for psychiatric research and training, inform our understandings of the nature of expertise, and thus guide service

developments and even how we frame mental health legislation. They have been remarkably unsuccessful. In tune with the recovery approach, critical psychiatry has sought to work with a *primary* focus on meanings, values and relationships, both in terms of how we help patients and identifying from whence their problems arise.

Empirical/therapeutic

The third assumption of the technological paradigm has to do with how we understand our interventions. What works in mental health and how does it work? The paradigm underscores an instrumental picture of mental health care. Our interventions are primarily about fixing neurological and psychological deficits. This is the fundamental assumption of EBM. When it comes to mental health problems such as states of depression, patients are routinely told that these are technical problems caused by faulty brain chemicals or cognitions and that the treatments prescribed are designed to fix these technical problems.

The empirical evidence, however, does not support the technological paradigm. For example, if we look at outcome studies for antidepressants, ECT and CBT (the main psychiatric responses to depression), it is clear that patients get better with all three. However, it is also clear that most of the benefit of these interventions can be explained by the ‘non-technological’ aspects of the treatments. A number of meta-analyses, for instance, have demonstrated that the placebo effect can explain most of the efficacy of antidepressant drugs. When it comes to the placebo effect, we are essentially looking at non-technical dynamics such as relationships and meanings at work. The technical narrative that the drugs are ‘fixing a chemical imbalance’ simply does not correspond to reality (Kirsch 2014).

Something similar emerges from the literature on ECT. Two reviews of comparisons of real with ‘sham’ ECT make this point. The controlled studies on ECT were all done some years ago (up to the 1980s) and are usually seen as supporting the efficacy of this treatment (e.g. the Northwick Park Study, see Johnstone *et al.* 1980). Sham ECT takes place when the patient believes that he/she is going to have ECT, has all the preparations for the treatment, but then does not receive the electrical current. In a review in the *Journal of ECT*, Rasmussen (2009: 57) concluded that, ‘substantial proportions of what seemed to be severely ill patients responded to sham treatment quite robustly’. The authors of the other review found no significant differences between the effects of real and sham ECT after the treatment period (Read and Bentall 2010).

Similar evidence has emerged from psychotherapy. Several studies have shown that most of the specific features of CBT can be dispensed with without adversely affecting outcomes. A comprehensive review of studies of the different components of CBT concluded that there is ‘little evidence that specific cognitive interventions significantly increase the effectiveness of the therapy’ (Longmore and Worrell 2007: 173). Psychotherapy works, but it does not seem to matter very much what model or what specific techniques are used. What really matters is the quality of the relationship between patient and therapist, whether the patient feels respected and valued, whether the encounter is meaningful (Cooper 2008).

Most people get over states of depression and many are helped by professional interventions. However, whether we like it or not, this does not appear to be due, in the main, to the technologies that are used and the subsequent effects on neurotransmitters or cognitive mechanisms, but rather the simple fact that there has been an intervention. What emerges from the literature on treatments for depression (Bracken *et al.* 2012) is the key importance of relationships and meanings and values. Getting these right is where the ‘action is’; these are the elements of our encounters that matter. What technology we use is not irrelevant, but it is of *secondary* importance.

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Apart from treatments for depression, the evidence coming from studies of recovery in people with psychosis and what is sometimes called serious mental illness (SMI) also points to the importance of non-technological aspects of care. The work of Larry Davidson (2003), Richard Warner (2003) and others in the recovery movement points to the importance of creating a therapeutic context that is respectful, hopeful and democratic. However, there is really no convincing evidence that all the research in genetics, neuroscience and neuroradiology has done anything much at all for our patients.

Ethical

This leads to a consideration of ethical issues. What we have in mind here is the corruption of a great deal of academic and clinical psychiatry by the marketing interests of the pharmaceutical industry. The critical psychiatry movement has been raising this issue for many years (Bracken and Thomas 2005; Moncrieff 2008) and, to some extent, we believe that we have been successful in convincing a growing number of our colleagues of its importance.

In his book *Deadly Medicines and Organised Crime: How Big Pharma has Corrupted Healthcare*, Peter Götzsche (2013: 38) quotes a previous global vice president of marketing for Pfizer, who states that,

It is scary how many similarities there are between this industry and the mob. The mob makes obscene amounts of money, as does this industry. The side effects of organised crime are killings and deaths, and the side effects are the same in this industry. The mob bribes politicians and others, and so does this industry.

While the pharmaceutical industry has corrupted a great deal of medical research and practice, it is clear that psychiatry has been a particular target. Götzsche (2013: 191) calls psychiatry ‘the drug industry’s paradise’. We agree with Robert Whitaker and Lisa Cosgrove (2015) that psychiatry has been corrupted and damaged. EBM, on its own, has not proved strong enough to resist such corruption. In fact, it would appear that the EBM process itself has been deliberately targeted and manipulated to serve corporate interests (Spence 2014). Critical psychiatry has sought to nurture a form of critical reflection that goes much deeper than what is provided by EBM.

Political

Lastly, we come to the political dimension of critical psychiatry. What we are looking at here is the social position of mental health service users and their relationships with professionals. Let us recall the three cornerstones of critical thinking that we got from philosophy and pedagogy: the questioning of common sense assumptions about the world and challenging the accepted paradigm, the promotion of dialogue as the engine of real progress and the ultimate goal of creating an ‘active citizenship’. Critical psychiatry has always been about the creation of a space where real dialogue can take place between service users and the professionals who are involved with them. We do not just mean dialogue in the clinical encounter, but rather the ability of professionals to hear – and to really listen to – the voices coming from the wider service-user and survivor movement.

We have seen that the technological paradigm is grounded in a reductionist philosophy that is inadequate to grasp the meaningful world of mental health and its problems. We have seen that research based on reductionism and positivism has yielded little, if any, help in the clinical field, and we have also seen the empirical evidence on how our interventions *actually* work point

to the centrality of the non-technological aspects of our treatments. Further, we have seen how finance from big pharma has served to keep the technological paradigm in place, sometimes through overtly corrupt means.

However, for us, the most serious problem with the technological paradigm has been the way it has served to undermine the conditions for real dialogue in our field. This is because it positions technical knowledge as the grounding authority for our discourse and debate about mental health. And while this elevates the professional, it forever positions the service user as the *recipient* of expertise. In the technological paradigm there is a role for service-user organisations and individual activists, but this is advisory only. Just as patient groups can be allies in the field of cardiology or endocrinology, they do not change the assumptions or the science of the discipline. They are there in a consultative role only. Their expertise will always be secondary to the technical expertise of the professional.

Conclusion

In its challenge to the technological paradigm and the common sense of mental health, critical psychiatry attempts to create the conditions in which real dialogue can take place between the different stakeholders. The recovery approach emerged from the service-user movement. We believe that it represents a revolutionary development in the understanding of mental health problems and it challenges us to respond very differently to them. While many governments, user organisations and professional bodies have argued for a shift to a recovery way of working and thinking, there is resistance. Some of this resistance is overt and obvious, but some is more covert and less apparent. Resistance often takes the form not of direct confrontation, but of incorporation and neutralisation. At its heart, the recovery approach involves a direct challenge to modernist psychiatry. Initially, psychiatry sought to ignore this development, but over time it has responded by defining recovery not in revolutionary terms, but as a sort of ‘add-on’ (Howell and Voronka 2012).

For us, critical psychiatry has been about deconstructing the authority of modernist psychiatry. By teasing out its problematic assumptions, by demonstrating its lack of scientific credibility, by questioning the empirical evidence in relation to its interventions and by highlighting its recent corruption by big pharma, critical psychiatry has sought to be a type of clearing operation. It has not tried to sell a new model to service users and their families. However, its critique of psychiatry resonates strongly with the recovery approach, which, for us, represents a very positive understanding of how we might make progress.

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Mad studies

Rachel Gorman and Brenda A. LeFrançois

This chapter is written by two mad studies scholars. One of us (Rachel) was a member of the Coalition Against Psychiatric Assault (CAPA) in Toronto, where she became connected with the emerging network of mad scholar/activists that later spurred Richard Ingram (2015, 2016) to coin the term ‘mad studies’ in 2008. The other of us (Brenda) was a participant at the Madness, Citizenship and Social Justice conference organised by Robert Menzies at Simon Fraser University in Vancouver in 2008, where she became excited by the new Canadian mad scholarship and took up the invitation to co-edit the book *Mad Matters* (LeFrançois *et al.* 2013) in order to feature that scholarship. Both of these major events – the coining of the term ‘mad studies’ and the Vancouver conference – collided in ways that have enabled activist scholarship emanating from the mad movement to find a politicised and theoretical home both inside and outside of the academy. We come together to write this chapter, bringing in our knowledges of this emergent ‘in/discipline’ (Ingram 2015, 2016), as well as our experiences as, respectively, a queer mad mixed-race woman who is a performance artist and disability studies academic and a queer mad white woman who teaches against the grain to trainee professionals as a social work educator and critical psychology academic. All this we bring to this joint writing of mad studies, framed within transnational, critical race and post colonial lenses.

Those who find themselves reading new terrain here might ask: but why mad studies? Although critiques of psychiatry have been around for decades, from radical and feminist therapists to antipsychiatry activists and critical psychiatrists (to name a few of the most prominent historic and current sources), none of these critiques have specifically centred the knowledges and theorising of those who have been deemed mad. Although mad studies scholarship is engaged in by allies as well as those deemed mad, the mad movement nonetheless remains central and intertwined within this scholarship. Given this focus, it is not surprising that, with the emergence of mad studies, much focused attention has been placed on the retrieving, documenting, understanding, revisiting and teaching of mad people’s history (Beckman and Davies 2013; Burstow and Weitz 1988; Chadha 2008; Davar 2015; Patel 2014; Reaume 2009; Reville 2013; Roman *et al.* 2009; St Amand and LeBlanc 2013; Starkman 2013). Indeed, we understand mad studies as a space of social action and theorising about oppression and psy-violence that centres the histories of psychiatrised bodies, particularly because those psychiatrised bodies have been

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suppressed and erased within other disciplines and bodies of knowledge, including those bodies of knowledge that critique psychiatric oppression.

In addition to this innovative way of studying and teaching mad people's history, mad studies provides a systemic critique of psy-violence, epistemic injustice (Donskoy 2015; LeBlanc and Kinsella 2016) and sanism (Fabris 2011; Poole *et al.* 2012) that includes, for example, reading psychiatric charts (that is, the daily notes that hospital personnel make about patients) against the grain (Daley *et al.* 2012) and exposing psychiatric violence through other forms of writing, research and social activism (see, e.g. Ben-Moshe *et al.* 2014; Burstow *et al.* 2014; LeFrançois *et al.* 2013; Russo and Sweeney 2016). Infiltrating academia, either via critical disability studies or as its own separate transdisciplinary field, we understand the progression of consciousness raising, social activism, peer-run services and psychiatric survivor research within the mad/psychiatric survivor movement to have moved beyond a social movement alone to one that now has its own in/discipline. Given its immersion within the mad movement, crucially, we see that mad studies takes place in a variety of spaces within or without academia, but never without community (LeFrançois 2016). Moreover, transnational, critical race and post colonial understandings have been integral to mad studies from its inception (Gorman 2013; Gorman *et al.* 2013; Gorman and Udegbe 2010; Haritaworn 2013; Kanani 2011; Mills 2014; Nabbali 2013; Patel 2014; Tam 2013; Voronka 2013), working to subvert the erasure of racialised and colonised mad bodies as well as their targeting and over-representation within psychiatric institutions.

Mad studies understands itself as an evolving project, where no one person or group carries authority over what it is now and what it might become over time. In addition, it has been envisioned as a collective project that has begun and will evolve primarily out of the political discussions and theorisings taking place among members of the mad community (Ingram 2016). Infused by mad cultural production (Dellar *et al.* 2000; Diamond 2013), mad studies aims to celebrate community and positive aspects of altered states of mind, without pathologising those experiences or glamorising or effacing what may be experienced as deep and unbearable distress.

Also of importance within mad studies is the focus on what Finkler (2014) refers to as a psychiatry survivor analysis or what Wolframe (2014) refers to as a mad reading or the maddening of text. Here we see the central issue of moving beyond consumer narratives (Costa *et al.* 2012) to honouring the knowledge production and theorising of those deemed mad (Finkler 2014; Sweeney 2016; Wolframe 2014). Not only does this theorising hold importance in terms of looking in and exposing the violence of the psychiatric apparatus, it opens up the many possibilities surrounding mad standpoints looking outward, as mad readings of the wider world (Ingram 2015; LeFrançois 2015). That is, the mad gaze, the maddening of text and the mad analyses of non-psychiatry-related social policy issues or on literature, the arts, politics, philosophy and so on, all have a home within mad studies.

Emerging debates

With this introduction to mad studies and its possibilities, we move now to a discussion of some of the emerging debates currently taking place within this in/discipline. In the remaining paragraphs, we will outline what we consider to be emerging theoretical debates that are made possible through the emergence of mad studies – and by interventions into mad studies by indigenous, critical race, queer/trans and feminist theories and theorists. At stake are questions of ontology/epistemology and debates over essentialism. Also up for discussion is whether mad studies can present us with a robust enough analytic framework that it can be understood as a critical social theory in its own right, through potentially grasping social relations beyond

a narrow study of psychiatric systems and the people who have been most directly subjected to them. Through an assessment of recent scholarship at the intersections of mad studies and settler colonial studies, critical race theory and queer and trans of colour studies, we will argue that there are important stirrings that may lead us towards a thoroughgoing mad theory that can help us understand the central role that ideologies of 'mental health' play in ongoing processes of colonisation, labour exploitation, racism and state violence.

We start with the premise that mad theory emerges at least in part from (and/or as a part of) mad studies. While there is no consensus about what mad studies is – or perhaps more importantly, no consensus about who can do mad studies – we will say broadly that '[m]ad studies takes social, relational, identity-based, and anti-oppression approaches to questions of mental/psychological/behavioural difference, and is articulated, in part, against an analytic of mental illness' (Gorman 2013: 269). We must attend to the fact that mad studies' emergence in the academic industrial complex creates a specific set of conditions for knowledge production, even as mad studies itself emerges from scholarship connected to mad movements. Therefore, in order to query an emergent mad theory at this historical juncture, we must understand it in relation to identity-based social movements that emerge in Western capitalist contexts and that are simultaneously contested by majority world and indigenous activist communities.

Psychiatry and scientific racism

Foundational epistemological and methodological contributions to a potential mad theory have emerged through mad studies projects of analysing and re-historicising histories of madness and psychiatry. Mad studies historiographies of psychiatry and the psychiatrised have been hard fought struggles, which began in the early days of mad and psychiatric survivor organising. It is through the perseverance of activists and scholars who have struggled for a mad people's historiography and through the strength of anti-racist and anti-colonial contributions to mad historiography by black and indigenous people and people of colour, that we are in a position to speculate on possibilities for mad theory. Despite the over-representation of racialised bodies as subjects of psychiatric violence, overarching social relations of racism and colonialism mean that we nonetheless witness the suppressing and erasure of the experiences of racialised mad people even more so than those of white mad subjects. This becomes, then, not only the erasure of psychiatric violence and sanism, but also the erasure of racism within this same dynamic. Centring the histories of psychiatrised bodies therefore requires interrogating and exposing the interconnections between the history of racism and the history of biomedical psychiatry.

Psychiatry and scientific racism share a common history of emergence and ongoing articulation. The scientific elaboration of the 'normal curve' can be historically traced as central to the constitution of mad and other disabled people as different and abnormal, reproducing a hierarchy of power, privilege and subordination (Campbell 2009; Chapman 2014; Davis 1995) that intersects with other markers of race, gender, class, sexuality and age, crafting the unmarked white mind and body as superior (Butler 2016). This casting of the superior–inferior dichotomy and the scientific racism through which it was codified was a central pillar in the colonial project (Césaire 1972; Fernando 1992; Tuhiwai Smith 1999). At the same time as colonial regimes and slave traders propagated racist ideologies and claimed their projects as benevolent – whereby primitive peoples with smaller brains who lacked self-control and advanced reasoning skills were helped by their superior masters – psychiatry was developing in the context of these socio-scientific epistemologies (Fernando 1992).

The contradictions of human science in its study of '[m]an's human others' (McKittrick 2013) meant that colonial scientists found very low incidence of what psychiatry was now calling

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‘mental illness’ within colonised populations (Cohen 2014; Fernando 1992). Uncivilised people were declared immune from bourgeois neuroses and psychoses, and some argued that slaves were only free of madness when in captivity (Fernando 1992). Indeed, psychiatry at the time bolstered the slave trade by classifying the ‘running away behaviour’ of slaves as a mental illness known as drapetomania (Fernando 1992; Kanani 2011). Within relatively little time, the marking of unruly racialised and colonised bodies became more pronounced in psychiatry, to the point where racialised and indigenous peoples were (and are) over-represented within mental health systems within the Western world (Cohen 2014; Fernando 1992; Fernando *et al.* 2012; Metz 2009; Voronka 2013).

Epistemology and ideology in mad theory

In our consideration of mad theory as emerging from mad people’s analytic perspectives, we must grapple with mad movements as social movements. Emerging from a social movement that is based on principles of self-identity, mad theory also contains at its kernel a tendency towards essentialism – the explicit or implicit argument that mad people have essential characteristics and are, therefore, identifiable as mad people. Ontological claims inevitably lead to epistemological ones – if we are trying to centre thinking that emerges from mad experience, it matters *whose* experience we are most interested in. Broader social relations of gender, race, class, sexuality and gender identity play out in Western-based liberal social movements, including mad movements. As mad movements are appropriated into the academic industrial complex as mad studies, radical antipoverty and antipsychiatry movements are both appropriated and de-emphasised. As a result, emergent mad identity tends towards dominant subjectivities. In similar ways, claims about the experience of being psychiatrised can be based on the imputed experiences of dominant subjectivities – for example, the longstanding claim by some activists that being psychiatrised is ‘like being colonised’ (Gorman 2013; Tam 2013) solidifies a mad subjectivity that erases the experiences of black and indigenous people and people of colour who are simultaneously resisting psychiatry and legacies (and ongoing violences) of colonialism.

Nor can we understand cultural ideologies of mad ‘essences’, or their social movement refractions, in the absence of psy-complexes and white supremacist sanism. Emerging mad subjectivities also must struggle against the ongoing institutionalised reproduction of psy-ideologies. This ideological struggle is perhaps most apparent in the so-called consumer perspective on the role of stigma in the oppression of psychiatrised people. In the ongoing competition for state and charitable funding, psychiatric hospitals and research complexes are recast as ‘helping’ institutions through massive anti-stigma campaigns and through the appropriation of patient testimony of ‘changed lives’ (see Costa *et al.* 2012). Through these campaigns, psychiatrised people, as well as the not-yet-diagnosed, are enjoined to confess our essential (chemical) differences or to be informed on by co-workers and loved ones.

These contemporary psy-techniques of forming and coming to know mad identity are in dialectical opposition to ex-patient and antipsychiatry consciousness-raising groups, where people deconstruct and critique experiences of distress and violent interventions and imagine alternative modes of support. While ‘stigma’ flags the ideological realm of psychiatric hospitals and service organisations, concepts like ‘sanism’ that emerge from mad studies fora (Fabris 2011; Poole *et al.* 2012) may provide more robust explanatory power than ‘stigma’. ‘Sanism’ has the potential to account for both discrimination against those perceived as mad and for psychiatric violence, while ‘stigma’ only accounts for the former. Indeed, in contemporary mental health campaigns, the ‘problem’ with stigma is that it causes delays in ‘getting help’ from what are, ultimately, oppressive systems.

Mad theory and/as critical social theory

As with the development of women's standpoint theory (with its onto-epistemological problems of the 'essential woman') and its relationship to broader feminist theory and gender studies, so too can we imagine a mad theory that goes beyond a focus on critiquing, abolishing and/or reforming psychiatry. Recent scholarship in mad studies reveals psy as an expansive overarching system that permeates and interlocks with other ruling relations – for example, settler colonialism and social work (LeFrançois 2013). A mode of critique becomes far more powerful when it can be integrated with other critical social theoretical positions and fields of study. Critical race theory scholar Sherene Razack (2015) and critical native studies scholar Dian Million (2013) have uncovered fundamental ways in which psy-technologies are co-constitutive of settler colonialism and reproduce white supremacy in the Canadian context. These scholars did not deploy mad studies concepts per se in order to develop their critiques; however, these authors are aligned with mad studies scholars and are committed to social justice. The insights of these authors reveal important possibilities for the future of mad theory and the scope of mad studies.

The most important potential sources for mad theory continue to be collective interventions into ways of knowing that come from outside the academic industrial complex, or that challenge its boundaries and authority. There are fundamental lessons to be learned from antipov-erty and anti-violence politics that emerge from mad perspectives (see Psychiatric Disabilities Anti-violence Coalition 2015) – these voices have always been anchors in mad and psychiatric survivor organising, yet they may be displaced as mad studies engages in the academic industrial complex. In addition, we must learn the painful lessons of anti-black racism in broader social-movement organising (Garza 2014) and consider the ways in which anti-black racism emerges in mad movement organising. For example, in the Toronto context, anti-racist organisers like the Urban Alliance on Race Relations (2002) and Black Lives Matter (Ross 2016) have been front and centre in the fight against police killings of black men with psychiatric labels, while many white-identified mad organisers have failed to recognise and grapple with the centrality of racism in cases of violence against people with psychiatric labels.

From the historic and ongoing significance of periodicals such as *Pheonix Rising*, *Asylum* and *Our Voice/Notre Voix* to the embodied theory produced through artistic sites such as Gallery Gachet and Friendly Spike Theatre Band, as well as the recentring of important historic contributions of anti-colonial writers such as Bessie Head (1974; Onyinyechukwu Udegbe, personal communication) and Meri Nana-Ana Danquah (1998; Mollow 2006), there are many important sources for a more thoroughgoing mad theory. Taken together, these interventions may help us gain a more concrete understanding of the ways in which psy, as a ruling relation, is a co-constitutive of patriarchy, settler colonialism and anti-black racism, among other logics of raciality (Kanani 2011). At its best, mad theory may help to elucidate and address some of the specific contours of broad concepts like 'settler colonialism'. At its worst, mad theory may reinforce white middle-class identity politics by valorising and recuperating less dominant white subjectivities.

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Part II

Critical histories of psychiatry

Madness

A critical history of 'mental health care' in the United States

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The late medical historian Roy Porter defined madness as the 'generic name for the whole range of people *thought to be in some way*, more or less, abnormal in ideas or behaviour' (1987: 6, emphasis added). He notes that, 'even today we possess no... consensus upon the nature of mental illness... Short of the discovery tomorrow of the schizophrenia gene, these controversial issues will not be quickly settled' (Porter 1987: 8–9). Despite decades of research, no genes or biomarkers have been discovered for any 'mental' disorder (Andreasen 1997, 2007; Boyle 2002). Though there are numerous theories about the nature of madness (Read *et al.* 2004), none have been scientifically validated. Despite these scientific uncertainties, one of these theories has persisted – namely, madness as medical disease. This presumption has devastated our understanding of it. Science generally advances through trial and error examination of testable hypotheses: those which explain previously unexplainable observations and can make novel predictions temporarily triumph (e.g. Carnap 1974: 6–16). Madness as medical disease fails to do this and marginalises alternative views.

What follows is a succinct history of how the age-old problem of madness became the medical problem of mental illness. The analysis identifies two recurring issues: one, the identification of a heterogeneous troubling segment of the population, the mad 'who persistently create havoc, discord and disarray... creat[ing] extraordinary burdens for others' (Scull 1993: 353), and the other, the escalation over time of bureaucratic institutional government supported 'psychiatric' control and coercion under the cover of medicine.

The beginning

The Greeks originated the discussion on madness and their ideas have been very influential. For them, madness meant the loss of reason – the noblest faculty of man, its highest expression being to 'know thyself' (Popper 1998). Reason was counterbalanced by its opposite, *irrationality*, which was viewed as the major threat to human survival. Western civilisation embraced the centrality of reason for human development while minimising the impact of irrationality (Porter 1987). The Greeks had two principal explanations of irrationality. One saw human existence as a struggle over 'great unbearable elemental conflicts of life' (Porter 1987: 12), managed by the therapeutic impact of spoken language to 'heal' the soul (the precursor to our 'talking cure' (Vatz and

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Weinberg 1994)), the other that madness was a medical illness based on the Hippocratic assertion that epilepsy was a medical disease and applied by analogy to madness as an illness caused by humoral imbalances (Porter 1987: 12). These two approaches, 'madness as badness and madness as sickness' (Porter 1987: 13), are still our explanatory models today.

The other recurring issue – of bureaucratic coercion of public dependents – has been a constant for over 400 years. Coercive practices emerged as marginal deviant groups exhibiting 'dangerous and delinquent traits' were increasingly seen as needing separation from society to prevent social unrest. First, their unconventional behaviour was cast as 'disturbing' the social order, but, because this might be construed as appropriate criticism of political authority by the powerless, it was rapidly recast as personal disturbance. The subsequent forced segregation of these disturbing deviants from society allowed them to be labelled as alienated in mind and behaviour (Porter 1987: 14–16).

'Bad mad' behaviour potentially justifies coercion because it may be seen as intentional and harmful to the polity. However, 'ill mad' behaviour does not. Illnesses are usually seen as unwilling; no self-control is ordinarily assumed and medical treatments are ordinarily voluntary. The disregard of this general rule in *involuntary treatment* of the mad presents an obvious ethical dilemma. Is the psychiatric claim that the troubling behaviours are true medical entities which must be properly subjected to routine coercion scientifically justifiable? Or, is medical jargon and imagery masking the unethical use of force in pursuit of control over 'the personal problems jurisdiction' (Abbott 1988)? To explore this question, we now examine how 'mad treatment' evolved in the United States.

From social concern to medical treatment

Views on madness in colonial America evolved from that of their European predecessors. It was a metaphysical *mélange* combining 'religious, astrological, scientific and medical elements' (Grob 1994b: 8). From colonial times until the mid-eighteenth century, the mad were just one subgroup of the 'poor'. Community assistance was rendered based on the state of poverty, not each subgroup's particular 'aetiology' (Grob 1973, 1994b). Very few people were considered 'mad' during the early colonial period (Grob 1973: 1–34). As urbanisation and the general population grew, the insane were offered almshouses (charitable housing) and outdoor relief (economic and related state assistance) like all worthy poor. Many worked productively and their bizarre behaviour was seen as just one of the vagaries of life 'pos[ing] social and economic rather than medical problems' (Grob 1994b: 6).

However, when inexplicable behaviour threatened public safety, it triggered legal force. For example, a colonial soldier who murdered his mother was adjudicated not guilty due to insanity. The court ordered lifetime confinement at public expense (Grob 1994b: 16). Boston, in 1729, developed the first separate structure for the 'mad' poor (Grob 1994a: 17). Shortly thereafter, entire 'hospitals' began to be erected to cure 'the sick stranger, the ill-kept resident, and wandering insane' (Rothman 1990: 45). The institutionalisation of the mad accelerated throughout the nineteenth century. The increased societal and individual stress of an urban population growing from 5 per cent in 1790 to 20 per cent by 1860 (Rothman 1990: 327) required bureaucratic reorganisation of the social welfare structure.

The community – cause or cure of 'mental illness'?

By the early 1800s many of the mad were forcibly confined and treated in suburban asylums (Grob 1994a; Rothman 1990). The three principles of their *moral treatment* being: the rapid

involuntary removal from the community into isolated institutions, assuring that these asylums were far from the inmate's community and fulfilling '[t]he charge... to bring discipline to the victims of a disorganized society' (Rothman 1990: 138). To impart order without brutality was the stated aim of this approach. Ideally, moral treatment required a rustic setting, housing no more than 250 inmates governed by a kind, paternal superintendent with close personal relationships with each inmate, guiding them back to *reason* utilising simple healthy physical work and a system of rewards and punishments (Whitaker 2002).

The reality differed. Asylums were routinely overcrowded by many hundreds. The superintendents were institutional managers not therapists. As Rothman (1990: 134) notes, '[the superintendent's] skills were... those of the architect and the administrator, not the laboratory technician'. Further, moral treatment did not eliminate physical punishment. Philippe Pinel – falsely credited with 'unchaining' the incarcerated mad – believed that successful moral treatment required psychological terror and fear (Pinel 1962: 63–91). Historian Andrew Scull concurs that it depended on 'the pervasive authority of the alienist [the nineteenth-century term for psychiatrist]... a system of rewards and punishments, constitut[ing] an extraordinarily powerful new... mode of *managing* patients' (1993: 379, emphasis original).

Medical management of mental health grows

In 1812, Dr Benjamin Rush (considered to be the father of American psychiatry) published the first American psychiatric textbook, *Medical Inquiries and Observations upon the Diseases of the Mind*. In it he declared that 'the cause of madness is seated primarily in the blood-vessels of the brain' (cited in Carrera 2017: 92). Based on no empirical evidence, this sentiment has become today's psychiatric mantra of 'mental illness is brain disease'. Early nineteenth-century reports claimed impressive successes for the moral treatment of this 'brain' disease; as recounted in Whitaker (2002: 27),

At McLean Hospital, 59 percent of the 732 patients admitted between 1818 and 1830 were discharged as 'recovered,' 'much improved,' or 'improved.' Similarly, 60 percent of 1841 patients admitted at Bloomingdale Asylum in New York between 1821 and 1844 were discharged as either 'cured' or 'improved.'

As popular support grew for this lay asylum treatment, physicians – feeling threatened by the potentiality of professional marginalisation – intensified their efforts to acquire medical jurisdiction over asylums. In 1824, the Connecticut State Medical Society built the Harford Retreat, with Dr Eli Todd as its medical superintendent. Todd (cited in Whitaker 2002: 28) argued that earlier lay asylum treatment had 'placed too little reliance upon the efficacy of medicine... and hence their success is not equal to that of... asylums in which medicines are... employed [therefore this institution will be adhering to]... truly combined medical and moral management'.

States funding public asylums supported this integrated approach which increased the use of powerful intrusive interventions such as blood-letting, physical restraint, electric shock and psychological terror (Porter 1997: 500). By 1844, the Association of Medical Superintendents of American Institutions for the Insane (later to become the American Psychiatric Association (APA)) was organised, committed to assuring that asylums always had doctors as superintendents. Additionally, German physician Rudolf Virchow's discovery of cellular pathology in the 1840s offered, for the first time, effective scientific medical treatment based on measurable signs, reported symptoms and demonstrable physiological lesions (Porter 1997: 304–47). This development emboldened alienists, based on their medical pedigree, to claim that 'mental illness' was just

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like other medical diseases, although ‘no evidence could... be produced to show that insanity had a somatic origin’ (Scull 1993: 241).

This shift in the US from the early colonial community concern about social dependents to the scientific management of human problems in the late nineteenth century was largely a bureaucratic re-categorising process. The collection and analysis of quantifiable data about dependent groups validated the rationality of administrative and bureaucratic activity. The bureaucrats developing policy regarding public dependents were confident in their ability to ‘promote... rationalization and systemization... to enhance the... effectiveness of public and private institutions’ (Grob 1983: 81). The medical management of madness required quantifying and labelling categories of behavioural ‘symptoms’ as diseases. Our current *Diagnostic and Statistical Manual of Mental Disorders* (DSM) diagnostic system is the direct offspring of the descriptive nosological work begun in the nineteenth century by psychiatrists such as Emil Kraepelin (Porter 1997: 512).

The successful nineteenth-century transition from lay to medical control of madness energised the mental health reform movement as it sought to convince the population and state governments to establish more and more asylums. One of those progressive leaders was Dorothea Dix. Dix herself suffered a mental collapse at the age of 34 and was diagnosed with ‘moral insanity’ (Gollaher 1995: 105). Part of her recovery was spent in England at the home of William Rathbone III, a friend of Samuel Tuke (then in charge of the York Retreat, the central facility providing moral treatment for the English mad in the nineteenth century). Tuke visited frequently, tutoring Dix on the Retreat’s principles. She ‘adopted them as the basis for her later ideas about asylums and psychiatric treatment’ (Gollaher 1995: 112). Although this experience made her a firm believer in the effectiveness of the treatment, ironically, her own recovery did not require moral treatment or a stay in any institution (Gollaher 1995). Dix’s desire to ‘help’ the mad resulted in her travelling, from state to state, lobbying legislators to fund state public insane asylums. She claimed that insanity was curable, the only obstacle to its elimination was proper funding. Thirty-two state mental institutions were founded or enlarged as a result of her efforts (Leiby 1978: 67).

Dix unfortunately relied on false statistics and claims about the curative powers of the treatment. She did not question the ‘scientific’ data because they supported her assumptions about ‘mental illness’ (Scull 1981a: 112). Rothman (1990: 131) reports that the,

statistics were inaccurate and unreliable. Not only was there no attempt to devise criteria for measuring recovery other than release from an institution but in some instances a single patient, several times admitted, discharged and readmitted entered the list as five times cured.

By 1880, about 140 public and private mental asylums managing around 41,000 patients were operating. At the end of the nineteenth century the mad were still a very small portion of social dependents. The US 1880 census listed 91,997 insane people out of a total population of 50 million (Grob 1983). So what explains the dramatic growth of ‘mental illness’ in the twentieth century to the point where, purportedly, one out of every five adult Americans is diagnosable (Kessler *et al.* 1994)?

The mad population grows by federal fiat

The twentieth-century horrors of two world wars were traumatic and spawned new ‘psychiatric’ problems, such as ‘shell shock’, ‘battle fatigue’ and malingering (a term for faking illness to avoid unacceptable circumstances). The political problems posed by the malingering of large numbers

of army recruits can be greatly reduced by recasting this activity as a diagnosable mental disorder (Szasz 1974: 32–47).

The threat of the negative publicity resulting from potentially thousands of young men unwilling to participate in war required a solution that would be acceptable both to the authorities and the 'malingerers'. Defining the feigning of insanity to get out of combat as a mental disorder rather than a moral and ethical dilemma, allowed the 'ill' individuals to be 'diagnosed' and 'treated'; allowing either a rapid return to active duty, or exit from the military with an honourable medical discharge. This approach took care of those already in the military. But what about those yet to be drafted? The passage of the Selective Service Act of 1917 created a War Department Division of Neurology and Psychiatry to evaluate and reject recruits diagnosed with psychiatric disorders. Thomas W. Salmon, the medical director of the National Committee for Mental Hygiene, recommended that military recruits who were found to be 'insane, feeble-minded, psychopathic and neuropathic' be rejected (Pols and Oak 2007: 2133). His assumption was that war neuroses resulted from permanent personal characteristics that tended to be unvarying and would make those possessing them permanently vulnerable and ineffective soldiers (Pols and Oak 2007). As a result, 330,000 individuals were excluded from the military in the First World War (Pols 2006: 145).

The Second World War expanded the federal government's involvement in mental health. General Hershey, director of the Selective Service System from 1941–70, presented data on the rejection of almost 2 million recruits due to psychiatric difficulties in his testimony to Congress, supporting the successful effort to pass the National Mental Health Act of 1946. This Act created the National Institute of Mental Health (NIMH) and gave broad authority to the federal government to develop and implement effective national mental health policy (Connery 1968). This 'discovery' of the staggering number of military-aged men with psychiatric problems impressed both politicians and the lay public with the seriousness of the national menace of 'mental illness'. The problem was that this explosive growth of 'mental illness' was based on false information (in this instance, an unreliable screening process). The diagnosing of millions of recruits as psychiatrically impaired was made by understaffed, insufficiently trained personnel, relying on invalid screening tools, in ludicrously brief interviews (two minutes) done in an atmosphere of racism and homophobia (Grob 1994b: 192–3). This process was ultimately abandoned (Pols and Oak, 2007: 2134) and superseded quickly by an apparent sharp increase of 'nervous breakdowns' in 'heathy' soldiers already fighting.

The most politically expedient explanation for the development of these 'mental problems' was the impact of the war itself on these men. The military psychiatrists argued that 'environmental stress... the actual conditions of combat played a major etiological role; predisposition was not a significant factor' (Grob 1994b: 193). They recommended 'first aid' psychiatry as the treatment of choice *in situ*, including, '[m]ild sedation, a night of sound sleep, and warm food... brief psychotherapy, rest and relaxation under psychiatric guidance' (Grob 1994b: 194). The simplicity and apparent success of such treatment suggested to the returning psychiatrists that 'treatment in civilian life, as in the military, had to be provided in a... community setting, rather than in a remote, isolated, and impersonal... institution' (Grob 1994b: 195). The emphasis on environmental causes helped foster theories of preventing mental disorders through the control of environmental factors. These efforts were congruent with the already established 'scientific' public health model in place for the prevention and treatment of infectious diseases. Since President Harry Truman's Scientific Research Board had already expressed strong interest in having the federal government support biomedical research and the need for developing national health policy, the incorporation of mental health seemed a natural progression (Grob 1994b). The National Mental Health Act of 1946

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embodied this commitment, authorising, ‘extensive research, demonstration projects, training programs, and grant-in-aid to the states’ (Connery 1968: 16). The NIMH provided the centralising federal authority to ‘stimulate a new form of community mental health activity... [T]reating “mental illness” in the patient’s normal environment rather than in a mental hospital’ (Connery 1968: 19).

The shifting psychiatric landscape

These developments were abetted by the various exposés of harmful coercive institutional practices published in the early decades of the twentieth century. They highlighted the problems of institutional care and the failure of its optimistic early promise. Here is how Albert Deutsch (cited in Grob 1994b: 204) described a visit to a psychiatric ward in the 1940s:

Cots and beds were strewn all over the place to accommodate... 289 mental patients packed into wards intended for 126.... (It appeared that about one-third of all patients...were under mechanical restraint that night-tied down to their beds by leather thongs, muffs or handcuffs linked to chains).

Though the condition of the nation’s state mental hospitals was apparently improving by the 1950s, few noticed. The post-war belief in the primacy of environmental and psychological causes of emotional disturbance supported arguments for early intervention and federal funding of community care in the 1950s and 1960s. Logically, it made sense that reintegration into the community would be curative, though there was no research support for this belief (Grob 1994b: 234–6).

Promoted as having great ‘scientific’ promise of managing or eliminating frightening psychiatric symptoms, the introduction in the 1950s of psychotropic drugs served further to justify rapidly reintegrating and treating the previously institutionalised in the community. ‘De-institutionalisation’ became the focus of mental health policy from the 1950s onwards. The federal expansion of mental health funding and policy consequently reduced the role of the state-run mental hospital system.

In 1955, the pharmaceutical company Smith, Kline & French (distributor of chlorpromazine – thiorazine in the US – the very first FDA-approved antipsychotic drug) provided a grant of US\$10,000 to subsidise the planning of the Joint Commission on Mental Illness and Health (JCMIH). Instrumental in creating the Mental Health Study Act of 1955, the JCMIH was rather conveniently selected under the Act to conduct a US\$1.5 million dollar study on mental health care. The resulting report was titled *Action for Mental Health*. This report recommended increasing the authority and power of the NIMH, establishing academic mental health research centres throughout the country, expanding the number of jobs in the mental health sector, and called for a significant increase in federal spending on treatment. The Act was another step towards consolidating the federal government’s authority over funding and the ‘standards for the... care of the mentally ill’ (Connery 1968: 45).

The 1956 amendment to the Public Health Service Act further centralised mental health policy, authorising grants for improving the methods of diagnosis and treatment of ‘mental illness’ and funding the NIMH to subsidise academic research on improving inpatient management and treatment techniques for state hospitals. These efforts by the NIMH to gain control as the decision-making authority for mental health research and funding, combined with the vigorous activities of professional lobbies, culminated in the passage of the Mental Health Acts of 1963 and 1965. These authorised the creation of comprehensive community mental health

centres throughout the US with the aim of seamlessly integrating and delivering the necessary mental health services to clients in their communities.

Dr Robert Felix, the then politically savvy director of the NIMH, in his pivotal US Senate testimony for the passage of the 1963 Act, predicted that it would facilitate, 'the day when the State mental hospitals as we know them today would no longer exist' (Connery 1968: 51). After its passage, state hospital populations plummeted; however, the hoped-for outcome of community-based care revolutionising the provision of mental health services so as to improve the independence and the well-being of the mad did not occur (Scull 1981b). In fact, it appears that this effort merely shifted many of the inmates into other unpleasant institutions like nursing homes and jails. In the 1970s, nursing homes had replaced mental hospitals as the primary residence of the mad. More than 900,000 mental patients were living in them, costing around US\$4.3 billion dollars, almost 30 per cent of total direct mental health expenditures (Scull 1981b). By 1998 the US Department of Justice estimated that 283,800 'mentally ill' prisoners were being held in the nation's penal institutions (Bureau of Justice Statistics 1999).

Regardless of the actual long-term outcomes, these activities served as the birthing ground for an 'interlocking directorate' of professional groups, mental health activists/lobbies, private individual and foundation donors, government bureaucrats and the pharmaceutical industry that, effectively, has come to shape and run the 'science' of mental health research and treatments in the United States (Connery 1968: 61). These developments have led to the current, strong, centrally organised political economy for dealing with public madness. The NIMH has become the principal distributor of mental health research funding (its research budget has grown from approximately US\$750,000 in 1948 to more than US\$1.4 billion in 2015). It also closely controls the development of national mental health policy. This dual role of the federal government in determining mental health policy and distributing research funds seeking to validate these policies has deeply politicised the development of scientific psychiatry. The NIMH is committed to biological explanations of madness and the therapeutic value of drugs. Projects committed to this research programme have funding priority (Gomory *et al.* 2011). Other projects (related to psychological, social, environmental and personal explanations of mad behaviour) are funded much less often. Thus, psychiatrist Nancy Andreasen (1984: 151–2, emphasis added) has remarked that, '[t]he person who wants to discover the causes of major mental illnesses... must proceed from a medical model and *assume* that they are diseases'. The most recent research agenda set by the NIMH reflects this sentiment. In 2007, the then NIMH director, Dr Thomas Insel (2007: 757), declared, 'as research during the Decade of the Brain (1990–2000) forged the bridge between the mind and the brain, research in the current decade is helping us to understand "mental illnesses" as brain disorders'. This sort of uncritical rhetoric appears to echo the sentiment of Benjamin Rush nearly two centuries later.

Conclusion

It seems that our brief historical tour of the phenomena of madness has left us close to where we began. Both coercion and concern in the name of science have, over the centuries, been applied to the treatment of the mad, sometimes concurrently. Early in America's history, families took care of their distracted relatives. As the country grew, the need for bureaucratic institutional structures became more pressing. Increasing population and urbanisation led to a more mobile populace, leaving fewer and fewer families intact to take care of their mad relatives. These circumstances, in turn, led to the creation of institutional substitutes for the care of these dependents. Simultaneously, a class of professional helpers emerged claiming special expertise in the management of the mad. These professional helpers first were lay managers, applying

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moral treatment, and then physicians offering medical explanations for understanding the mad; society was persuaded, even though no empirical evidence supported their medical claims. The nineteenth century served to transition mad treatment from lay to medical institutional treatment, while the twentieth century served to transition management of the mad from the state government-built and -organised public mental asylum system to a federally controlled community-based mental health system incorporating the federal government, psychiatric professionals, various interest groups and pharmaceutical corporations. These stakeholders formed a biomedical industrial complex beneficial to all but the clients, who have generally been victimised by this contemporary system of operations (Gomory *et al.* 2011). This well-coordinated, lucrative commercial enterprise continues in the twenty-first century to control psychiatric funding, research and policy development, even though we still do not have a scientific clue as to what madness is.

In Shakespeare's time when it came to understanding madness we could only deal in a tautology, as he wrote famously in *Hamlet*: 'what is't but to be nothing else but mad?' (cited in Porter 2002: 1). Today we are left not exactly with a tautology, but with a mystery. The modern term for mad behaviour is the medically encapsulated notion of 'mental illness', but that term really refers to many different hypothesised behavioural syndromes. The term 'mental illness' remains a black box. It is argued by the biomedically inclined that these syndromes are medical diseases, although not a single one of these syndromes has a diagnostic biomarker. Dr Insel himself decamped in 2015 from the NIMH to Google, having failed to validate mental illness as a disease, and yet we still involuntarily hospitalise 1.4 million US citizens under that rubric (Gomory *et al.* 2011). He and other psychiatric authorities, like religious leaders prophesising a future of peace and harmony, continue to enjoin us to be patient for a little while longer, when these biomarkers will definitively be identified, initiating a psychiatric utopia. A utopia where psychiatric science will deliver the medically appropriate cures for what behaviourally ails us. That psychiatric nirvana has yet to arrive.

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Medieval mysticism to schizoaffective disorder

The repositioning of subjectivity in the discourse of psychiatry

Alison Torn

In his works *Discipline and Punish* (1979), *History of Madness* (2006a) and *Psychiatric Power* (2006b), Michel Foucault presents three histories: a history of the division between madness and reason, a history of institutions and a history of power. For Foucault, these histories are not only inter-related but mutually dependent, with the division between reason and unreason marking both the silencing of madness and the development of psychiatry, thus making madness fundamentally a discourse of power. While focusing less on institutions and more on the specifics of language, the Russian critical literary theorist Mikhail Bakhtin proposes a similar argument, suggesting that dominant groups such as psychiatry who emerged in response to sudden cultural changes, attempt to impose an authoritative discourse which, through the assertion of its power, marginalises other discourses (Bakhtin 1981). Bakhtin's argument that authoritative discourse is a way of maintaining hierarchical relations within the dialogical relationship fits with Foucault's descriptions of institutional discourses creating and maintaining relationships between power and knowledge. What Bakhtin adds to Foucault, however, is a focus on dialogue and the way it reaches both into the past and the future through the dialogical relationship. This chapter draws on both theorists to explore how pre-Enlightenment accounts of madness have been retrospectively positioned within the authoritative discourse of psychiatry as early examples of psychosis. As such, what were previously understood as religious experiences have been converged with psychotic experiences, making much of what happens in the spiritual domain a matter of madness – a practice that continues in the present day. The implications of this convergence are not only that alternative explanations of unusual experiences are marginalised, but, importantly, the voice of the individual is marginalised if not silenced by the authoritative and professionalised discourse of science, specifically psychiatry.

Understandings and responses to unusual experiences such as visions and voice hearing have shifted over different social, cultural and temporal contexts, so that what is defined as mad or normal in one space and time takes on different meanings in another (Cangas *et al.* 2009; Hodgkin 2007; Porter 1987). For example, in different socio-historical contexts visual and auditory hallucinations, social withdrawal, self-neglect and delusions of grandeur become visions, voice-hearing, solitude, fasting and the belief that one has been chosen for a specific

task by a higher power. So while there is arguably historical evidence supporting the existence of phenomena akin to schizophrenia for over 2,000 years, with descriptions of visions, hallucinations and delusions remaining constant over the centuries, the paradigms in which we understand and construct these experiences have shifted markedly. While primarily instigated by the Enlightenment and the move from religious to secular explanations of unusual phenomena, this shift has gathered increasing momentum since the emergence of psychiatry as a medical discipline in the nineteenth century. Such differing interpretations highlight the fundamental tension between science and religion, which is reflected in the tendencies of academics and clinicians to use pre-Enlightenment accounts of madness as evidence of the historical provenance of mental illness (Craun 2005; Freeman *et al.* 1990; Macalpine and Hunter 1956; Murray *et al.* 2012). However, such early accounts of what others deem ‘madness’ were experienced in a different socio-cultural framework in relation to religion, making both the experience and the narrative of madness very different from those possible today.

In order to illustrate the central argument that social and historical contexts are pivotal to the understanding and interpretation of unusual experiences, this chapter examines the medieval text *The Book of Margery Kempe* (Staley 2001), a text that has been subjected to clinical and academic scrutiny in the search for historical evidence of the existence of psychosis. Taking both a pre- and post-Enlightenment perspective highlights how the boundaries between madness and mysticism are situated in the dialectical relationship between cultural frameworks and subjectivities. With the experiencing subject embedded in time, space and a network of human relations that are all pivotal to the validation of human experience, the chapter concludes by suggesting that the search for meaning should inform interpretation of others’ experiences at all times, taking precedence over current concerns regarding categorisation.

Margery Kempe (c.1373–c.1440)

Margery Kempe was born in the English Norfolk town of Lynn (now Kings Lynn) around 1373, the daughter of a mayor. She subsequently became the wife of John Kempe, also a prominent burgess, with whom she had 14 children. *The Book of Margery Kempe* (Staley 2001), which was dictated to at least two scribes, begins with the self-acknowledged onset of madness following the birth of her first child (c.1393/4). This pre-empted a spiritual crisis for Margery, resulting in her separating from her husband and leaving her children in order to pursue a holy life, with pilgrimages to Jerusalem, Rome and other holy sites across Europe. The book, which is written in the third person as it was dictated to a scribe, describes both Margery’s spiritual and physical journey over a 25-year period as she seeks to establish her spiritual authority as a result of her personal conversations with Jesus and God, spiritual visions and enactments of miracles (Staley 2001). Such was the strength of her spiritual experiences that she frequently broke into outbursts of prolonged wailing and writhing in public spaces, much to the irritation and amusement of lay observers. As Kempe, the author, describes, within her home town and on her travels, Margery received a polarised reception from both lay people and established religious authorities who either revered or resented Margery; no one was indifferent.

The extraordinary nature of Kempe’s account and the contemporary dichotomous reception of Margery is reflected in academic reactions to her experiences, specifically whether the account is one of mysticism or madness. For some clinicians and academics, Margery’s early self-confessed episode of madness determines their interpretation of the remaining narrative within this paradigm, despite Kempe herself clearly distinguishing between what she perceives as an isolated episode of madness and her embarkation on a mystical life (see, e.g. Claridge *et al.* 1990; Craun 2005; Freeman *et al.* 1990). One of the most frequently cited scenes provided as evidence

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of psychopathology gives an embodied phenomenological account of Margery's unusual sensory experiences, a long-standing feature of her adult life:

Sometimes she felt sweet smells with her nose; it was sweeter, she thought, than ever was any sweet earthly thing that she smelled before... Sometimes she heard with her bodily ears such sounds and melodies that she might not well hear what a man said to her in that time unless he spoke the louder. These sounds and melodies had she heard nearly every day for the term of twenty-five years... She saw with her bodily eye many white things flying all about her on every side, as thick in a manner as motes in the sun... Also our Lord gave her another token, which endured about sixteen years, and it increased ever more and more, and that was a flame of fire wonderfully hot and delectable and right comfortable, not wasting but ever increasing of flame. Staley 2001: 64–5

In the extract quoted and elsewhere in the book, Kempe attempts to communicate to the reader her embodied spiritual experience, drawing upon established religious metaphors to communicate her spiritual passion. However, some writers have interpreted Margery's experience from a modern, psychiatric perspective. For example, Craun (2005: 656) boldly claims that,

Kempe was psychotic for much of her adult life... Kempe continued to have psychotic symptoms throughout the remainder of her life... [her] account provides the modern reader with a unique opportunity to hear the voice of a woman with serious mental illness who lived 600 years ago.

Other authors have interpreted Margery's experiences in a more contextual framework – for instance, positioning them in the medieval cyclical construction of melancholia and mania (Freeman *et al.* 1990). Indeed, the content of Margery's experiences could be construed as classic psychotic symptoms: visions, auditory, olfactory and tactile hallucinations, grandiose delusions, self-neglect (Margery's penances of fasting, being inadequately clothed), social withdrawal (from her family and friends) and feelings of passivity. However, to situate Margery's experiences within a medical framework dismisses the social meaning of her behaviour and the possible theological interpretations of medieval society. For example, central to the orthodox liturgy is the conception that devotional words uttered are expressed through the senses (Good 2001). Kempe belongs to a strong tradition of mystics who represented their experiences in thick, detailed and highly naturalistic descriptions (for example, her writings are reflective of the works of Richard Rolle, Walter Hilton and Saint Bridget). Extreme emotion (in modern times, viewed as a sign of mental instability) was therefore a fundamental feature of spirituality, conveying both the seriousness and truth of the religious experience (Hodgkin 2007). Such intense spirituality was not repositioned within a medical framework until the 1650s (Hodgkin 2007); a development that led to mystical experiences which were embodied in strong emotions and physical sensations being categorised as pathological (Kroll *et al.* 2002). Thus, it is important to note that Margery's unusual experiences are embodied in a timespace that supports and justifies a mystical interpretation, as she draws upon a range of established spiritual texts grounded in religious and cultural traditions known throughout medieval Europe. In this context, Kempe's embodied descriptions cease to be tactile or olfactory hallucinations or grandiose ideas, but become experiences that result from spiritual passion.

For Margery, the strength of her internal, private spiritual experiences necessitated an externalised manifestation through public displays of crying and writhing in religious spaces. However, it is evident from Kempe's narrative that these were poorly received by those who witnessed them:

And, as soon as she perceived that she should cry, she would keep it in as much as she might, so that the people should not have heard it, for it annoyed them. For some said it was a wicked spirit vexed her; some said it was a sickness; some said she had drunk too much wine; some banned her; some wished she had been in the harbor; some would she had been in the sea in a bottomless boat; and so each man as he thought.

Staley 2001: 51

As Kempe describes, her fits of crying aroused an extreme response from lay people, whose constructions pivot around medieval concepts of madness (wicked spirits, sickness, drunkenness) (Harper 1997). In contrast, established clergy such as the Archbishops of York and Canterbury supported and endorsed Margery's experiences, saving her from charges of heresy. Such polarised views indicate the liminal position Margery had between different communities, lay, pilgrim and religious – in contrast to the scorn of lay people, holy individuals revered Margery and her behaviour as being a symbol of devout passion and holiness. However, as with her internal experiences, her externalised behaviours have been subject to diagnostic scrutiny. Kalian and Witztum (2002) cite Kempe as a possible example of 'Jerusalem-syndrome', which refers to the eccentric behaviour of tourists and pilgrims who visit the Holy City that can lead to psychiatric hospitalisation. Similarly, Claridge *et al.* (1990) provide an analysis that focuses on the episodes of religious fervour and Margery's subsequent rejection by others, placing a psychiatric interpretation on the events of her life. Taking Kempe's narrative and applying a psychiatric assessment tool that measures psychotic illness over a prolonged period of time (the *Schedule for Affective Disorders and Schizophrenia-Lifetime* (SADS-L)), the authors conclude that, '[g]iven this mixture of affective and schizophrenic features a modern psychiatric diagnosis for Margery Kempe would most likely be "schizoaffective psychosis", precipitated in the first instance by childbirth' (Claridge *et al.* 1990: 69).

However, as with her internal, private experiences of visions and voices, her externalised behaviours and others' responses to them makes sense in the religious context of the day as, it could be argued, Kempe constructs Margery as a 'Pauline' (or 'fool for Christ') – an important Christ-like figure in the Middle Ages. This character stems from Paul's second letter to the Corinthians (chapter 11, verse 21) where he states, 'I am speaking as a fool' (Bible Gateway 2016). The Pauline fool is eccentric, nomadic, socially disruptive and controversial, feigning madness – behaviours all evident in Kempe's account. Through such behaviours within the ordered world, this holy fool attempts to break free from earthly bonds and, by doing so, is perceived as mad. Crucially, therefore, this fool was not a genuine madman subjected to medical scrutiny, but someone who was held mad by others in order to be wise for God (Harper 1997; Hodgkin 2007: 91). For Foucault (2006a), a pivotal feature of madness epitomised in the figure of the fool was that it revealed the truth and essential wisdom to the other. Thus, there was a dialectical relationship between madness and reason, whereby madness had the power to both instruct the wise and highlight faults in human nature, providing a reflection of 'some other's mode of being' (Bakhtin 1981: 59). Madness therefore becomes a source of power. As a mystic it could be argued that Margery was positioned on the fringes of madness/reason; as Neaman (1975: 61) observes, 'in the eyes of the medieval church, the mystic was divinely sane despite and even because of the fact that ordinary sinners considered him irrational'. Thus, madness was closely related to religious experience and, in this respect, Foucault suggests the mad both revealed and belonged to the limits of the world. This, he argues, was exemplified in the literary construct of the *Narenschiff* (or 'ship of fools'), an important literary object filled with imaginary heroes, moral models and symbolic voyages (Foucault 2006a). As a literary device, the ship of fools is laden with meaning, highlighting the liminal position of the mad in medieval society and, as a metaphor, Foucault

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argues that the position of the mad has always been, and remains, one of exile and marginalisation from society.

Discursive authority and meaning-making

The professional narratives on Margery's experiences tell a different story to those of Kempe the storyteller. They provide an account which becomes, in Bakhtinian terms, an authoritative discourse that cannot be challenged, whose status is 'off limits', or as Dentith (1995: 57, emphasis added), writing on Bakhtin, describes, 'it seeks to withdraw *beyond dialogue*, to surround itself with an uncrossable exclusion zone'. Such accounts, premised on power, create a discursive hierarchy, with the authoritative discourse at the top speaking what is deemed to be the unproblematic truth and all other discourses deferring to this (Dentith 1995). It is via the authoritative discourse that judgement, explanation and placement of others occur, as psychiatry uses Margery as a productive source of knowledge, categorising her behaviours and labelling her as an object of science. However, it could be argued that a comparable process takes place via the hegemonic and patriarchal discourse of religion, which is similarly authoritative. One of the critical differences between these two discourses lies in subjectivity. For Margery, the construction of her experiences within a religious framework facilitates meaning, thus enabling her spiritual voice, whereas construction of her experiences within a scientific framework silences her voice, closing down meaning. From its privileged position, psychiatry, therefore, attempts to speak not only for the present and future, but also for the past as an identity is ascribed to Margery which is not actively sought and cannot be resisted, a position Frank (2006: 966) argues is profoundly unethical:

For Bakhtin, all that is unethical begins and ends when one human being claims to determine all that another is and can be; when one person claims that the other has not, cannot, and will not change, that she or he will die just as she or he always has been.

The debate over whether present-day psychiatry has the authority to interpret unusual experiences within a pathological paradigm highlights a historical tension between science and religion – in particular, whether they occupy distinct spheres. In relation to Margery's experiences, psychological research suggests that spiritual and psychotic experiences are fundamentally different from one another, suggesting that not all unusual experiences are pathological (see, e.g. Heriot-Maitland 2008; Jackson 2010; Jackson and Fulford 1997; James 1982; Loewenthal 2007; Romme and Escher 1993). Spiritual experiences tend to be unbidden, positive in nature, actively sought and culturally confirmed by others. Conversely, psychotic experiences, while also unbidden, tend to be negatively received, unsought and remain unconfirmed by others, being judged as bizarre and particular to the individual. If this distinction is accepted, a strong argument can be made for Kempe's experiences being fundamentally spiritual.

Those who speak through the authoritative voice of psychiatry, however, will maintain their position that Kempe was psychotic, as evidenced in her early self-confessed episode of madness, which was uninvited, unequivocally malign, judged bizarre and extremely distressing for both Margery and immediate others. However, in her proposed discontinuity model, Clarke (2010) contends that the psychosis/spirituality dichotomy is invalid, instead arguing that historical accounts of spiritual experiences frequently occur at times of crisis thus incorporating 'spiritual dangers', as in Kempe's case of madness when she was besieged by 'flame-tongued devils'. Drawing on the work of Jung and Laing, Clarke argues that the malign, dark, perilous experiences may form part of a transformative process of the self which is both enriching and healing. This relationship between negative spiritual experiences and personal transformation is akin to

Underhill's (1961) 'dark night of the soul' stage of mystical progression – a phrase associated with both spiritual crisis and recovery (Durà-Vilà and Dein 2009; Ridgway 2001). The suggestion is that malign experiences as described in Kempe's single self-confessed episode of madness are not necessarily related to poor mental health in the longer-term. Margery describes the dangers of such experiences, which threatened her sense of being, but, with intensive support, a safe environment and a frame of reference within which meaning and identity were anchored, Margery's selfhood was transformed as opposed to being diminished, becoming a spiritual turning point in her mystical narrative.

Accepting Clarke's argument that the psychotic/spiritual distinction is meaningless opens up space to attend to the meaning of individuals' experiences and a more considered understanding of the relevance of spirituality and what it means to be human. Undoubtedly, the religious and spiritual contexts of Margery's experiences resonate with those struggling with unusual experiences today, as individuals pursue a search for meaning about the experience and the self (Barker and Buchanan-Barker 2005). In relation to Margery, having a culturally available mystical framework was essential to the development of understanding and meaning, with the mystical paradigm being more beneficial for her than one which demonised her experiences and threatened her being. Finding a believable framework became Margery's central concern, becoming, in narrative terms, the object of her quest. Arguably, religion provided Margery with a structure that afforded dignity and freedom, a space that valued beliefs and meaning and, thus, enabled the construction of a meaningful identity.

Conclusion

The debate over whether Margery Kempe was mystical or mad will no doubt continue, but the pivotal question should be who has the authority to determine particular interpretations of her experiences. Authority needs to take account of the subject and author, together with the specific contexts in which the narrative is embedded, rather than in terms of the usual dichotomy between science and religion. Modern interpretations reflect a weakening of the religious interpretative framework, which can be attributed to the introduction of a biological framework of causality, abnormality, illness and treatment promoted by the biomedical model. For those undergoing unusual experiences in the present day, the imposition of such a model not only threatens and devalues an individual's belief system, but also it may potentially reduce the effectiveness of a valuable framework of meaning, thereby depriving voice-hearers (for example) of a potential framework and coping strategy (see Longden *et al.* 2012). As this chapter has highlighted, within psychology and psychiatry there needs to be a greater concern with the spiritual beliefs that underpin unusual experiences and their value to individuals. Critically, the value-laden judgments that underlie concepts such as schizophrenia need to be challenged both outside and within the professional sphere.

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The myth of the Irish insanity epidemic

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Driven by recommendations of the Select Committee to Consider the State of the Lunatic Poor in Ireland (1817), a centrally administered public asylum system under British colonial administration was established in early nineteenth-century Ireland. The Select Committee asserted that, for reasons ranging from ‘hereditary... scrofulous habits of the lower classes’ to ‘the use of ardent spirits... [and] mercury’ (Select Committee to Consider the State of the Lunatic Poor in Ireland 1817: 21), there was a high rate of ‘Irish insanity’ in the colony. The report of the Select Committee went on to recommend that purpose-built asylums were the appropriate intervention for this Irish disposition to insanity. In response, exclusive legislation for the island of Ireland was passed by the colonial government sitting in Westminster, London, which resulted in ‘nine District Asylums successively erected and established in different parts of the country’ (Inspector of Lunatic Asylums 1846: 5). These asylums became part of what was the largest and most enduring mental health intervention to take place on the island of Ireland (note that the island of Ireland refers to the 32 counties of Ireland prior to partition in 1922. Post-partition, the island of Ireland consists of the ‘Irish Free State’, which then became the ‘Republic of Ireland’ in 1937, comprising of 26 counties in the south, and Northern Ireland which remains part of the United Kingdom, comprising of six counties in the North). This asylum system was remarkably robust in its upward trajectory, expanding continuously through a period of major national upheavals including: the great famine of the 1840s and the resulting chronic population decline which continued until the 1930s; the struggle for independence; the partition of Ireland and establishment of the Irish Free State in 1922; the civil war from 1922–4; and the challenges of nation-building. Even after the realisation of Irish independence in the south of Ireland, the asylum system (now referred to as the mental hospital system) continued to expand, reaching its high point in 1956 with 21,720 people resident on a single night; at the time, this figure represented the world’s highest rate of psychiatric incarceration at 710 people per 100,000 of population, followed by the USSR at 618 and the US at 511 (Brennan 2014: 33).

The existence of an Irish ‘insanity epidemic’ has been refuted in detail in the author’s recent work, *Irish Insanity 1800–2000* (Brennan 2014). However, while the reality of an Irish ‘insanity epidemic’ is a myth, the intensive incarceration of individuals within Irish asylums/mental hospitals was very much a sad truth. To understand this truth, in the absence of any biomedical rationale, one turns to established social theory to explain this unusually high trajectory of

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institutional confinement. Indeed, the Irish case, with its demonstrably intensive use, should provide a classical example which illustrates critical theories addressing mental hospital utilisation. However, key features of Ireland's social and historical trajectory illuminate shortcomings with these established critical theories as well.

Grand narratives and the problems of the Irish case

The contributions of Foucault to the creation of critical, comparative multi-causal histories cannot be underestimated, an approach to historical sociology which has some continuity with that posited by Weber (Holton 2003; Turner 1992). Of particular note is Foucault's interruption of 'progressive histories' of success which have been championed by medicine generally and psychiatry in particular (Brennan 2011). Such 'progressive histories' set out a narrative of ever-improving scientific advancement, with mental illness understood as the fixed point of reference that requires identification, categorisation, intervention and cure.

This Foucauldian perspective challenges us to transcend the acceptance of diagnostic language as a value-free principle, the logic of power inequality within the clinical process, the rationality of incarceration and the propaganda of cure. The response to leprosy in Europe is identified by Foucault (1967) as seminal to the evolution of practices of confinement, encompassing the physical construction of locations of confinement (*leprosaria*) operationalised through technologies of classification, segregation and intervention. A migration of practice is charted, with the 'insane' replacing 'lepers' as the subject of incarceration. This migration of practice reaffirms the social functionality of the built environments of confinement, provides a new population of subjects for the scientific gaze and endorses the occupational security for the professions practising within the markets of deviance. As Foucault (1967: 5) argues of the period of the 'great confinement',

Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in these same places, the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals, and 'deranged minds' would take the part played by the leper... salvation was expected from this exclusion, for them and for those who excluded them as well.

However, Ireland had a comparatively limited experience of leprosy and there was an absence of any extensive institutional intervention for such diseases (Brennan 2014). Indeed, prior to 1800, there was little institutional provision for any social problem on the island of Ireland. Social problems were, in the main, managed at the family and community level, informed by 'Brehon law' which encapsulated ancient laws, traditions and practices developed in the pre-Christian era. Brehon law set out various provisions regarding reduced rights and responsibilities for individuals considered to be insane, as well as, importantly, the care obligations of families for such individuals (Robins 1986). A key legacy of these provisions was the absence of any established built locations of institutional confinement or community practice of large-scale segregation – in practice, the family was the context and location of care provision within Brehon law. As such, the nineteenth-century legislative provisions for the establishment of an Irish asylum system was very much a 'greenfield' innovation rather than being established on pre-existing built environments, professional structures or legal practices of institutionalisation.

Furthermore, the Irish asylums – established in 1817 as a centrally administered national system – pre-date the later wide-scale asylum expansion in what was a modernising Europe. Indeed, most critical contributions on the history of mental hospital confinement are premised

within macro contexts characterised by a classical transition to modernity, the rise of capitalism and the expansion of private enterprise. This complex interface between asylums and macro-economic life was observed and critiqued by Foucault (1967, 1973), with asylums problematised as employers, business opportunities, producers and consumers of goods and strategic drivers to local economies. These institutions also served to order the competitive labour market required for capitalist-based economies by removing and confining the unemployable and non-productive. Ironically, these 'non-productives' were then utilised for 'free labour' through what became known as 'industrial therapy', which distorts the wider market for the goods produced as wage-free labour was not available to industrialists beyond the asylum.

The complex economic interface between asylums and wider society was also considered by Andrew Scull (1979). He observed the wide-scale rise of a capitalist dynamic, both in the public realm and in the domestic family setting (and in both rural and urban areas), to be a factor underpinning asylum expansion. For Scull (1979: 30), it was not the growth of the cities which could, alone, explain an expanding asylum system, but rather 'the effects of the advent of a mature capitalist market economy and the associated ever more thorough-going commercialization of existence'. However, Ireland was a 'later moderniser, a latecomer to modernity' (Tovey and Share 2000: 41), with comparatively limited penetration of capitalism at the local community and family level (Arensberg and Kimball 2001). Until the late twentieth century, Irish society was, arguably, not an adjunct to the market. While economic and technological modernisation was occurring in Ireland during the nineteenth century, this 'was absorbed at a pace allowing it to fit the way of life pursued by the members of the community' (Byrne *et al.* 2001: iii) – a point consistent with Scull's observation that '[t]he market system spread to incorporate all but the Celtic fringe' (Scull 1979: 30). Indeed, at a local level, asylum use was most intensive in the non-industrialised rural regions of Ireland (Finnane 1981; Walsh and Daly 2002), where traditional forms of family social cohesion, rather than the capitalist dynamic, shaped family social life.

Another economic dynamic observed as a catalyst to asylum expansion is the impact of direct capitalist enterprise, or the 'trade in lunacy' (Parry-Jones 1972). Such theories link the profit motivations of investors in institutions of confinement to the proliferation of practices and systems for categorisation and incarceration (also an important and valuable theoretical observation in the contemporary context of the expansion of private prisons (see Dolovich 2005)). Essentially, the success of a private business enterprise that provides built locations or services of incarceration is premised on a continual flow of residents, be they 'lunatics', 'criminals', 'delinquents' or 'deviants'. However, in Ireland there was very limited private enterprise in asylum provision. The national asylum system was very deliberately developed through colonial social policy, centrally administered and publicly financed. For example, by 1900 there were 16,404 residents in public asylums (8,912 males and 7,492 females) compared with 709 residents in private asylums (325 males and 384 females) (Brennan 2014: 142–4). As such, there was very limited private enterprise or commercial profit-making in the institutional confinement of the 'insane' in Ireland.

Hence, while the critical economic theories addressing mental hospital incarceration provide insights that transcend the dominant biomedical theories, the Irish macroeconomic circumstances are at variance with the conditions on which these theories are premised. With restricted private enterprise in asylum provision, weak penetration of capitalism at the community and family level and late engagement with economic modernity at a national level, one would anticipate a very conservative level of asylum expansion in Ireland during the nineteenth and early twentieth centuries, though this was simply not the case. Furthermore, as mentioned above, by the mid-twentieth century Ireland had the highest rate of mental hospital bed utilisation in the world, the second and third highest rates being in the USSR and the US, respectively. At that

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point in time, these three geopolitical entities had very different economic, historical, social and political conditions; in fact, the variance of conditions could hardly have been more pronounced. This raises questions regarding the validity of any theory asserting a unifying macroeconomic explanation of asylum expansion.

Foucault (1967) also observed the power of religious bodies to differentiate the moral/sane from immoral/insane during the eighteenth and nineteenth centuries, noting that such religious organisations across Western societies became involved in the control, management and ownership of the asylums, thus establishing control over both demand and supply of the services for the insane. This church–state nexus is common throughout the Western world and across a range of social interventions including education, hospitals, maternity services and child welfare. In Ireland, the church–state relationship was very strong, particularly following independence in 1922. Indeed, despite the recent exposure of extensive abuse (physical, sexual and emotional) within Irish church-run institutions (O’Sullivan and O’Donnell 2012), this historical arrangement remains in place today (for example, the Catholic Church continues to own and control over 90 per cent of Irish primary schools, which are public schools funded through public taxation). Highly unusual in the Irish historical context, however, the national asylum infrastructure in Ireland did not develop in conjunction with established religious organisations. As mentioned earlier, the administrative structures for the Irish asylum system were first established in 1817. This pre-dated Irish Catholic Emancipation in 1829, which was the starting point of church–state arrangements for social interventions (first formed for the provision of primary education (see Coolahan 1981)). In terms of bureaucratic, legal, administrative and professional structures, the Irish asylums system was ‘precast’ in 1817, and hence it remained outside the later-formed church–state partnership. It is worth noting that most Irish church-run institutions have undergone extensive public scrutiny, which entailed the exposure of abuse, prosecution and various systems of redress (O’Sullivan and O’Donnell 2012). In contrast, the public asylums/mental hospitals, which were the largest sites of Irish confinement, have not been subjected to the same level of scrutiny. In practice, while the Catholic Church in Ireland became a major arbitrator of public morality, it remained largely tangential to the Irish asylum system.

The impact of colonialism on the Irish experience of mental hospital utilisation is another area that warrants consideration. Colonial theories emphasise the tendency of colonial authorities to assert their superiority and rationalise the need for colonialism by denigrating ‘natives’ as being inclined to insanity or other forms of deviance (see, e.g. the Select Committee to Consider the State of the Lunatic Poor in Ireland 1817). Thus, an insane colonised population is constructed as being in need of social control, which is realised through high rates of asylum utilisation. Thus, we should see significant declines in the incarcerated populations once independence is achieved. However, that definitely did not happen in the Irish case. While the colonial context very much informed the design and development of the Irish asylum infrastructure and administrative bureaucracy, there was ample opportunity to reform this system post-independence, hence a colonial theory is difficult to defend. For example, while the Republic of Ireland was self-governing and free of colonial control post-1922, the most intensive period of Irish mental hospital utilisation was not realised until the mid-1950s. Furthermore, while the high prevalence of mental hospital usage among Irish communities living in the UK is well observed by Greenslade (1992, 1997), the level of mental hospital residency in the UK is far lower than that of the Irish in Ireland. For example, more than 50 years after the realisation of independence, the rate of mental hospital residency in the Republic of Ireland was 710 per 100,000 of population, twice that of England and Wales at 357 per 100,000 of population (Brennan 2014: 84).

A common ontological theme that underlines the critical historical perspectives explored above is a willingness to transcend biomedical understandings of insanity/mental illness and the trajectory of asylums/mental hospital utilisation. This approach is very useful as it allows for an engagement with a host of dynamics including the economic, political, religious, community, family and personal contexts. However, the assertion of an overall schema (or grand narrative) emerging from any of these critical historical perspectives may neglect to take account of the dynamics driving a particular trajectory of asylum utilisation within a particular jurisdiction.

Unpacking the Irish case

Three points of change are of particular importance to the trajectory of asylum/mental hospital usage in Ireland: namely, its early formation in the early nineteenth century, its peak and turning point in the mid-twentieth century and its eventual closure at the commencement of the new millennium. During these three points in time there were substantive changes to social dynamics at the macro and micro levels and between the points are two periods of consistency – the first, an upward expansion of the mental hospital population and the second, a gradual demise.

There was an absence of any pre-existing physical infrastructure or administrative bureaucracy on which the Irish asylum system was established; hence, it emerged from a ‘standing start’ or ‘greenfield’ situation. As noted above, while many parts of Europe were moving from an agricultural to an industrial economy during this period, Ireland remained a predominantly rural and non-industrialised island with limited penetration of capitalism, particularly at the local and family level. Rates of emigration were high, and poverty and social deprivation were widespread (particularly during the great famine of the 1840s), which in turn drove chronic population decline. During this period, legislative decision-making took place in London, overseen through a colonial administration based in Dublin. In terms of social policy, this created a degree of disconnect between the expressed localised needs, the articulation of these needs in terms of policy, the legislative undertakings required and the fiscal management of interventions in terms of taxation, expenditure and consumption. For instance, the need for asylums in Ireland was established by an expert group (namely, the Select Committee to Consider the State of the Lunatic Poor in Ireland in 1817), legislated for remotely and administered centrally. Local Irish communities did not demand, build or pay for local asylums to cater for local need; however, the presence of wide-scale deprivation drove the localised utilisation of these institutions as a remedy for a host of social problems (Brennan 2014).

In terms of localised access to asylums, the Criminal Lunatics (Ireland) Act of 1838 (O’Neill 2005) and the Lunacy (Ireland) Act of 1867 (Kelly 2009: 363) provided a judicial system of asylum admission, which was operated through local courts. This legislation was fluid, wide ranging and liberally applied at a time when diagnostic criteria were all-encapsulating; this created a valve-like dynamic (rather than a revolving door), with more people entering asylums than leaving. The continuously growing asylum population was managed through the building of new asylums and the expansion of those earlier established. These institutions in turn became major employers, and staff wages were a significant driver of local economies. First organised through lay ‘moral management’, the expanding Irish asylums became increasingly recognised as both an important location for the development of professional power and an arena for scientific advancement. A willing and eager medical profession moved to gain control of these institutions, establishing a monopoly over inspection, management and clinical intervention by the mid-nineteenth century (Brennan 2014).

All of these factors combined to create a momentum that tended towards asylum expansion; however, it is important to note that none of these factors related to the mental state of the

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admitted individual. While the expressed function of the asylum was to cure or relieve the suffering of the insane, in Ireland these institutions performed a host of latent functions including direct employment, professional power, scientific advancement, a cash flow to local economies and the warehousing of Ireland's socially deprived. With few checks in place and weak cohesion in terms of planning, expenditure and utilisation, the trajectory of this institutional expansion was remarkably robust for more than a century, unaltered by existential national events such as famine, population decline, civil war and independence.

Similar to its inception, it was factors beyond the individual mental state that eventually commenced the decline of Irish mental hospitals. The 1945 Mental Treatment Act provided new mechanisms for admission, moving the power of decision-making for admission from the judicial realm to a 'clinical setting' within mental hospitals. While long-term incarceration was still possible under this Act, it did provide for 'voluntary' admission (although, once admitted, self-discharge was subject to a 72-hour notice during which time the patient's status could be changed). The 1945 Act was introduced during a period which saw an increased tightening and standardisation of diagnostic criteria in the shape of the *International Classification of Diseases* (ICD), first published by the World Health Organization (WHO) in 1948, and the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), first published by the American Psychiatric Association (APA) in 1952. These changes very much placed Irish mental hospital admission completely within the realm of medical control and psychiatric practice. However, contrary to the classical antipsychiatry perspectives which link medical control with asylum/mental hospital expansion (Foucault 1967, 1973), in Ireland this enhanced medical control stimulated a *decline* of Irish mental hospital residency. New interventions and technologies, in the guise of psychopharmacology and electroconvulsive therapy (ECT) were also introduced. While the impact of these treatments on the mental state of individuals subject to them is highly questionable (indeed, the damaging impact of these interventions on patients has been well documented (Whitaker 2010)), the use of drugs and ECT does appear to have impacted on the professional 'mind-set' of the psychiatrists in as far as successful clinical/pharmaceutical intervention followed by discharge was now perceived as an indication of clinical competence and expertise. As such, it could be argued that it was a change in professional thinking and practice – now focused on intervention and discharge – that drove decreased mental hospital residency from the 1950s onwards, rather than an actual 'cure' focused on the level of the individual patient's brain functioning.

An important factor to note is that the actual decline of Irish mental hospital residency rates commenced in 1957, which pre-dates social policy changes aimed at achieving such reductions. The social policy shift towards de-institutionalisation and community psychiatry in Ireland was initially set out in the *Commission of Inquiry on Mental Illness* (Commission of Inquiry on Mental Illness 1966), then in the *Planning for the Future* report (Department of Health 1984) and, finally, in the *Vision for Change* document (Department of Health and Children 2006). Rather than leading change, these social policies gave commentary to a process already underway. The 'vision' articulated in *Vision for Change* was the complete closure of the old mental hospitals; however, by the time of its publication in 2006, the once-massive national network of large institutions had fewer than 3,500 residents. This 'vision' would have been visionary if it had been articulated any time between independence in 1922 and the high point of mental hospital usage in the 1950s, when over 20,000 individuals were confined.

The completion of the demise of the Irish asylums/mental hospitals was again realised through factors which had nothing to do with the mental state of individuals – just as the Irish insanity epidemic was a myth, so were the contemporary claims of professionals to now have a 'cure'. A new mental health act was passed in 2001 which provided for mandatory legal advocacy for involuntary admission and renewed systems for inspection. Economically, Ireland was

modernising rapidly around this time, with substantive growth in the multinational technology and pharmaceutical industries, particularly from the mid-1990s until the economic crash of 2007 (a period described as the ‘Celtic Tiger years’ (O’Toole 2010; Riain 2014). Offset by job and financial opportunities elsewhere, the economic importance of mental hospitals within local economies rapidly diminished. Indeed, at the political level, the existence of these institutions of incarceration had become increasingly problematic since Ireland’s adoption of the UN’s Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care in the 1990s (United Nations General Assembly 1991).

Conclusion

The multi-causal methodological research adopted by critical historical approaches to mental illness provides for a rich and nuanced engagement with the macro and micro factors driving programmes of incarceration. Such critical theories transcend narrow biomedical rationale for asylum expansion, enabling an analysis of incarceration beyond reference to the mental state of the admitted individuals. However, some of the core narratives and theoretical tenets emerging from the established critical schools appear to be challenged when empirically considering the Irish case. While Ireland experienced the most intensive programme of mental hospital utilisation, its social, economic, political and religious circumstances render it as a poor fit for the classical critical social theories. An understanding of the Irish experience of asylum/mental hospital utilisation is enriched through the utilisation of the historical methodology approaches common within critical social theories. However, the adoption of a grand theoretical narrative as a starting point would appear to limit, rather than enable, an analysis of the trajectory of asylums/mental hospitals in Ireland.

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Autism looping

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Over the last quarter century, the prevalence of autism in the US has increased from one in 2,500 in 1989 to one in 68 in 2010 (Baio 2012). Explanations for the autism ‘epidemic’ either suggest that there was a real increase in the number of cases caused by environmental toxicity (Roberts *et al.* 2007), or that it has resulted from a broadening of diagnostic criteria, along with increased public awareness and a greater availability of services (Croen *et al.* 2002; Fombonne 1999; Grinker 2007). These explanations, however, fail to hold up under even the most cursory scrutiny. Given that the diagnostic criteria for autism were broadened just before the epidemic began – first in 1987, with the revised, third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R) (American Psychiatric Association 1987) and then in 1994, with the fourth edition of the DSM (DSM-IV) (American Psychiatric Association 1994) – an explanation in terms of increased levels of environmental toxicity seems not only less plausible, but also untestable since there is no biomarker for autism that would allow comparison across historical periods (Goldani *et al.* 2014). At the same time, an explanation in terms of broadened diagnostic criteria is equally unsatisfactory. It begs the obvious question: why were diagnostic criteria broadened? Was it due to better scientific understanding of autism, or was it due to ‘medicalisation’? Clearly, this question resurrects the original debate about the causes for the epidemic and merely leads us down a rabbit hole of infinite fractalisation (Abbott 2001).

A more fruitful approach is to invert the original question and to ask not why autism is more prevalent now, but why it was rare in the past. Why did the numbers not increase earlier? This line of questioning is calculated to direct attention to the *conditions of possibility* that are necessary for autism to be identified, differentiated and diagnosed on a large scale. To ask about conditions of possibility is not to deny the reality of autism, but neither is it to treat autism as a ‘natural kind’. The orienting approach is ‘dynamic nominalism’. Autism is neither fact nor fiction, but a *classification*. As such, it has certain effects on the individuals classified (and their families), who act in response to the knowledge of being classified or in response to the institutional arrangements the classification entails. These actions, in their turn, ‘loop’ or revert back upon the classification and change it, thereby rendering the condition a ‘moving target’ (Hacking 1995, 2007).

Between retardation and illness

The moment we ask why autism was rare in the past, our attention is directed to the institutionalisation and de-institutionalisation of mental retardation. The naming of autism by child psychiatrist Leo Kanner in 1943 coincided with the beginning of an unprecedented wave of institutionalisation of young children diagnosed as ‘feeble-minded’ (Goldstein 1959). This meant that the conditions of possibility for identifying and differentiating autism on a large scale did not exist at the time. The institutional and spatial arrangements of custody, as well as the unfavourable staff to patient ratio offered no basis for observing or differentiating autism, not least because overpopulation and neglect at the residential institution produced what looked like autistic symptoms on a massive scale – withdrawal, indifference and self-stimulatory behaviours were widely understood to be reactions to the institutional environment. More fundamentally, individuals were institutionalised not on the basis of an IQ (intelligence quotient) test, but if they were found to be ‘socially incapable’ due to some form of mental deficiency (Tredgold 1947: 1–6; Wallin 1949: 20–36). From the point of view of assessing and providing for ‘social incapacity’, there was not much point in distinguishing autism from the more global category of mental deficiency. Autism was indistinct, below the radar.

As a result, the de-institutionalisation of mental retardation – a lengthy process which began in the early 1970s and lasted at least two decades – was the crucial event which created the conditions for the current epidemic. De-institutionalisation led to the creation of a new institutional matrix composed of community treatment, special education and early intervention programmes, wherein children were observed, sorted and categorised not on the basis of degrees of ‘social incapacity’, but rather in terms of how they fitted into familial, educational and rehabilitative settings, and their variable responses to the new therapies practised there (see discussion below). Cross-national comparison furnishes ready evidence for this argument: autism rates are the highest today where de-institutionalisation began earliest and proceeded the furthest (that is, in the UK, Canada, the US, Sweden, Norway and Denmark). In contrast, where de-institutionalisation did not take place or was delayed – as in France – autism rates today are quite low even in the presence of a highly developed medical system and fully mobilised autism parents’ advocacy organisations (Eyal *et al.* 2010: 58–62).

De-institutionalisation played a crucial role in the expansion of autism, however, not simply because the children were now at home and could be closely observed and diagnosed. There was a deeper reason. From the moment that autism was first named by Kanner (1973), it *represented a blurring of the boundaries between mental retardation and mental illness*. Kanner’s article reported on the cases of 11 children who were originally referred to him because their parents disputed the diagnosis of feeble mindedness they were given. Kanner (1973: 41) agreed with the parents that the children were ‘all unquestionably endowed with good cognitive potentialities’. How could he know this? He pointed out that the parents of autistic children were typically middle-class, in intellectual professions and highly intelligent. The children also did not *look* feeble-minded. They were well-formed, even pretty (Kanner 1973: 39–41). We may snicker, but contemporaries, especially the parents, took this as fairly convincing proof. At the time, there was an institutional division of labour between child-guidance clinics, which treated the behaviour problems of middle-class children, and the institutions for the retarded, which held mostly lower-class adolescent ‘morons’ (Jones 1999: 7–8; Kanner 1964: 141–2; Nehring 2004: 371–2). The fact that the children were middle-class and that there was no evident genetic defect in the family was taken as proof that this was not feeble-mindedness. Despite the class bias, I would argue that this was a profoundly liberating moment. The recognition demanded by middle-class parents ultimately paved the way for a more universal extension of rights.

Kanner (1949: 10–11) suggested that there was a form of feeble-mindedness that was only ‘apparent’, not real, and that often it was really autism underneath the appearance. Autism was primarily a ‘disturbance of affective contact’ (Kanner 1973) – that is, something that at the time was understood along the lines of mental illness or psychosis. Indeed, two of the 11 children were, at one point, hospitalised as schizophrenic; at one stage Kanner (1949: 27) implied that autism may have been caused by maternal coldness, a standard (for the time) explanation for mental illness. Yet, he quickly abandoned this idea and reverted to his original claim that the condition was inborn. His equivocation was highly productive. It meant that autism served as a ‘wedge’ with which to pry open a space between illness and retardation, a ‘zone of indiscernibility’ (Foucault 2003) where it would be impossible to determine – within the understanding of the period – who is mentally ill and who is feeble-minded. By the same token, Kanner did not think autistic children should be institutionalised or hospitalised, but should be given intensive therapy to realise their potential. He envisioned a comprehensive system of surveillance of the full range of childhood ailments – from problem behaviours to psychosis to feeble-mindedness – with child psychiatrists assigning children to different tracks on the basis of careful diagnosis and therapy (Kanner 1964: 142–3).

From the 1940s onwards, the history of autism can be told as a series of attempts to bring this in-between domain into being. De-institutionalisation finally created the conditions to do so. It formalised this zone of indiscernibility as the new category of the ‘developmentally disabled’, who no longer were to be held in custodial institutions, but would receive treatment. Yet, their treatment was not oriented to a cure (as in illness) but to ‘habilitation’ – that is, making able.

Between expert and lay

The irony is that it was not child psychiatry that managed to carve this in-between domain, but a completely different actor – namely, the parents of children with autism. The second reason, therefore, why autism was rare in the past is because it was impossible to bring into being this in-between domain without enlisting the collaboration of middle-class parents. To put it in a nutshell, the blurring of boundaries between mental illness and mental retardation could not be achieved without a corresponding blurring of boundaries between experts and laypeople. In the previous arrangement, children’s destinies were sorted by the institutional distinction between child guidance and the residential institution, which neatly corresponded to, and confirmed, class distinctions. Without this institutional pre-sorting it became the task of the clinician to diagnose and decide *social destiny* – that is, who has ‘potential’ and should get intensive therapy and who should not. This form of power – medical diagnosis of social destiny – is much too formidable and fraught to be wielded by any one person or profession. It cannot be exercised without striking a coalition with middle-class parents. This is why another condition for the expansion of autism was a thorough rearrangement of the relations between experts and the parents of children with autism.

Of course, this did not happen peacefully because somehow both sides recognised their mutual interest in coalition. The story of autism is one of ambivalence, resistance and looping. Kanner’s initial move was, indeed, highly ambivalent. On the one hand, he sought to enrol the interests of middle-class parents on behalf of child psychiatry – telling them that their children were in need of careful diagnosis and therapy which would ‘bring hidden potentialities to light’ (Kanner 1949: 29–31). On the other hand, he charged that the children were ‘brought up in emotional refrigerators... treated more as coldly watched and preserved experiments than as human beings enveloped in the warmth of genuine parental affection’ (Kanner 1949: 27).

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This ambivalence was built into the position that Kanner occupied in the network of clinical expertise. The main data he used to diagnose and describe autism were parental reports (1973: 1–2, 6–8, 12). Whose, therefore, was the diagnosis? Kanner's? The parents'? Or both? The network of clinical expertise included several mechanisms that attributed the diagnosis to the clinician, among which were the closed door of the clinician's office; the privacy of his notes; the abstracted case summary; and the fact that the clinician was privy also to the observations of referring physicians or experts at various residential schools and child study homes (Kanner 1973: 6–7, 17–19). Hence, even though the parents furnished most of the observations, the diagnosis was primarily attributed to the clinician's acumen. To these mechanisms we can add 'mother blaming', the above-quoted reference to 'emotional refrigerators' and various comments about the parents' 'obsessiveness' (Kanner 1973: 42). It functioned as a 'trial of attribution' (Latour 1987: 118–19), since it downgraded the credibility of parents' reports even while drawing on them, thus attributing the diagnosis to the clinician's insight (Sullivan 1984: 239).

However strange it may seem to us today, mother blaming also served to secure parents' cooperation with the clinician. Parents were not initially resistant to the discourse that depicted them as complicit in their child's condition because this discourse gave hope that a cure was possible, removed the stigma of organic defect (May 1958: 126–7) and provided them with identity as 'autism parents'. Parent blaming was a confessional form of power (Foucault 1976). It had a 'deep, unhealthy charm' (May 1958: 124–5). It worked by stigmatising individuals as sinners, eliciting their confession and teaching them to view themselves through psychiatric categories. It also provided them with an identity as 'autism parents' by forging a unique bond of resemblance with their children. Kanner observed that the parents resembled their children in tell-tale ways – they were highly intelligent, but also obsessive and cold, 'preoccupied with abstractions and limited in genuine interest in people' (Kanner 1973: 135). Thus, the diagnosis of autism brought into being a new human kind composed not simply of the diagnosed individual, but a dyad – the autistic person and the 'autism parent' bound together through this similarity imputed by Kanner. When parents began to act on the basis of this identity, rejecting the stigma of causation but embracing the resemblance – interpreting it as genetic, brandishing it as evidence of their children's potential, leveraging it into a claim for expertise about their children – they completely rearranged the relationships within the clinical network and created a social actor that could finally realise Kanner's original vision.

The key figure was Bernard Rimland, a psychologist and father of a boy with autism, who, in 1964, published a book, *Infantile Autism*, which is widely acknowledged today as a forerunner of modern autism research. There are three crucial developments that intersect in Rimland's book. First, it gave rise to the modern autism parents' movement. Immediately following its publication, Rimland joined with other parents to form the National Society for Autistic Children (NSAC), designed as a lobby on behalf of autistic children and a 'national self-help group' combatting the stigma attached to the parents (Warren 1984). Thus, the stigmatised identity created by Kanner looped to become the focal point around which a form of resistance took shape. Ultimately, as Hacking (1995) predicts, the actions of the human kind brought into being by the diagnosis reverted back upon the classification and rendered it a 'moving target'. As autism parenting was de-stigmatised, the diagnosis became more palatable and the autism population began to grow and to include also higher-functioning children. Ultimately, the broader diagnostic criteria for autism in DSM-III-R were written by another parent, Lorna Wing, founder of the British National Autistic Society (NAS). She drew on the diagnostic schemes produced by NSAC, NAS and their affiliates (Waterhouse *et al.* 1992).

Second, at the end of Rimland's book there was a checklist that parents could fill and send back to Rimland with descriptions of their children's symptoms. Within a week of publication,

Rimland began receiving completed checklists from parents. He would score the forms and return the results – along with an analysis of the child – back to the parents (Rimland 1971). In short, Rimland found a way to rewire the flow of information in the clinical network of expertise so that the diagnosis was no longer attributed solely to the clinician. Rimland's alternative network opened the clinician's office door and allowed parents to look inside. What they saw there was not reassuring. Rimland (1971: 165–6) found that out of 445 children in his study, who saw two different clinicians, only 55 received the same diagnosis! Following Rimland's work, autism diagnosis was transformed. It is now done using standardised checklists drawing heavily on parental reports; it is a collaborative affair, involving teams of psychiatrists, psychologists, speech and occupational therapists, as well as the parents.

Significantly, Rimland's interventions took place *before* the revolution attributed to Robert Spitzer and the DSM-III (American Psychiatric Association 1980). Much ink has been spilt about the DSM and its putative 'cultural authority' (Kutchins and Kirk 1997; Watters 2010). Consequently, the autism epidemic is often attributed to changes in the DSM criteria (Grinker 2007). I think this is erroneous. The 'cultural authority' of the DSM is but a thin veneer under which churns a maelstrom of other forces over which psychiatry has very little control (which is why the DSM keeps getting revised). Moreover, diagnosis is a collaborative act involving a network of actors, devices and institutional settings. The effectivity of the DSM is premised not on psychiatry's domination of this network but, on the contrary, a more egalitarian arrangement of its relations with laypeople and non-medical experts. In the case of autism, changes to the DSM were secondary in comparison with the history described here. To begin with, they lagged behind clinical practice. Clinicians in the mid-1980s were diagnosing autism not according to DSM-III criteria, but on the basis of an understanding of autism as a spectrum, which anticipated the 1987 DSM-III-R revised criteria. The same phenomenon was noted before the publication of the DSM-IV (Croen *et al.* 2002: 213; Waterhouse *et al.* 1987). This is because clinicians rarely diagnose 'by the book', but typically on the basis of similarity to a 'best example' derived from their experience (Hacking 1995; Luhrmann 2000), an experience which is shaped by the institutional matrix within which they are located. In the case of autism, this matrix was not built by psychiatry, but by parents' organisations in collaboration with non-medical therapies and forms of expertise.

Between cure and custody

The third innovation introduced by Rimland was the inclusion of behavioural therapists in the parents' alternative network. At NSAC's founding meeting, Rimland gave a lecture about the therapy pioneered by Ivar Lovaas, a behavioural psychologist at UCLA (the University of California, Los Angeles), whose work he observed. Rimland emphasised that Lovaas's method was a 'technique that parents could learn with demonstrable success' (Rimland 1972: 573). Lovaas, indeed, was keen for parents to learn his method and use it themselves. Working in relative isolation, with an intensive method that could not be scaled up without a whole army of paraprofessionals, he realised that his best bet was to 'give away our professional skills to lay people, and the sooner the better' (Lovaas 1993: 628). Indeed, Lovaas's applied behavioural analysis (ABA) became the mainstay of parent-run special schools, as well as the main therapy practised by parents at their homes (Silverman 2012: 93–124). ABA provided parents with a relatively simple, practical way to address the everyday problems they faced, while its rigid routines and strict rules worked to secure the begrudging cooperation of the children (Park 1974). Most importantly, behaviourist tools for recording and charting observations transformed autism from a unitary syndrome into a set of loosely related autistic behaviours measurable in exquisite detail. Now

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it became possible to make graded distinctions between children (that is, to construct autism as a spectrum) and to demonstrate that a child could potentially learn, develop and progress over time if treated with intensive therapy.

Through the door thrown open by Rimland now came other experts hitherto subordinated to psychiatry or altogether absent from the autism field – not only behavioural therapists, but also occupational and speech therapists, special education specialists and practitioners of increasingly esoteric therapies (parents in the US, Canada and Australia today use *108 different types of treatments* in total, with an average of *seven per child* (Green *et al.* 2006)). De-institutionalisation provided a propitious ecology for these new methods of treatment. By the end of the 1970s they largely replaced insight psychotherapy as the main form of autism treatment, despite the fact that none of them could cure autism or significantly undo severe initial handicaps of intelligence and language (Rutter 1983: 210–11). The success and spread of these therapies, therefore, was not due to their technical superiority but to their *social innovativeness*: the fact that they could be grafted directly onto the everyday practices of parents and patients; the solution they provided to the manpower problem by outsourcing therapeutic labour to parents; and their ability to postpone the diagnosis of social destiny and disperse it onto multiple local authorities – psychologists, therapists, special education teachers, parents – and periodic decision points. At the same time, however, the spread of the therapies meant that autism was transformed from a syndrome with ‘cardinal symptoms’, as Kanner called it, to a list of ‘items of autistic behaviour’ that could be worked upon separately, and from a rare illness into a wide spectrum of social and communicative deficits. This is because the therapies functioned *as grids of specification that target, differentiate and determine the diagnostic value of certain specific aspects of behaviour, communication and comportment*.

De-institutionalisation gave rise to an undifferentiated mass of children with ‘developmental disabilities’. Especially, it became less meaningful to strongly distinguish autism from retardation. Wing (1973: 118) argued that it was,

pointless... to draw sharp lines between autistic and ‘not really autistic’ in educational practice... The question to ask about each child is – what are his handicaps, what are his skills and what can we do to help him?

This pragmatism reflected not only the new realities of de-institutionalisation, but also the *modus operandi* of the therapies. Lovaas, for example, claimed that the techniques of ABA were indifferent to the distinction between retardation and autism, which he dubbed a ‘hypothetical’ entity.

Upon this new landscape, now lacking ‘sharp lines’, the therapies layered a new grid of specification based on the internal economy of the therapeutic exchange, what it demanded of the patients and how they responded. This grid of specification grouped together and foregrounded certain behaviours, especially those pertaining to communicative rapport, while discounting and marginalising others. Evidence for this looping dynamic is provided by the sort of things that began to fall out of the diagnosis of autism – for example, self-injurious behaviours. Rimland (1964: 59) said that he did ‘not know any [autistic]... children who did not have the rocking and banging of head’. In the DSM-III (American Psychiatric Association 1980), however, self-mutilation was no longer a necessary criterion for diagnosing ‘infantile autism’, but only for the lesser diagnosis of ‘pervasive developmental disorder’ (mostly similar to autism, but without the requirement of ‘utter lack of interest in people’). In DSM-III-R (American Psychiatric Association 1987), self-injurious behaviours were merely an ‘associated feature’. Finally, in DSM-IV (American Psychiatric Association 1994) they were no longer mentioned. A psychiatrist with years of experience diagnosing and treating autism concurred that ‘it’s my clinical impression that there is a lot less hand biting now than twenty years ago’ (Siegel 1996: 74).

As self-injurious behaviours were increasingly controlled by behavioural therapies, they were progressively considered as outside the core symptoms of autism (Schopler 1978: 169).

Another example is the ‘cardinal symptom’ of autistic aloneness and utter lack of interest in people (Rimland 1964: 8). All the new therapies involved what Grinker (2007) described colloquially as ‘being in your child’s face’. This meant that aloneness was no longer delineated as a singular and essential quality. The sharp lines that surrounded it faded into the background; foregrounded, instead, was a certain equivalency between the multiple ways – from aloofness to oddness – in which communicative rapport could break down. Thus, what was previously understood to be the core of the syndrome was stretched into a continuum of ‘impairment of social interaction’. For example, the diagnostic criteria for autistic disorder in the revised, fourth edition of the DSM (DSM-IV-TR) (American Psychiatric Association 2000) states that a child can be diagnosed with autism if there is a ‘failure to develop peer relationships appropriate to developmental level’ and a ‘lack of spontaneous seeking to share enjoyment’ (that is, someone we might colloquially refer to as a ‘loner’, but who clearly would not have been recognised by Kanner as ‘autistic’).

Over the long term, what happened between autistics and therapists began to redefine what autism really was: both the boundaries and the core of the syndrome. It changed what the clinicians knew they should be looking for. Then it was reported back to parents in advice books, which meant that clinicians would, indeed, see in their offices more or less what they had expected – namely, the new prototype shaped by the new institutional matrix. In this way, the movement started by Kanner completed a 180-degree loop and ended up with a substantial revision of how autism looks and feels, is understood, classified and counted.

Conclusion

The history I recounted here is not a ‘critical’ one. To demonstrate that autism is a ‘moving target’ is not to expose it as fiction. To analyse the social conditions of possibility for autism’s spread is not to denounce a pernicious medicalisation. On the contrary, I think that, on balance, the spread of autism – understood as shorthand for a different paradigm for thinking about and intervening in childhood disorders – is a positive development. It means that impairment is understood as specific rather than global, with the necessity to assess also ‘splinter skills’ and areas of strength. It involves an assumption that the child may possess an underlying potential that could be activated. It emphasises early intervention because there is a ‘window of opportunity’ to alter a child’s trajectory. And it consists of an ethical commitment to recognise and support disabled personhood. These are noble commitments. If there is a critical edge to this history, it is in pointing to the limitations of the current paradigm. Two groups, in particular, are excluded from its benefits: those still deemed ‘intellectually disabled’ rather than autistic and the very same autistic youngsters once they become autistic adults (that is, when the window of opportunity has closed). The proper response to the autism epidemic, I would argue, is not to seek to reduce the patient rolls, but to redouble our efforts to guarantee ‘non-categorical’ equity and continuity in access to services and therapies.

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Part III

Medicalisation and pharmaceuticalisation

The changing drivers of medicalisation

Meredith R. Bergey

Social scientists have long been interested in how certain behaviours and social issues become defined or treated as mental disorders. Although the rise of psychiatry as a medical speciality contributed greatly to processes of medicalisation in the mid- to late twentieth century, other drivers are increasingly playing a role today. This chapter discusses some of these changes and points to various mediating factors that influence medicalisation, concluding with some suggestions for further research.

Defining medicalisation

‘Medicalisation’ refers to a definitional process by which previously non-medical problems become defined or treated as medical conditions (Conrad and Bergey 2015). The term ‘medicalisation’ first appeared in the 1960s and 1970s in sociological literature on deviance. Pitts (1968) spoke fairly positively of medicalisation as a new form of social control over deviant behaviour. In contrast, Zola (1972) was more critical of medicalisation’s potential to serve as a mechanism of social control and to de-politicise social problems, while Illich (1976) was critical of the medical profession’s expanding jurisdiction and the potential for iatrogenic effects. Conrad (1975, 1976) (and later Conrad and Schneider 1992) spoke more specifically about how the classification of behaviours as mental disorders represented, in the first instance, the medicalisation of deviant behaviour. Since these early works, the term ‘medicalisation’ has been applied more broadly in research on the construction of medical and psychiatric knowledge related to various human conditions, experiences and life events (Conrad 2007).

Characteristics of medicalisation

Medicalisation is not a binary process. It can occur in degrees ranging from full to minimal medicalisation (Conrad and Potter 2000). Whereas fully medicalised conditions (e.g. schizophrenia) have established medical diagnoses and/or treatments, minimally medicalised conditions (e.g. sexual addiction) lack widespread medical recognition or acceptance. Medicalisation is also bidirectional. For instance, Asperger’s disorder (AD), attention deficit/hyperactivity disorder (ADHD), depression and post-traumatic stress disorder (PTSD) reflect behaviours and/or traits

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that have been ascribed medical meanings (Conrad 1975; Conrad and Slodden 2013; Rose 2006). Although fewer cases exist, de-medicalisation can occur as well; examples include homosexuality and masturbation (Conrad 2007).

Medicalisation can also involve the redefinition of existing medical categories. For example, ADHD was thought to be a disorder of childhood until roughly the 1990s, but is now considered to be a lifespan disorder (Conrad and Potter 2000). Finally, the term 'medicalisation' does not presuppose the existence or non-existence of a biomedical problem, although some scholars may adopt such a stance (Conrad and Barker 2010). Inclusion in a diagnostic compendium or the existence of a medical intervention does not necessarily reflect an objective mental health condition, but rather that a condition has achieved some level of legitimacy with the medical profession as a medical disorder (Conrad 2007).

Potential consequences of medicalisation

Although not using the term 'medicalisation' explicitly, some early critics considered the expansion of medical knowledge to be a form of medical imperialism (e.g. Illich 1976; Szasz 1970). Critiques of psychiatry have raised concerns about the seemingly unfettered pathologisation of human differences and medicine's ability to act as a mechanism of social control and surveillance through institutionalisation (e.g. Foucault 1965; Goffman 1961). These and other early works depicted the medical profession's expanding jurisdiction (Freidson 1970) concomitant with society's growing dependence on medical intervention and decreased capacity to act autonomously in dealing with matters related to health (Zola 1972).

There have been concerns both in the scholarly literature and in the media with the 'over-medicalisation' of society (Conrad and Bergey 2015; Moynihan 2002). For instance, sociologists focusing on the emergence and treatment of mild depression (Horwitz 2015; Horwitz and Wakefield 2007) note the potential pathologisation of human emotions such as sadness and grief. While over-medicalisation may certainly be a concern, both over- and under-medicalisation have undoubtedly occurred at different times and in different contexts (Conrad and Bergey 2015).

Another consequence of medicalisation is that it can individualise (and thus, de-politicise) issues by dislocating them from structural causes (Zola 1972). Biomedical interventions and policies often disregard social context and cross-cultural differences in health-related experiences (Lock 2001). The medical model reduces social problems to matters of symptoms, prognosis and treatment, which can take on the quality of medical fact, as opposed to the subjective experience of some broader circumstances (Waitzkin 1989). By turning attention and responsibility towards the individual, attention is often deflected from socio-political and economic determinants of health and related interventions (Lock 2001).

This is not to say that medicalisation cannot have positive effects. Interventions for medical problems (such as medication or therapy) have undoubtedly helped countless individuals address health-related concerns, reduce stigma and function better in society (Conrad 1997; Conrad and Bergey 2015). Medicalisation can also eliminate certain social roles and expectations (e.g. related to school, work and caregiving) (James and Edel 1964; Scheper-Hughes and Lock 1986) and remove or reduce blame and responsibility.

The lack of medical consensus about a purported condition often has important implications for a person's experience of illness and sense of identity. A diagnosis can be transformative; it can be integral to restoring meaning to a person's life (Barker 2005). A diagnosis can also be important for a physician who is struggling to alleviate their patient's uncertainty and suffering. In some instances, a diagnosis serves to legitimise both parties and the patient-physician relationship itself (Barker 2005).

Drivers of medicalisation

The idea that mental illness is an individual and societal problem has existed for centuries under such labels as lunacy, madness and insanity (for a detailed review, see Conrad and Slodden 2013). It was not until the early nineteenth century, however, that such issues began to fall under medical jurisdiction. Rush's (1812) early writings on 'diseases of the mind' was influential in promoting the notion that individuals exhibiting certain deviant behaviours have diagnosable disorders that require medical care. Later discoveries and advancements (e.g. electroconvulsive therapy (ECT) and certain psychodynamic therapies) fuelled optimism in medicine's ability to identify and treat various mental disorders.

Psychiatry's growing influence in the twentieth century as a medical speciality played an important role in defining mental health issues as pathological, diagnosable disorders (Scully 1977). The field's shift away from psychodynamic perspectives towards biological and diagnostic psychiatry was particularly instrumental in shaping new paradigms about the aetiology and treatment of mental illness (Rothman 1971). This shift is reflected in the different iterations of the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Whereas the first two editions (American Psychiatric Association 1952, 1968) drew heavily upon psychoanalytic theory (Horwitz 2001), later editions adopted a biomedical model of disease – emphasising individual, biological symptomologies over social determinants. The growth in diagnostic psychiatry has seen a concomitant increase in the number and range of diagnostic categories since the first DSM was published in 1952.

Whereas physicians played a central role in medicalisation in the past, various stakeholder groups (e.g. consumer and advocacy groups, the health insurance industry, researchers, physicians and pharmaceutical companies) increasingly play a role today, often collectively (Conrad 1997, 2005; Figert 2011; Kutchins and Kirk 1997). Physicians are still integral to the process, albeit more as gatekeepers to diagnosis and treatment, or partners in collective action, rather than as sole or dominant drivers (Conrad 2007; Padamsee 2011).

The pharmaceutical industry has become a major driver of medicalisation. As the history of anxiety medications in the US illustrates, research and development of new drugs and repurposing of pre-existing drugs for new uses can drive medicalisation (Herzberg 2010). Abraham (2010) depicts a 'pharmaceuticalisation' of medicine, such that pharmaceutical interventions are increasingly being used to treat a broad range of human conditions. This trend is likely to expand as the drug industry becomes more transnational in scope. Pharmaceutical companies have invested heavily in identifying and treating certain conditions in global contexts, as cases such as depression and ADHD illustrate (see, e.g. Conrad and Bergey 2014; Watters 2010). Being profit-driven, pharmaceutical companies have tended to focus their efforts on developing treatments that address long-term conditions and conditions that affect larger numbers of people – usually at the expense of more acute and/or rarer conditions. Additionally, marketing has tended to target populations in wealthier countries (Busfield 2010).

Medicalisation may also be achieved by, or in association with, an existing social movement (Conrad and Bergey 2015). Examples include PTSD with the Vietnam Veterans movement (Scott 1990) and premenstrual syndrome (PMS) with the women's movement (Figert 1996). Relatedly, consumers and patient advocacy groups have become influential drivers of medicalisation in recent decades (Conrad 2007). Such groups can spur the process on by lobbying the medical profession for recognition and legitimisation of contested or relatively unknown conditions or treatments. ADHD is an illustrative case as various lay, professional and medical claims emerged in the 1980s and 1990s to support an expansion of the diagnostic criteria for ADHD to include adults (Conrad and Potter 2000).

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Multiple drivers of medicalisation can operate together through collective action. In such cases, the desired outcome may align, although the motives may differ. For instance, an advocacy group might seek medical recognition for a condition so as to open the door to treatment. A drug company may have an interest in well-being, while also wanting to sell their product. The development of new technologies has enabled the measurement of biological and genetic parameters, which have then been interpreted in ways that have contributed to new medical diagnoses, prognoses and treatments. Clarke and her colleagues (2003, 2011) suggest that a greater focus on technoscience, particularly, drives ‘biomedicalisation’ today; the development of new technologies often comes with the promise that human differences will someday be fully explained. Being able to identify and measure novel aspects of human biology and genetics may be associated with a concomitant drive to label them in medical terms. The term ‘geneticisation’ has been used to describe a process by which ‘differences between individuals are reduced to their DNA codes, with most disorders, behaviours, and physiological variations defined, at least in part, as genetic in origin’ (Lippman 1991: 19).

Dissemination of research involving the collection and analysis of large datasets (e.g. in epidemiologic and clinical research) on social and biological determinants of health has contributed to the perception that we are all at risk of something health-related (Lupton 1995, 1999). This perception can facilitate medicalisation over new arenas of human experience if individuals are characterised as ‘pre-patients’ at risk, even if they might be otherwise healthy and without symptoms. In a similar vein, technological advances in genetic research and testing are, increasingly, being used to identify individuals who may be at risk of developing mental disorders such as depression (Shostak and Conrad 2008).

Attention in this section has been on medicalisation, but the factors noted above may also drive de-medicalisation. The case of homosexuality is illustrative of this point: gay rights activists – including some psychiatrists – lobbied and picketed the APA in the early 1970s to have homosexuality removed from the DSM. A task force was then formed to reconsider the Association’s stance and homosexuality was eventually removed from the manual in 1973 (Conrad 2007).

Factors mediating the spread of medicalisation

Mediators refer broadly to the mechanisms and resources that support (or detract from) medicalisation. Examples of mediators include the internet, mass media (e.g. television, radio, newspapers, magazines, journals and books), direct-to-consumer advertising (DTCA), health insurance, government policies, clinical education and diagnostic and clinical guidelines. This list is by no means exhaustive, nor is it mutually exclusive. Furthermore, just as drivers can operate in conjunction, more than one mediator may be relevant at one time.

The internet has dramatically increased the availability and dissemination of health-related information (Fox 2005). Health information is one of the most frequently searched subjects online (Cohen and Stussman 2010) and the internet offers various possibilities for online consultations with health experts (Ayers and Kronenfeld 2007; Nettleton *et al.* 2005). It also provides opportunities for self-help and mutual aid through numerous illness electronic support groups, newsgroups, chat rooms, list-serves and bulletin boards (Fox and Fallows 2003). Individuals can assemble online to discuss their experiences, spread awareness and even mobilise to seek medical legitimisation of a contested disorder (Barker 2008). The internet also provides a platform for information and advertisements – often tailored to specific individuals – that can lead to reaffirmation of a medical label or self-diagnosis and follow-up with a physician.

DTCA is frequently used by pharmaceutical companies to market both their products and the conditions associated with them. Such advertisements may involve different forms of mass media.

For instance, television and billboard advertisements helped spread the notion that extreme shyness (labelled as social anxiety disorder (SAD)) is a medical condition that could be treated effectively with the antidepressant drug *Paxil* (Lane 2007). This case also points to the mediating influence of policies on medicalisation, as the relaxation of government regulations in the 1990s contributed to increases in DTCA (Moynihan and Cassels 2005), which rose in the US from US\$55 million in 1991 to US\$4.2 billion in 2005 (Conrad and Leiter 2009). Annual spending on DTCA for prescription drugs tripled between 1996 and 2000, reaching US\$2.5 billion (Rosenthal *et al.* 2002). DTCA for prescription drugs is currently only permitted in the US and New Zealand. Companies may also circumvent certain restrictions on direct marketing by producing commercials that do not discuss specific treatments but, rather, discuss issues associated with a condition and suggest seeking medical advice (Busfield 2010).

Pharmaceutical companies utilise additional methods to target prospective patients, physicians, psychologists and other groups (Timimi 2008) – they run press releases, send company representatives to doctor's offices, fund conferences and disseminate various types of branded merchandise (e.g. mugs, notepads and pens) (Busfield 2010). For example, aware of the role that teachers often play in recognising potential cases of ADHD, drug companies have approached teachers with educational materials that include information about psychotropic treatment options (Phillips 2006). They have also assisted in funding ADHD-related conferences, where they have representatives on hand to present information about their products (Bergey and Conrad, 2018).

The health insurance industry mediates medicalisation by dictating what types of diagnostic tests and treatments they will cover. They play a role in controlling what criteria patients must fulfil to become eligible for treatment, as well as what type of treatment they can receive. For instance, managed care practices have been used by behavioural health organisations seeking less expensive means of treatment with fewer hospitalisations, decreased lengths of hospital stay, decreased use of specialist services, limited psychotherapy and increased reliance on drug treatments (Mayes *et al.* 2008).

Clinical education is another potential vehicle for medicalisation. Once a condition has been medicalised, diagnostic and/or treatment practice is reified and disseminated through education and training. The designation of a medical category can quickly permeate health fields (e.g. medicine, nursing, psychology and so on) through the training of current and new student clinicians (although the acceptance and uptake of a new or altered definition or treatment may vary). The training of overseas students can also serve as a vehicle for spreading diagnostic categories and treatments across national borders (Conrad and Bergey 2014).

Diagnostic and clinical guidelines are a related mediating factor for medicalisation. Examples of diagnostic guidelines include the APA's DSM and the World Health Organization's (WHO) *International Classification of Diseases* (ICD). Examples of clinical guidelines include the American Academy of Pediatrics' (AAP) and the UK's National Institute for Health and Care Excellence's (NICE) suggested practices for treating mental health and behavioural conditions (see aap.org and nice.org.uk, respectively). Although the intended audience for these guidelines is typically clinicians, the information is often readily available for interpretation and use by other groups as well. For instance, support groups may cite or provide links to such documents on their websites as part of the general discourse concerning a given condition.

Recognising the mediating factors in medicalisation is important because the mechanisms by which definitions and treatments are supported and/or propagated are likely to influence the extent to which they are adopted and the consequences of such adoption. Moreover, mediating factors may not be equally accessible to all groups. The medicalisation process is often skewed in favour of those with greater resources. Differing sides of a debate concerning a

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medical definition or treatment may not be heard equally owing to the unbalanced distribution of power between drivers; large pharmaceutical companies have the resources to mount mass marketing campaigns that reach large and varied audiences, whereas the methods available to an advocacy group, comprising a small number of affected individuals, would typically be far more limited.

Mediating factors can also be used to impede medicalisation or support de-medicalisation, although there have been far fewer cases of such processes occurring. For instance, the Kinsey reports (e.g. Kinsey *et al.* 1953) and other studies emerging in the 1940s and 1950s contributed to a changing public discourse around masturbation – one which suggested that masturbation was neither uncommon nor a medical issue. Ultimately, the extent to which mediating factors influence medicalisation will depend on the extent to which the message they carry resonates with physicians and shapes or reinforces diagnosis and medical practice.

Concluding remarks and future directions

Medicalisation has become an important area of study in social science research on health and medicine in recent decades. An increasing number of researchers in the fields of anthropology, sociology, history, medicine, public health and bioethics are utilising the term and undertaking research on this process (Conrad and Bergey 2015). Reflecting upon this literature, several areas emerge for future research and discussion.

In contrast to the drivers of medicalisation, the mechanisms that support or impede this process have received little attention. For example, how do such mechanisms interact and how might access vary across groups? With the exception of Conrad *et al.*'s (2010) study, the economic costs of medicalisation are another topic that has been relatively unexplored. Further research is necessary to understand medicalisation's impact on individual and national health care expenditures.

When physicians have been examined, research on medicalisation has tended to focus on the medical profession's control over knowledge and practice, rather than their subjective experiences. Several exceptions have recently emerged which suggest that clinicians may feel disempowered or helpless when dealing with conditions for which there is incomplete or ineffective medicalisation (see Crowley-Matoka and True 2012; Ivry 2010). Further research is necessary on the implications of medicalisation for clinicians' experiences in diagnosing and treating conditions and how those experiences can influence the patient-provider relationship.

Literature on medicalisation has typically focused either on structural factors or individual, subjective factors. Additionally, research on medicalisation tends to align with either scientific objectivism or social constructionism (Behague 2009). Some scholars suggest that research situated within social constructionist frameworks, while yielding important insights into individual experience, separates such subjectivity from broader contextual circumstances (Butt 2002). Others argue that attention to structural factors leaves individual agency less explored. Such perspectives reflect broader conversations about the importance of exploring both micro- and macro-level contexts – subjective experiences and collective relations, local contexts as well as broader economic and political factors (e.g. Singer 1989; Taussig 1980).

Furthermore, much of the literature on medicalisation focuses on country-specific cases. A growing body of literature seeks to explore the globalisation of diagnostic categories and treatments (see, e.g. Bergey *et al.*, 2018; Conrad and Bergey 2014). Such migration raises numerous questions, including if and how a category and/or intervention is adopted, whether it is interpreted and experienced in different ways in different contexts and whether there is any resistance involved. Given the continuing expansion of medicine in the twenty-first century and

the impact of Western medical knowledge, diagnoses and interventions as part of the globalisation of biomedicine, it is likely that the dynamics of the medicalisation process will continue to evolve and be of interest to social scientists (Conrad and Bergey 2015).

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Female sexual dysfunction

Medicalising desire

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Female biological function has long figured as the focus of medicine. The womb has been held responsible for many maladies, from convulsive distempers to hysteria and psychopathy. Sydenham (1850: 56), the great classifier of disease, considered hysteria to be, next to fever, the ‘commonest’ disease of his day. Victorian society was fixated on how menstruation fragilised a particular class of society woman and restricted her engagement in physical activity and social leadership (Vertinsky 1994). George J. Engelmann (1900: 9–10), president of the American Gynecological Association, explained the tyranny of female physiology in his 1900 address to the association:

Many a young life is battered and forever crippled in the breakers of puberty if it crosses these unharmed and is not dashed to pieces on the rock of childbirth, it may still ground on the ever-recurring shallows of menstruation, and, lastly, upon the final bar of the menopause ere protection is found in the unruffled waters of the harbor beyond the reach of the sexual storms.

Sexuality and libido too have been included in this medical fixation. As one interesting example, in the late nineteenth century, a shift in cultural mores towards more overt expressions of female sexuality was reined in by psychiatrists characterising sexually assertive females as sexual predators who sought to entrap young men through their ‘uncontrolled sex impulses’ (Lunbeck 1987: 521).

These antecedents provide a foundation for modern Western medicine to exert its influence over women’s health. It persists in its fragilising metaphors of menstruation, menopause and birth; menstruation is seen as a curse, birth a trauma and menopause a burden (Martin 1997). It also underpins the framing of female sexuality in medical terms. As is well defined in the sociological literature, medicalisation is far more than simply the result of a conscious effort to bring particular conditions or phenomena under the purview of medicine. The drivers of medicalisation are increasingly positioned outside of medicine, issuing instead from the pharmaceutical and biotechnology industries and from the patient-consumer, primed by these commercial entities to consider themselves in need of medical support (Clarke *et al.* 2003; Conrad 2005).

There are a number of important points that we will make in this chapter. The first will be to identify the agents and actors involved in the medicalisation of female sexuality and the interests served by seeing libido in medical terms. Second, we will explore how the commodification of hypersexuality and discourses around female inequity contribute directly to the characterisation of low levels of sexual desire as disease. We will see how, in the context of the normalisation of female hypersexuality, the commercial interest in developing a lucrative pharmaceutical aid to female sexuality has resulted in the perfect storm for the development and promotion of female sexual dysfunction.

Medicalisation and intent

The term ‘medicalisation’ is one of a limited number of sociological terms that has found its way into the vernacular (Furedi 2006). With it comes the implication that an ordinary phenomenon has been assigned to medicine in some inappropriate manner. The use of the term surfaced in the 1970s with, initially, an anti-medicine stance. Thomas Szasz (1960) and Ivan Illich (1976) both made reference to medicalisation as medical imperialism: the conscious action by medical professionals to expand their purview. However, assuming that doctors are responsible for usurping normal life events and placing them under medical control is inadequate, if not inaccurate, for understanding the phenomenon. Zola (1972) and later Conrad (1992) theorised medicalisation on the basis, not of conscious power, but of an increasing reliance on the professional to make sense of common adversity and travails.

While it would be correct to say that the medical profession did make vigorous attempts to direct the attention of lay people towards professional doctors, as opposed to ‘non-scientific’ practitioners – both to stay healthy and when they fell ill (indeed, the first professional body uniting doctors, the American Medical Association, was based on protecting its practitioners from competition of ‘the untrained, the empirics and the quacks’ (King 1982: 1749)) – the expansion of medicine’s realm of action relies on numerous other drivers. The critical scholar should consider that more important than recognising that a particular condition has been medicalised is to identify the social forces which have pushed it to be medicalised and what interests are served by a particular phenomenon being considered as medical in nature.

Whose interests?

The interests in the medicalisation of women’s sexuality today are firmly anchored in the pharmaceutical industry. Female sexuality and its variations have been defined as medical in nature by this industry in order to define it in terms of pathology and, thereafter, to market the concomitant cure. This drive to medicalise has been anchored in the commercial success of the compound, sildenafil (marketed as *Viagra*). Sildenafil’s introduction in 1998 was characterised as the most successful market launch of a pharmaceutical product ever, with prescriptions of 10,000 pills per day (Hill and McKie 2008). Pfizer, the manufacturer of sildenafil, implemented the strategic use of the term ‘erectile dysfunction’ (in contrast to ‘impotence’) to describe the condition that sildenafil would treat. By so doing, they shifted the representation of the condition from a demoralising lack of power to a diagnosis – a medically labelled putative disease state. The diagnosis opened the way for the drug’s marketing success. Sildenafil was targeted at a very broad group of men and claims from a high-profile survey that over half of men over 40 had problems with erections (Feldman *et al.* 1994) helped to blur the distinction between normal variations in sexual response and disease.

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Numerous industry players have been working on finding a substance with as much commercial appeal for women as sildenafil has had for men. As compounds started to look potentially viable, the industry had to establish the existence of conditions for which they could serve as treatment in order to market a cure (Tiefer 2003). Low libido became the diagnosis of choice.

In 1997 and 1998, meetings were held in Cape Cod and Boston respectively to develop a consensus about female sexual dysfunction. The former included half pharmaceutical industry representatives and half clinicians and researchers, invited because of their ties with the industry (Rosen, cited in Moynihan 2003). A consensus statement to define female sexual dysfunction was developed at the latter (Moynihan 2003). This statement pressed for urgent investigation to develop new definitions of sexual dysfunction (Basson *et al.* 2000). Boehringer Ingelheim, the company working on a compound which seemed to have promise as a ‘pink *Viagra*’, funded a survey which asserted that one in ten women had low sexual desire, or ‘hypoactive sexual desire disorder’ (HSDD) (Shifren *et al.* 2008). It failed, however, to truly assess ‘dysfunction’. Items like being ‘angry about your sex life’ or ‘unhappy about your sexual relationship’ that could represent a healthy response to an abusive or non-communicative relationship were transformed into evidence of disease.

It was important to frame HSDD as a biological problem for a variety of reasons. First, as with sildenafil, it made the label more palatable to potential patients by underlining that the problem was in the woman’s body, not in her mind. And, second, divorcing sexual difficulties from a woman’s culture, relationship or previous experiences enabled the implementation of symptom-based screening tools and measurement scales which then justified treatment.

Each screening tool differed depending on which company funded its development. Procter & Gamble-funded researchers developed the *Profile of Female Sexual Function*, focusing on post-menopausal women (Rust *et al.* 2007), while a Boehringer Ingelheim-supported *Decreased Sexual Desire* screener cast a wider net (Clayton *et al.* 2009). Despite core similarities, the definition of the disorder underlying these tools shifted in line with the mechanism of action and target audience of each drug under development. For example, Boehringer Ingelheim asserted that neurotransmitters rather than hormones were pivotal in the problem of HSDD (Boehringer Ingelheim 2010), an approach shaped by their serendipitous discovery that flibanserin, a drug originally tested for use as an antidepressant, seemed to have a positive effect on female libido. Ray Moynihan (2010: 698) has described this progression:

When drugs affecting blood flow were looking like a winner, the notion that some women had an ‘insufficiency of vaginal engorgement’ had scientific currency. When testosterone was proposed, the condition was a probable hormone ‘deficiency.’ And now... we are informed that low libido is mainly due to a chemical problem inside a woman’s brain.

With these screening tools as the foundation for the promotion of HSDD as a disease, the pharmaceutical industry built an intricate campaign based on female rights and equity in order to sell a cure that they were hard at work developing. They argued that women’s sexuality had been neglected and set about convincing women themselves that this was the case.

Women deserve better

The market which big pharma was eager to exploit was anchored in the sale of sexuality in general and female hypersexuality in particular. The common display of the female body in sexually provocative and erotic postures positions hypersexuality as a female norm and, as the paragraphs which follow will illustrate, a female *right*.

Boehringer Ingelheim's application for US market approval for flibanserin was unsuccessful and the company sold the compound to Sprout Pharmaceuticals which launched a campaign entitled *Even the Score*. This campaign, whose links with, and creation by, the pharmaceutical industry were not overt, presented itself as advocating 'women's sexual health equity' (Moynihan 2014). Chaired by Susan Scanlan, a well-known advocate for women's rights, her central role was no doubt influential in the decision by many other women's groups to sign on to this campaign, adding legitimacy. Unlike other women's rights campaigns, this one focused narrowly on women's sexual equality in terms of approval of drug treatments for women's sexual problems. Claims such as '[b]iology needs to be addressed equally. Society can't keep ignoring the biology of sexual issues with women' (Even the Score 2016) and 'women deserve better' (Even the Score 2014) positioned both female sexual disorder and the imperative for heroic science to come to women's aid as redressing putative historical social wrongs inflicted upon women by medicine's lack of interest in their problems. This framing was inconsistent with long-standing feminist concerns about women's loss of autonomy through over-medicalisation (Heather and Zeldes 2008).

One remarkably bold video, a project of *Even the Score*, features sombre and straight-talking physicians detailing why women's sexuality requires more attention and support from medicine (Even the Score 2014). These pundits argue that men had been offered *Viagra* with far less robust science than was available to understand women's sexual problems. The doctors in the mini-documentary are all identified as sexual health experts, yet – unbeknownst to viewers – are also linked either to Boehringer Ingelheim or Sprout Pharmaceuticals as consultants, medical advisors or sponsored researchers. They also recruited prominent female actresses as spokeswomen, relying upon their iconographic position as sex idols, with self-reported experience of low libido. Lisa Rinna, an actress who performed in the television shows *Days of our Lives* and *Dancing with the Stars*, featured prominently on Boehringer Ingelheim's website. Perhaps more importantly, Rinna reached out to everyday women, asking them to consider if they had the same problems as she did. At the same time, doctors taking continuing medical education (CME) modules on HSDD were receiving content authored by clinicians with ties to Boehringer Ingelheim (Abel *et al.* 2009; Meixel *et al.* 2015). As Leonore Tiefer (cited in Nordrum 2015) comments, the industry 'figured out a way to game the system by providing prepared patients and making those patients available to the FDA [the US Food and Drug Administration] and the press. It was sort of one step beyond celebrity spokespeople.'

The perfect storm – or a tempest in a tea cup?

Importantly, one must recognise that the power of a diagnosis to legitimise distress is an important driver of medicalisation; the diagnosis absolves the individual of responsibility for their plight. Women experience a wide spectrum of levels of desire and it has taken a concerted effort to demonstrate that this should be considered in diagnostic terms. There is a dynamic of consumption here in which the effective manipulation of consumer need results in a diagnostic state (see Aronowitz 2008). In the case of female sexuality, the sexual female is simultaneously a commodity and a consumer. Spontaneous hypersexuality is marketed and generates a longing which is pathologised and then re-presented with its concomitant cure, similarly available as a consumer item. The pharmaceutical industry acts as 'an engine of medicalization' (Conrad 2005), transforming longing into disease. The diagnostic posture confirms the presumed ontological, already-always-there nature of the illness.

But, paradoxically, the attempt to market a medicine for women's sexual problems has also been plagued by pitfalls. Among the range of therapeutics available, sildenafil proved ineffective

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in women (Basson *et al.* 2002); the testosterone patch did little better and its market approval was denied by the FDA in the US. *Intrinsa*, a testosterone patch for women, was withdrawn from the European market in 2012 ‘for commercial reasons’ (European Medicines Agency 2012). Flibanserin was approved in the US in 2015, but sales are extremely low (Colby and Edney 2015).

We must, however, linger for a moment on the FDA approval for flibanserin. Even though the drug was rejected in 2010, 2013 and 2014 (US Food and Drug Administration 2015a) and the 2015 application included no new effectiveness studies compared with that of 2013, the FDA gave Sprout Pharmaceuticals the nod. This is paradoxical considering some of the important issues about inadequate effectiveness and safety concerns which had previously been voiced. A small added safety study on interactions with alcohol, presented in 2015, was poorly designed (a sample of 25 participants including only two women) and showed results that were less than reassuring. When used with alcohol, flibanserin caused such large drops in blood pressure of a quarter of the participants that they required medical intervention (US Food and Drug Administration 2015b). The most likely reason for flibanserin’s approval was intense pressure on the FDA from the Even the Score campaign, which characterised the FDA’s refusal to approve the drug as sexist, arguing that men had many drug treatments for sexual problems and women had none (Gellad *et al.* 2015; Woloshin and Schwartz 2016).

Flibanserin was approved despite the recommendation of the FDA’s clinical reviewers and cross-disciplinary team leader not to approve it (US Food and Drug Administration 2015b; Woloshin and Schwartz 2016). The main rationale provided by the FDA was that ‘there are no approved medications for HSDD, that the condition can cause substantial distress and have profound effects on relationships and well-being, that some women have a clinically meaningful response to treatment’ (Joffe 2015). The FDA states that around 10 per cent more women taking the 100mg per day dose than those on placebo had a meaningful benefit (US Food and Drug Administration 2015b). However, the drug’s frequent side effects of sleepiness, fatigue, dizziness and nausea would have meant that many women on the study likely guessed correctly they were on the drug (Jaspers *et al.* 2016).

Ironically, the most problematic outcome in all of the flibanserin trials was the one that the drug aims to treat: desire. The first three trials were designed to have a combined primary outcome measure of the number of satisfying sexual events that a woman had in each 28-day period and daily ‘e-diary’ recordings of her sexual desire level. For the drug to be considered more effective than placebo, it needed to do significantly better on both counts. The woman’s ‘e-diary’ asked her to record each day what her most intense level of sexual desire was, ranging from ‘no desire’ to ‘strong desire’. The stronger the recorded desire per day, the better a woman is assumed to be doing. In other words, the best score comes from a report of ‘strong desire’ on all days. In all three studies, women’s daily reports of their desire levels failed to differ significantly between the drug and placebo (US Food and Drug Administration 2015b).

These results highlight both the odd definition of ideal sexuality within these trials and the elusive nature of efficacy measures when desire – a socially and culturally charged phenomenon – is the anticipated effect. Despite these conundrums, female hypoactive sexual desire disorder provides a powerful example of the fascination with female sexuality as a matter for medical concern. What the diagnosis has also managed to forge is considerable opposition. There is not space in this chapter to explore this in depth, but it should be noted that while the pharmaceutical industry has rather cynically used women’s equality as a tool for its own purposes, its actions have generated considerable dissent. Organisations such as New View (newviewcampaign.org) and Pharmed Out (pharmedout.org) have taken powerful stances to counter the arguments that 1) low sexual urge should be seen as problematic and, even when it is, that 2) doctors and medicines should be the preferred solution. While the pursuit of pharmaceutical enhancement

of women's libido looked to place low libido under medical control for the foreseeable future, time will tell if it has, in fact, done the opposite.

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Biomedicine, neoliberalism and the pharmaceuticalisation of society

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In the Global North, the twenty-first century could be deemed an age of the ‘pharmaceutical imagination’ (Marshall 2010), constituted by two parallel processes: an increasingly rigid and narrow definition of ‘healthy’ or ‘normal’ human experience; and a growing reliance on the use of pharmaceutical products to attempt to reach a state of perceived health or normality. One of the clearest examples of this trend is in the area of psychotropic medications for the treatment of mental health conditions. Gambrill (2014) describes an explosion in psychiatric diagnoses over the past few decades, whereby behaviours previously considered to be within the expected range of human experience are now classed as mental disorders; within the same period, the use of psychotropic drugs has risen exponentially in the United States and other Western countries. In 2013, mental disorders topped the list of the most costly health conditions in the US, with spending at US\$201 billion (Roehrig 2016). Despite the arrival of a range of ‘holistic’ and ‘alternative’ paradigms in the mental health arena that have sought to explore the potential of non-drug approaches, ‘it is difficult to overstate the *central role* that drug treatment plays in modern-day psychiatry’ (Moncrieff 2008: 2, emphasis added).

This chapter discusses the connection between the success of the biomedical paradigm of mental health and the emergence of neoliberal ideology. To do so, it draws upon literature that has examined the socio-political conditions that have supported the rise of biomedical ideas about mental health (see, e.g. Beresford 2016; Cohen 2016; McWade 2016; Morrow 2013). This critical literature can be distinguished from scholarship that has discussed the rapid expansion of psychiatric diagnoses within Western contexts without reference to broader political processes. For example, Frances’s (2013) discussion of diagnostic inflation within psychiatry critiques the proliferation of psychiatric disorders in contemporary times, which has led to new forms of psychiatric intrusion into areas of everyday life previously beyond the scope of psychiatry, including childhood tantrums and grief. By calling for mental health workers to be aware of pharmaceutical influences and to re-focus resources towards more ‘traditional’ areas of psychiatry (for example, schizophrenia), his analysis offers only a partial critique of psychiatric power, which ultimately has disempowering and re-stigmatising effects for those who are left with the label of ‘real’ mental illness (Hanisch and Moulding 2011). Furthermore, while an analysis of psychiatric expansion that examines the multi-billion dollar profits of pharmaceutical corporations is extremely important, it is unable to fully capture the role played by psychiatric categorisation in

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supporting contemporary neoliberal ideology (Cohen 2016). As neoliberal societies are predicated on a commitment to unregulated and privatised economic relations, the ability to make firm distinctions between individuals who are useful to the free market and those who are not becomes very important. Within such contexts, psychiatric assessment processes which are able to name as mentally ill those who fail to perform the roles of industrious workers, amiable consumers and self-sufficient individuals clearly have the capacity to perform a key function. For this reason, it is necessary to explore the broader political context that sits behind the thriving status of mental health discourses within contemporary societies and the development of new ideas about the problems that psychotropic drugs might solve – namely, neoliberalism.

Biomedicine and neoliberal personhood

Neoliberalism, both as an ideology and a governmental policy framework, is premised on a belief in the capacity of free markets to deliver human well-being, coupled with a reduction in government expenditure and strong notions of individual responsibility (Karagkounis 2016). A preoccupation with individualism connects neoliberalism to the medical model of health, and makes the two meta-frames especially compatible (Lynch 2017). By focusing on brain-based illnesses that are said to be caused by genetic and chemical vulnerabilities, and treatable via medication, psychiatry emphasises the importance of individual functioning, while shifting attention away from broader social factors: '[i]f drugs weren't taking our attention away from social problems', states Moncrieff (cited in Hall 2016: 162), 'there might be greater resistance to economic trends that make people's lives difficult. Instead we blame individuals'.

Through utilising the language of illness, psychiatric discourse is able to sidestep the destructive effects of the social inequalities produced within late capitalism, instead constructing experiences of despair and disenchantment as evidence of disease within individuals. In recent times, the dominance of psychiatric discourse has continued to flourish, despite rigorous critique and a range of scandalous findings related to the evidence base of psychiatry – for example, mounting scientific evidence against the widespread assertion that mental illness is caused by chemical imbalances (Lacasse and Leo 2005) and the acknowledgement by critical psychiatrists that psychotropic medications do not treat mental disease, but rather change people's behaviour by causing sedation and a range of other, largely adverse effects (Moncrieff 2008). The important function played by psychiatric discourses in supporting neoliberal ideology – through disabling an awareness of social structures by replacing them with notions of disease – helps to explain how these potentially devastating controversies have caused very little damage to the social status and prevalence of psychiatric discourses within contemporary Western societies. Hence, biomedical descriptions remain firmly impressed upon everyday constructions of mental illness. For example, in their launch of the campaign Depression: Let's Talk, the World Health Organization (World Health Organization 2017, emphasis original) contends that depression is:

an illness that can happen to anybody. It causes mental anguish and affects our ability to carry out everyday tasks, with sometimes devastating consequences for relationships with family and friends. Fortunately, depression can be prevented and treated... The ultimate goal of the campaign is that more people with depression, in all countries, seek *and get* help.

Campaigns such as these situate mental illness as an under-recognised and insidious biological condition, with a medical response offering the only source of relief. Although on other occasions WHO has discussed the need to consider broader social and political contexts relating to a range of global health issues (World Health Organization 2008), within this excerpt the

discussion of social context is limited to a statement about the *effects* of mental illness on a person's life. By linking mental illness to difficulties with everyday tasks and relationships, WHO demonstrates that, within the process of assessment for mental illness, there is a noticeable link between what is deemed to constitute mental health and social norms – in this case, the capacity to be productive and to maintain stable relationships. Such norms are not neutral and timeless; rather, they are constructed as ideal traits within neoliberal societies, wherein the worth (and 'mental health') of individuals is assessed according to their capacity to contribute to the market as both workers and consumers (Esposito and Perez 2014). Productivity and sociability can be viewed as useful traits for fulfilling these roles. As summarised by Vassallo (2013: 572), '[t]he neoliberal subject is a rational competitor in the marketplace... life outcomes are treated as a matter of personal responsibility... the neoliberal subject is active, calculating, and continuously striving for betterment'.

Indeed, a cursory glance at the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) reveals that psychiatric decision-making about whether an unusual behaviour should be deemed a mental illness is commonly based on an assessment of whether it is causing impairment in 'occupational functioning'. Nevertheless, biological psychiatry draws upon the language of illness to conceal its role in perpetuating social norms and expectations. For example, Moncrieff and Middleton (2015: 264) argue of schizophrenia that it is,

a label that implies the presence of a biological disease, but no specific bodily disorder has been demonstrated... The disease model implicit in current conceptions of schizophrenia obscures the underlying functions of the mental health system: the care and containment of people who behave in distressing and disturbing ways.

It is possible, then, to analyse the role played by psychiatric discourses in identifying individuals who are non-compliant with the increasingly narrow possibilities for citizenship available within neoliberal societies. Whether non-compliance takes the form of active protest against social norms, or less obvious forms of dissent (for example, distress relating to unachievable social expectations), biomedical psychiatry offers a solution in the form of pharmaceutical regulation. As Greenberg (2010: 354) notes of depression, '[w]hy bother calling it a disease at all? Why not just say that the drugs help us to be the kind of endlessly flexible and resilient self that our culture has long demanded and leave it at that?'

In other words, mental illness classification and the prescription of pharmaceutical solutions should not be viewed as an unbiased, scientific process, but rather as a process arising within particular social contexts that elevate specific types of personhood as 'normal'. Since notions of mental illness are based on vague notions of 'disturbance', 'syndrome' and 'dysfunction' (Burstow 2015), psychiatric assessment is open to interpretation based on cultural and economic drivers which influence how 'healthy' behaviour is able to be defined. Consequently, irrationality (a cornerstone of several psychiatric diagnoses) can be viewed as grounded not only on Eurocentric ideas about 'normal' human experience, but also as directly linked to economic demands within neoliberal societies which require people to read market signals in a way that will produce profitable results (Esposito and Perez 2014). Similarly, it becomes reasonable to view mild forgetfulness in older age (the main characteristic of mild neurocognitive disorder (MND), a new addition to the latest DSM) as evidence of mental illness only within societies with shrinking welfare states that have left people with no choice but to remain endlessly marketable and productive employees into their older age. This situation is exacerbated within contemporary workplaces with accelerated work schedules that have rendered previously acceptable levels of production deficient (McGee 2012).

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The concealment of social conditions

The white, masculinist values that have long been embedded in notions of ideal personhood – and the conflation of these values with normative notions of ‘mental health’ – mean that women and a range of other socially disempowered groups have historically been at particular risk of psychiatric pathologisation (Vassallo 2013). This risk, however, is even more heightened in neoliberal societies, wherein the scope of public welfare provision has been radically reduced in an effort to reduce government public expenditure (Beresford 2016). Within such contexts, the role of social services has been transformed from the provision of comprehensive and contextualised support towards a ‘responsibilising’ paradigm. As a result, the role of social workers and other human service professionals has shifted towards the provision of prescriptive advice to service users, who are expected to take autonomous steps towards the self-management of their own welfare, regardless of their material circumstances (Liebenberg *et al.* 2013). The people who are most likely to experience difficulties in navigating through such systems are those on the margins of society, with access to the fewest social and material resources. In contemporary psychiatrised contexts, their failures are more readily explained in terms of personal dysfunction and mental illness rather than as stemming from the effects of poverty and a range of other structural inequalities. Consequently, they are left with few options other than to admit their incapacities and seek medical and pharmaceutical repair, leading to a vast over-representation of certain cultural groups (women, indigenous people, homeless people, transgender people and so on) as mental health service users (Rogers and Pilgrim 2014).

The interplay between psychiatric discourses and broader socio-political contexts remains, however, a thoroughly under-examined issue. A pertinent example of the absence of an awareness of socio-political factors within psychiatric practices is found in the disproportionate diagnosing of women in comparison to men across a plethora of psychiatric categories (including sleep disorders, mood disorders, sexual dysfunctions, personality disorders and eating disorders). Such patterns are rarely considered in terms of women’s socio-political positioning within neoliberal societies and the pathologisation of the performance of femininity, as well as ‘difficult’ women who do not acquiesce to a subordinate role within work and family contexts (Ussher 2013). Instead, sex differences in diagnostic rates have been repeatedly attributed to a neglect of men’s issues by psychiatry, along with high levels of help-seeking behaviours among women in comparison to men (see Branney and White 2008). While the effort of scholars to use this explanation to attempt to address the issue of male suicide is understandable (e.g. Blisker and White 2011), it is also necessary to acknowledge the numerous women who undergo psychiatric treatment who have not sought it (Pescosolido *et al.* 1998). Moreover, it is unlikely to be a coincidence that men (and, in particular, white men) – who occupy the most privileged and idealised identity within neoliberal contexts – are the group most likely to escape the attention of psychiatric instruction (Meerai *et al.* 2016). Meanwhile, psychiatric intrusion carries the expectation that women will engage with pharmaceutical regimes which position them as faulty individuals while masking the effects of gendered experiences of poverty, violence and discrimination. When men do come to the attention of psychiatric services, gendered pharmaceutical marketing strategies function to perpetuate masculine privilege, by imbuing notions of mental health recovery in men with sexual and social dominance (Gardner 2007).

Pharmacology and self-surveillance

As an addition to overt tactics of social control, neoliberal societies are predicated on strong notions of self-surveillance as a strategy for managing behaviours and experiences (Beresford

2016). With the erosion of collectivist approaches to welfare, self-surveillance obligations in neoliberal societies reposition individuals as managers of their own risks (O'Malley, in Garrett 2015). Psychiatric discourses play a key role in the promotion of a self-monitoring and responsible mental health service user, who actively engages in an entrepreneurial project of mental health recovery. While people diagnosed with mental illness are at risk of social exclusion and discrimination due to the perception that they lack the attributes of 'normal' citizens (Hamer *et al.* 2014), psychopharmacology offers an attractive strategy through which their behaviours might be re-shaped in order to mimic productive citizenship. Therefore, while neoliberal ideologies regulate the behaviour of citizens through the enactment of a firm distinction between 'us' and 'them' categories (which aids in the identification of citizens who are failing to live up to market demands), a liminal category is available to people labelled with an illness who accept this assessment and comply with medical instructions in order to 'correct' their limitations (Runswick-Cole 2014). In this way, although the identification of mental illness implies a deficiency, pharmaceutical modification offers an optimistic pathway through which people can reach a place of 'managed difference' (McRuer 2006). The process through which pharmaceutical engagement claims to enable people to regain their social positioning as healthy citizens is useful in explaining how a psychiatric diagnosis and the prescription of pharmacological interventions is sometimes understood by service users to be an 'empowering' experience (Bland *et al.* 2015). This optimistic response to psychiatric intervention becomes even more understandable when considering the paucity of available information on the many potential harms and risks that may be associated with taking psychotropic medication (Young *et al.* 2015).

The further expansion of mental health self-monitoring practices as a moral obligation undertaken by responsible citizens has been spurred on by mental health awareness and early intervention campaigns, which are based on the premise that mental illness is a hidden issue that could affect *anyone* (see Active Minds 2017). This notion of universality has resulted in self-surveillance strategies that are required of *all* citizens, not only those classed as already unwell. Although early intervention efforts have been widely embraced as linked to mental illness prevention and the reduction of mental illness stigma, the demands that they place upon people – to self-diagnose and to seek professional assistance early – place people at risk of a lifetime of mental health intervention and medication in response to even the slightest of aberrations (Whitaker 2010). Ironically, although mental health awareness campaigns claim to reduce the stigma of mental diversity by making it easier to discuss difference or to seek help, they are, in fact, instrumental in contributing towards the social intolerance of anyone who conceptualises their experiences outside of a biomedical framework (McWade 2016). In this way, the compulsory nature of mental health self-monitoring increases the power of psy-knowledges in everyday life, leading to a belief that nearly every human problem can be resolved through a combination of personal effort and psychopharmacology.

Concluding reflections

Discussions about the limitations of biomedical psychiatry are starting to attract increased mainstream attention. Unfortunately, the vast majority of such critiques have failed to attend to the function that neoliberal ideology has played in allowing psychiatric and pharmacological discourses to thrive and expand within contemporary Western contexts. Although the aggressive marketing tactics employed by pharmaceutical corporations should not be ignored, it is also necessary to explore how the promises of a return to 'healthy' rational and stable personhood put forward by the pharmaceutical industry are of immense benefit to the advancement of a neoliberal political agenda. An analysis of the nexus between psychopharmaceuticals and neoliberal

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discourses enables critical mental health scholars to explore the political conditions that have supported the astonishing growth of the psychopharmaceutical industry – an expansion that has occurred not as a result of increasing scientific evidence supporting a biological basis for mental illness, but *despite* such evidence.

Mental health workers are ‘trained not to notice the state’ (Rossiter 2001). Any attempt to examine the expansion of psychiatric knowledge that does not consider its political functions will be unable to recognise the important role played by psychiatry within neoliberal contexts in situating individuals as responsible for managing the effects of poverty, violence and other forms of social oppression. While the problem of mental illness over-diagnosis has become a more widely debated issue, the vast majority of these discussions have failed to attend to the political work that is performed through the process of psychiatric categorisation itself. Such insufficient analyses result in problematic suggestions, such as the need for a more ‘therapeutic’ approach within mental health services or a more optimistic view of the capacity for people to ‘thrive’ or ‘recover’ from their distress, without any connection to how this may be an impossible feat in the absence of any societal changes. Unfortunately, scholarship on the social determinants of mental health (which questions biological causation and makes some useful suggestions about the links between social inequality and the development of mental distress) does not sufficiently investigate the role of psychiatric categorisation in perpetuating neoliberal expectations within Western societies (Cohen 2016). By arguing for enhanced mental health service provision targeted towards socially marginalised groups (through, for instance, more psychiatric assessments and increased access to medications), social determinist arguments run the risk of increasing the power of psychiatric discourses to conceal social inequality through an expansion of psychopharmacological governance. Critical mental health scholars must therefore be vigilant in relation to calls for more ‘humanistic’ approaches to psychiatric service provision when these merely reproduce the same ideas about ‘dysfunctional’ or ‘unwell’ individuals which are present within a disease model of mental health, while continuing to invisibilise (or, at best, downplay) the structural inequalities produced within late capitalist societies. Identifying the macro-level political processes that underpin psychiatric assessments might seem an insurmountable goal upon first glance, as it involves mounting a case against the neoliberal fixation with classifying structural problems as individual ailments. It is, nonetheless, a necessary and urgent step in working towards more socially just responses to people who unsettle conventional notions of rational and productive personhood.

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Part IV

The politics of diagnosis

The DSM and the spectre of ignorance

Psychiatric classification as a tool of professional power

Owen Whooley

Psychiatry has long been plagued by a stubborn, inconvenient fact: the knowledge regarding the nature of mental distress remains elusive. The search for a mechanistic, aetiological understanding of mental distress, be it psychological, neurological, genetic or otherwise, has been frustrated time and time again (Grob 1998). As such, psychiatry lacks basic knowledge of its object. This ignorance risks undermining the aspirations of the profession and inducing a legitimisation crisis. A looming threat, psychiatry's ignorance is not a mere absence of knowledge. Rather, it has a palpable presence, which is redolent in psychiatric discourse, professional reforms efforts and anti-psychiatry critiques. Thus, more so than other medical specialities, psychiatrists must formulate ways to manage ignorance and mitigate its effects. Indeed, the resilience of American psychiatry over the past 150 years, despite the problems in its knowledge base, is a testament to the more or less successful strategies it has developed to domesticate its ignorance.

For the past four decades, nosological reforms have been the primary means by which American psychiatrists have staved off the effects of their ignorance and propped up their professional authority. Central to these efforts have been revisions to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), a nosological manual that defines the criteria for every recognised mental disorder by the American Psychiatric Association (APA). Mapping, categorising and defining the universe of mental distress have stood in for mechanistic, aetiological knowledge, providing a veneer of understanding and mastery where there is little. Basic conceptual problems have been translated into technical-seeming issues like reliability and measurement. Thus transformed, they become obfuscated and muted. And insofar as the DSM has become institutionalised throughout the US mental health system – and increasingly on a global scale – it is now the de facto standard classification of mental disorders, yielding legitimacy for the profession.

As the prominence and relevance of the DSM has grown, so too have the professional stakes surrounding it. While the external controversies receive extensive media coverage, less attention is paid to disputes internal to the profession, which exert a profound effect on the DSM and, by extension, prevailing understandings of mental distress. This chapter explores the recent history of the DSM to reveal the professional politics ungirding the production of the manual. To do so,

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it takes a sociological approach to the practice of classification. Classification encompasses more than the mere ‘reading’ of nature or empirical reality; it involves an array of judgements, interpretations and trade-offs among interested parties. The ‘practical politics’ of classification affect the very design and construction of classification schemas themselves (Bowker and Star 1999: 44). A sociology of classification therefore elucidates the extra-scientific social, cultural and political factors involved in the production of classification systems, as well as the effects of these on the schemas developed, which can reverberate far downstream in practice. Standardisation of classification schemas (should they occur) represents the contingent outcome of negotiations between heterogeneous actors (Timmermans and Berg 2003). Because ‘each standard and each category valorizes some point of view and silences another’ (Bowker and Star 1999: 5–6), the process of classification is deeply political. Thus, despite their often contested origins, classification schemas – couched in the trappings of objective science – can remake the world by defining its contours (Timmermans and Epstein 2010).

Insofar as the DSM has been the primary vehicle for legitimating psychiatric authority in the past four decades, any critical appraisal of contemporary psychiatry must start by interrogating psychiatric classification. The first part of this chapter discusses the revisions made with the third edition of the DSM in 1980 (the DSM-III; see American Psychiatric Association 1980), a crucial moment for the American psychiatric profession. The story of the DSM-III is well-trodden ground by historians and social scientists alike (see Decker 2013; Horwitz 2002; Kirk and Kutchins 1992). My goal is not to reproduce these accounts, but to ‘read’ the DSM as an historically emergent strategy to manage psychiatry’s long-standing ignorance. An under-appreciated innovation of the DSM-III was its role in legitimating nosological reform as a tactical means to mitigate psychiatry’s ignorance. The DSM became more than just a nosological manual; it became a vehicle of a certain way of thinking about mental distress, one that served to solidify psychiatry’s scientific credibility. After attending to the origins of this strategy, the second half of the chapter turns to the contentious revision of the DSM-5 (see American Psychiatric Association 2013), which attempted to repeat the ‘paradigm-shifting’ accomplishment of the DSM-III to no avail. The case of the DSM-5 suggests the limits of the strategy of shoring up professional prestige through nosological reform. By homing in on validity, the DSM-5 task force unintentionally drew attention to psychiatry’s ignorance, in the process compromising the reputation of the DSM and, by extension, the profession itself. DSM-5’s failure suggests that, going forward, the DSM and classification in general will assume less importance in psychiatry’s professional repertoire to manage its ignorance.

The DSM-III and the emergence of an ignorance management strategy

For most of psychiatric history, nosology was an afterthought. The first two editions, DSM-I (American Psychiatric Association 1952) and DSM-II (American Psychiatric Association 1968), were considered marginal documents, largely ignored by clinicians and used primarily to serve various bureaucratic imperatives. The DSM-III changed this. Today, it is viewed as the means by which a ‘paradigm shift’ was secured, shifting psychiatry away from a Freudian, psychoanalytic framework to a more avowedly biomedical one.

In the 1970s, psychiatry faced a professional crisis of manifold origins. Social science research revealed the unreliability of psychiatric diagnosis (e.g. Kendell *et al.* 1971; Rosenhan 1973), while emergent labelling theories depicted psychiatrists as agents of social control, pathologising deviance to legitimise its repression (e.g. Scheff 1967). This research, along with exposés of mental hospitals, fuelled a growing antipsychiatry movement, which questioned the very legitimacy of the profession.

Within the profession itself, a new generation of psychiatrists chafed under the dominance of psychoanalysts. They espoused discontent with the psychoanalytic paradigm, which, to their minds, had produced endless speculative tracts but little sound scientific research. In opposition to the dominant dynamic psychiatry derived from psychoanalysis, this group of reformers (centred at Washington University in St Louis) articulated a new direction for psychiatry. In place of psychoanalytic emphasis on theory and the individual psyche of the patient, they took their cues from Emil Kraepelin, a contemporary of Freud, to re-establish the scientific bona fides of psychiatry by wedding it to biomedical research (Blashfield 1982). These 'neo-Kraepelinians' sought to establish a 'tough-minded' research programme built on the careful classification of mental distress as disease categories (Guze 1970). Unlike their psychoanalytic counterparts – who perceived diagnosis and classification as unimportant to the goal of treating individual psyches – neo-Kraepelinians held nosology in high esteem, recognising not only its conceptual importance, but also its strategic significance as well. Seeking a means to promote their biomedical vision for psychiatry, they found it in the unlikely place of the revision to the DSM. The stated reason for revising the DSM-II in the 1970s was to coordinate efforts with the simultaneous revision of the World Health Organization's *International Classification of Diseases* (ICD), a task to which most of the profession, particularly those of a psychodynamic orientation, were indifferent. Insulated from scrutiny by this indifference, Robert Spitzer, chair of the DSM-III task force, gathered together a group of neo-Kraepelinians to radically revise the classification system. They replaced the diffuse, vague descriptions of neuroses with standardised classifications of disorders based on phenomenological symptom manifestations. This revision reconceptualised mental distress as discrete disorders, analogous to physical illnesses. The promise behind these revisions was that by creating reliable categories and standardising diagnosis, the DSM-III would facilitate biomedical research on mental disorders and align psychiatry more closely with medicine proper.

Cognisant that many psychodynamic psychiatrists would resist this reinvention, the task force, for strategic reasons, maintained that the new classification system was descriptive, atheoretical and officially agnostic towards any particular school of psychiatric thought. (That a classification system can be atheoretical is dubious; even if such theory is unarticulated and smuggled in, all classifications systems are undergirded by basic theories of the things being classified.) When psychoanalytic leaders of the profession finally learned of the proposed revisions, they belatedly mustered a protest, focusing their attention on the proposal to eliminate 'neurosis' from the manual (Bayer and Spitzer 1985). But the momentum behind the revision could not be stopped. A last-minute compromise was brokered whereby neurosis would be included in parentheses next to the new diagnostic labels of the equivalent categories, literally reducing psychoanalysis to a parenthetical in the manual. Compromise in hand, the manual was published in 1980 and immediately diffused through the mental health system. By meeting many extant interests (including those of pharmaceutical companies, insurance providers and the US Food and Drug Administration (FDA)), the DSM-III became the de facto standard classification of mental disorders in a few short years.

The shift towards a biomedical model was by no means as abrupt as conventional histories of the DSM-III hold it to be. Nor was the revision the sole cause of this reinvention of psychiatry along biomedical lines. But the DSM-III became the most public embodiment of these changes, a visible instantiation of the turn away from Freud. In the decade following its publication, critics and proponents alike began to frame the manual as a 'paradigm shift' (Compton and Guze 1995; Mayes and Horwitz 2005). Not quite a myth, not quite accurate history, this conventional narrative linked the resolution of psychiatry's crisis and its reinvigoration as a medical speciality to nosological reform. Mental distress, formerly viewed as the by-product of psycho-sexual development, emanating from intrafamilial dynamics, was ontologically remade to resemble physical

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diseases. While mental ‘disorders’ did not yet rise to the status of ‘diseases’ – the mechanisms underlying them remained opaque – the subtext of the DSM-III task force’s rhetoric was clear: they someday would be. Psychiatric expertise was repositioned away from the ambiguous realm of neuroses onto the apparently more stable ground of disease entities. They could now point to the neat DSM-III categories, systematically defined in the trappings of scientific rhetoric, in signalling their biomedical authority. The more institutionalised the DSM-III became, the more its heuristic categories became reified, their origins in expert consensus forgotten. The reformers’ biomedical model was valorised and psychiatry’s jurisdiction stabilised.

The DSM-III revision accomplished important work in domesticating and reframing psychiatry’s basic ignorance. It attributed the responsibility of this ignorance to Freud and his followers, whose unscientific, speculative discourse had led psychiatry astray. By revolutionising psychiatry’s basic thinking towards its object, the DSM-III and the ‘paradigm shift’ narrative that emerged in its wake relegated this ignorance to a dark past, creating a rupture by resetting the field’s research chronometer. Moreover, it promoted the promises of the biomedical model, projecting a future in which reliable diagnostic categories provided the foundation for a robust programme of biomedical research that would finally overcome psychiatry’s long-standing ignorance.

Thus, the most significant accomplishment of the DSM-III was not scientific but professional; having come face-to-face with its own ignorance, reformers used the DSM-III to re-establish psychiatry’s legitimacy during a time of existential crisis and fervent antipsychiatry sentiment. The lesson imparted to future generations of psychiatrists was clear: nosological reform could be a powerful professional tool. Being able to define and categorise phenomena went a long way towards creating a façade of control over, and knowledge of, those phenomena.

The DSM-5 and the pitfalls of history repeating

In *The Eighteenth Brumaire of Louis Bonaparte*, Karl Marx (1907: 5) famously argued that all great events in history occurred not once but twice, the ‘first time as tragedy, the second time as farce’. Marx’s analysis of political revolution can be extended to intellectual revolutions. Thirty years after the DSM-III revision, the DSM-5 task force tried to repeat the feat of the DSM-III, attempting to secure another paradigm shift via nosological revision. Once again confronted with psychiatry’s basic ignorance, the task force borrowed the language of ‘paradigm shift’ when laying out their ambitions for the revision. With psychiatry once again at a ‘crossroads’ (Lopez *et al.* 2007: S6), the task force sought to ‘alter the limited classification paradigm now in use’ (Kupfer *et al.* 2002: xv) and achieve changes on par with the DSM-III. It was time for a “‘radical” new taxonomic paradigm’ (Helzer 2011: 85). Yet, unlike in 1980, the DSM-5 ended in farce.

The major concern driving the DSM-III revision was the reliability of diagnoses – the extent to which diagnostic criteria would yield agreement among clinicians. But while reliability was the official target of the revision, the ultimate goal was always validity – the extent to which diagnoses describes the actually existing diseases. Reliable categories would pave the way for research elucidating a mechanistic, aetiological understanding of mental disorders, from which more valid classifications would be obtained. In contrast, the DSM-5 task force wanted to address validity head on. This decision was born of frustration with the lack of demonstrable progress in psychiatric research since the DSM-III, for which many on the task force blamed the DSM-III system itself. Pointing to problems of comorbidity, heterogeneity and reification, the task force worried that the DSM-III categories may have improperly carved nature at its joints and, as such, led researchers astray (Phillips *et al.* 2003).

The question was what would this paradigm shift look like. Initially, the task force hoped to construct new categories on the bases of research findings in neuroscience and genetic science.

However, it was quickly determined that this was premature. Once this determination was made, the task force might have discarded its pretensions of resolving validity. Instead, it doubled down, revealing the powerful allure of nosological reform as a strategy to manage and mitigate the effects of psychiatric ignorance. The task force advocated for a dimensional reconceptualisation of mental disorders as the means by which a paradigm shift would be realised.

Dimensionalisation would reconceive mental disorders as divergences on continua between normality and pathology, a difference in degree rather than kind. This marked a departure from the DSM-III categorical logic. It sought to transform the dominant understanding of mental disorders from discrete diseases – analogous to physical illness – to problems existing on a spectrum with normality. Thus committed to dimensionalisation, the question remained as to how to dimensionalise the DSM-5. After many accommodations, the task force settled on introducing dimensional logic through the inclusion of severity scales for each diagnostic category (Regier *et al.* 2011).

Even as the task force scaled down the content of its proposed revisions, it continued to invoke paradigm shift when speaking of the revision. This rhetoric raised red flags among some within the profession, particularly those involved in previous iterations of the DSM. Whereas the DSM-III revision unfolded in relative obscurity, its success rendered all subsequent revisions large-scale, high-profile events. As such, the DSM-5 task force, unlike its DSM-III predecessors, faced intense scrutiny as it proceeded to seek paradigm shift. Opposition to the revision among psychiatrists grew, led by former DSM-III and DSM-IV chairs Robert Spitzer and Allen Frances, respectively. They argued that the task force was acting rashly and prematurely, without transparency. In assessing the state of psychiatry, opponents of the DSM-5 revision process preached patience, arguing that another paradigm shift following so soon on the heels of the DSM-III was not only unnecessary, but would also backfire. Rather than mollify, such a revision would highlight psychiatry's ignorance, poisoning the reputation of the DSM and compromising the legitimacy of the profession.

This internal dispute became news fodder and unfavourable media attention focused on the revisions. Pointing to the reputational dilemmas the profession was now facing, critics of the DSM-5 task force convinced the APA Board of Trustees in 2010 to set up an independent advisory committee to review the proposals in light of their empirical justification. The resulting Scientific Review Committee (SRC) demanded existing empirical support to justify any changes (Kendler 2013). Because the empirical base of psychiatry is overwhelmingly based on the DSM-III paradigm, it was difficult – if not impossible – to find empirical research support for dramatic changes. The SRC imposed a degree of conservatism on the process, as it forced all proposals to be reconciled with the DSM-III. Those that did not were rejected, those that could not were withdrawn. No paradigm-shifting changes could meet this new bar of scrutiny. The task force's aspirations withered and, by 2011, it abandoned the rhetoric of paradigm shift. When published in 2013, the DSM-5 upheld the existing classification schema – the new edition maintained the status quo, as the categorical system of the DSM-III remained in place. The severity scales were left out of the manual altogether, aside from a couple of exemplars relegated to the appendix for things to be studied in the future.

Not only did the DSM-5 task force fail to secure a paradigm shift, by pursuing one, it also compromised the APA's status as *the* authority in defining mental distress. In response to this public failure, just mere weeks before the publication of the DSM-5, the National Institute of Mental Health (NIMH) announced that it was moving away from the DSM. It would now encourage researchers seeking its funding to eschew DSM classifications and instead adopt an alternative model of classification, Research Domain Criteria (RDoC). This decision represents a profound shift in the universe of psychiatric nosology. The era of one-manual-serves-all seems

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to be coming to an end as research interests are decoupled from clinical and bureaucratic interests. While the DSM will remain influential, its hegemony has been compromised and, with it, psychiatry's claim to expertise.

Conclusion

Given psychiatry's long-standing ignorance, as well as the previous professional success of nosological reform, the DSM-5 task force's aspiration to solve validity in a similar manner displayed a certain logic. In invoking paradigm shift, the task force set out to move beyond the DSM-III, to produce something novel and distinct that would overcome psychiatry's ignorance. Better reliability, the DSM-III's primary goal, had proven to be no panacea. The DSM-5 task force, in an effort to one-up the DSM-III, chose to target validity directly. The problem for the task force is that, without some major research breakthrough, any claims to better validity would be just that – claims. Mental disorders, in their essence, *may* be dimensional in nature and, thus, dimensional classification *might*, in fact, be more valid than DSM-III's categories, but without identifying the causal mechanisms to support this claim, one could never know for sure. Classification itself cannot adjudicate this issue.

In other words, by targeting validity, the DSM-5 task force set itself up for failure. Reliability can be established by fiat and consensus; validity cannot. If a group agrees on standardising their communal heuristics they can achieve consistency in diagnostic practice even if these heuristics are arbitrary. But validity holds 'nature' or 'reality' as its referent. Standardising diagnosis only gets one so far; it matters little if everyone agrees on diagnostic categories, if what they agree on is wrong. Thus, once the DSM-5 task force jettisoned the goal of developing a new classification from neuroscientific or genetic findings as premature, the question the revisions faced was: in reference to *what* were the new proposals valid? On what basis should one accept DSM-5 diagnoses over DSM-III or over some other schema? Without the very sort of research breakthrough that the DSM-5 itself was trying to induce, the DSM-5 task force tried to put the valid classification cart before the research horse. It turned to classification to achieve something it could not.

With the failures of the DSM-5, the usefulness of nosological revision in managing psychiatry's ignorance seems to have been exhausted. Psychiatry can only carve and recarve, define and redefine, the poorly understood universe of mental disorder so much, before outsiders begin to suspect that it is merely rearranging deck chairs. Eventually, the interpretive, extra-scientific dimensions of this strategy become evident. The DSM-III conferred scientific credibility upon psychiatry; its categorical schema presented seemingly concrete mental disorders that suggested biomedical expertise. However, any subsequent revision threatens this credibility by revealing the contingency, indeterminacy and politics undergirding psychiatric classification. The DSM-III staved off reckoning and was immeasurably important in legitimising the profession during a time of crisis. Improved diagnostic reliability brought a measure of coherence to psychiatric research, yet brought it little closer to the long-elusive understanding of mental distress. Going forward, it is evident that classification can no longer achieve the same kind of success in mitigating ignorance.

Once again, psychiatry is left to confront its long-standing ignorance, but now without a crucial tool in its repertoire for combatting it. Psychiatric classification is poised to resume a more appropriate place as an important but relatively mundane aspect of psychiatric practice, rather than the locus through which psychiatry tries to resolve its basic conceptual issues. The DSM-III bought the profession time and cooled antipsychiatry sentiment, but three decades later psychiatry finds itself no closer to resolving its fundamental ignorance and, once again, in search of a management strategy.

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The attributes of mad science

David Cohen, Tomi Gomory and Stuart A. Kirk

From psychiatry's beginnings around the late 1800s, when medical doctors entered the growing insane asylum enterprise and sought to possess it, the profession proclaimed its roots to be in medicine and its practitioners guided by medical knowledge. Psychiatry's foundational claim is that various distresses and misbehaviours are a species of bodily disease that it calls 'mental illness'. The claim has become widely accepted and remains so despite the shortcomings of the main developments psychiatry has led or joined: institutionalisation in insane asylums (1850s–1950s), induced comas, convulsive treatments and lobotomy (1920s–50s), de-institutionalisation from state hospitals into coerced and voluntary community care (1960s–80s) and, since the late 1970s, expanding the range of mental illnesses to cover half of American adults and prescribing psychoactive drugs as first response to anyone distressed or misbehaving.

As it widened its scope from a few lunatics to all of society, the psychiatric enterprise morphed into the 'mental health' enterprise, today a vital piece of the biomedical-industrial complex (Gomory *et al.* 2011). Though the enterprise includes all the different helping professions and the educational and justice systems, with contradictory schools of thought and practices, it holds firmly to the belief that the essence of mental illness lies in aberrant biology. This belief receives little, if any, empirical support from available evidence (Kirk *et al.* 2013). Often called the field's 'dirty little secret', the failure to identify any unique biological processes, signs or lesions to validate psychiatry's central claim began to be squarely acknowledged by the top US mental health authorities starting in the early 2000s (Insel 2009). Today, researchers around the world discuss the failure in detail as they ponder how to pursue the search for validation (e.g. Kapur *et al.* 2012; Zachar *et al.* 2015). Nonetheless, the belief persists and is continually asserted as a self-evident truth. Its power as a meaningful narrative for the relief/recovery/persistence of distress cannot be understated. It draws partly on deep-rooted views of dis-order as disease and disease as imbalance, and partly on more recent lay and professional discourses fuelled by pharmaceutical marketing (Cohen and Hughes 2011). Currently, no alternative narratives seem as compelling and none has multinational corporate champions. Meanwhile, in other societies the 'Americanisation of mental illness' (Watters 2010) snuffs out already weakened local vocabularies of madness. For all these reasons and others discussed ahead, the central claim equating distress with disease has consequences: it permits the American Psychiatric Association (APA) to cyclically develop, sanction and sell a recognisably invalid classification system, the *Diagnostic and Statistical Manual*

of *Mental Disorders* (DSM); it encourages organisations, researchers and clinicians to erroneously but vigorously portray non-specific behaviour-controlling psychoactive chemicals as precision medicines targeting bodily malfunctions; and it convinces mental health clinicians to use or threaten to use coercion as an integral part of ‘treatment’ for disturbing behaviour. These are some direct consequences of what we call a ‘mad science’.

Mad science pretends to explain, and to relieve, suffering and unhappiness. However, it has failed to explain them scientifically and it remains doubtful whether it relieves them effectively (Kirk *et al.* 2013). What it has done is enable several professions, in conjunction with governments and lay society, to identify and manage, as treatable mental illness, distressing and disturbing deviant behaviour of individuals within families, schools, the workplace and society generally.

The characteristics of mad science

Since the 1950s, scholars from various disciplines have challenged psychiatric claims and explanations. Is madness a medical concept (Burstow 2015; Sarbin and Mancuso 1980; Scheff 1966; Szasz 1961)? Are psychiatric treatments and institutions different from other methods of controlling and coercing those who violate laws or behave differently (Cohen 1990; Conrad and Schneider 1980; Kittrie 1971; Szasz 2007)? And, is the actual practice of psychiatry shaped more by social and moral values than guided by a preponderance of valid medical evidence (Boyle 2005; Fisher and Greenberg 1997; Kirk and Kutchins 1992; Moncrieff 2008; Ross and Pam 1995; Whitaker 2010)?

In all scientific fields, regardless of the judgement that observers may make about a field’s basic assumptions or paradigm, researchers, being fallible human beings, while working within that paradigm occasionally or regularly make errors, such as employing inadequate methodologies and misinterpreting data or reaching wrong conclusions (Ioannidis 2014). However, analysing community treatment, diagnosis and drug treatments in mental health (Kirk *et al.* 2013), we concluded that these errors of scientific work are endemic in that field. In other words, when it comes to science that seeks to understand and treat madness as a medical disorder, flagrant misinterpretations of data, avoidance of valid or rigorous designs and claims of success despite obtaining negative results or false positives are *the norm*.

A telling example lies in the assertions of the developers of the DSM since the late 1970s that explicit criteria for each diagnostic category would improve the reliability (consistency) of diagnosis and lead to breakthroughs in its scientific validation. Introducing the new approach that characterised the third edition of the DSM in 1980 (the DSM-III; American Psychiatric Association 1980), the APA used reliability studies of the manual conducted by the developers themselves as evidence that the diagnostic criteria had achieved ‘far greater’ reliability than DSM-II (American Psychiatric Association 1968), without acknowledging the impact of allegiance bias. Assertions of progress were made in a series of publications and echoed in the psychiatric literature for decades. So confident were the authors of the revised version of the third edition (the DSM-III-R; American Psychiatric Association 1987) and the subsequent fourth edition (the DSM-IV; American Psychiatric Association 1994) that no extensive new reliability studies were undertaken until just prior to the launch of the DSM-5 (American Psychiatric Association 2013) in 2013. These studies, also conducted by individuals with a personal stake in the success of DSM-5, showed no trend towards higher reliability – in fact, the opposite (see Kirk *et al.* 2015). After years of controversy about its promised paradigm-shifting features, upon its release DSM-5 was rejected by Thomas Insel (then director of the National Institute of Mental Health (NIMH)), who said it would not be used to conduct research because it lacked validity

(Insel 2013), while the head of the DSM-5 task force admitted that ‘we’re still waiting for [the promised] biomarkers’ of diagnoses (Kupfer 2013). In sum, reliability has not improved and diagnostic validity (the correspondence of DSM diagnoses with natural entities) remains weak despite 50 years of exhaustive bio-psychiatric research. Yet, none of this seems to matter to the mental health infrastructure, where the DSM remains the central organising text.

Similar distortions have occurred in clinical trials of drugs, the research centrepiece of psychiatric treatment since the 1960s. Considered the ‘gold standard’ to demonstrate effectiveness of a treatment by randomly and blindly allocating presumably similar participants to different treatment groups, the controlled trial has been corrupted beyond recognition, sometimes resembling an infomercial (Healy 2012). Durations of trials typically remain under two or three months, though drugs lose effectiveness over longer periods (Lieberman *et al.* 2005; Nierenberg *et al.* 2010; Perlis *et al.* 2006). Early responders to placebo are dropped from trials (Kirsch 2010). Inert placebos are compared to drugs with sometimes stupefying behavioural effects. Whether, as a result, the double blind (the single guarantor of the integrity of a trial) has been broken is rarely tested (Even *et al.* 2000). Many subjects undergo two consecutive abrupt drug withdrawals, with no assessment of confounding effects on any outcome. Adverse effects are typically elicited by ‘spontaneous’ reports rather than by specific questioning, and describing in publications how they are assessed takes one-tenth the space used to describe how beneficial effects are assessed (Hughes *et al.* 2016). About half of the serious adverse effects reported in early web-based clinical reports from sponsors are absent from later published articles (Hughes *et al.* 2014). Lastly, studies failing to demonstrate a drug’s superiority to placebo are more likely to remain unpublished (Turner *et al.* 2008). Despite these and many other dramatic deviations from the scientific method, even experts keenly aware of them claim the efficacy of psychiatric drugs is well founded.

No matter how meticulously conducted, all studies are human projects with human limitations. Still, profoundly flawed studies funded by the federal government are presented as breakthroughs by scientists at prestigious universities and echoed by media outlets (who almost unfailingly omit to inform readers when the findings are refuted, see Gonon *et al.* 2012). These communities praise the findings and exaggerate their significance: reliability is improved; community treatment is effective and rarely coercive; medications are safe and they work. The conclusions enter repositories of ‘evidence-based practices’ or ‘best practices’, institutionalising some of the weakest science. To be fair, the tendency to exaggerate self-servingly findings from research is also observed in medicine and in science generally (e.g. see *Business Week* 2006; Ioannidis 2014).

Major institutional arrangements shield mad science from the usual requirements of science. These enablers include the distortions of ‘big science’, the ceaseless addiction to money and power that has institutionalised conflicts of interest (Whitaker and Cosgrove 2015) and the government’s role as principal funder of the medicalisation enterprise.

Large, obstinate pursuits

Today’s headline-making studies published in the major psychiatric journals are often the products of ‘big science’: they involve sizeable teams and committees of researchers at multiple centres in different countries, who recruit large samples of patients and collect enormous amounts of data. The studies, usually funded by federal institutes and employing expensive technologies, may take ten years to plan and execute. Because of these long-term intellectual and financial efforts, the investigators, funders and outside institutional players have a significant stake in making findings – whatever they may be – appear as successful. This is the familiar ‘too big to fail’ strategy. The

wisdom or courage to label negative findings as ‘failure’ (that is, as requiring a major change in direction, new funding priorities or a new guiding paradigm altogether) may be lacking, except with hindsight (Nicholson and Ioannidis 2012).

The field of psychiatric genetics currently exemplifies big science (Sullivan 2010). The notion of a genetic cause for the extreme distress, mood states and misbehaviours labelled ‘schizophrenia’ has long pervaded psychiatric thinking. Scientifically, it rests on observations of higher concordance of schizophrenia among identical twins compared to same-sex fraternal twins (the former share 100 per cent of their inherited genetic variants from their parents, the latter, 50 per cent), in addition to family and adoption studies. Attributing the difference in concordance rates to genetic variation is only possible if one accepts the ‘equal-environment assumption’ – that despite identical twins’ much more similar appearance to others than fraternal twins’, identical twins are not treated more similarly by their environment. On this weak foundation (for critique, see Fosse *et al.* 2015; Joseph 2015), heritability coefficients have been calculated indicating that schizophrenia is highly ‘heritable’ (Sullivan *et al.* 2003). As a result, an enormous search for causal genes has gone on since the 1970s but failed to find ‘candidate’ genes that made hypothetical sense within the disease model.

Still, the search accelerated dramatically since the human genome was mapped in 2003 and, especially, since 2007 as the cost of gene sequencing dropped. The current search consists of trawling the genome with no hypothesis except the belief that genes must exist. Scores of genome-wide scans, however, have led to a ‘missing heritability’ conundrum – namely, no discovery of common genes or mutations (often called single nucleotide polymorphisms (SNPs)) that might account for the high heritability coefficients, and certainly no confirmed discoveries of genes that cause the hypothesised construct of schizophrenia (Joseph 2013). Nonetheless, the search continues, devouring huge costs and personnel, with many studies listing hundreds of authors who collaborate around the world. Their objective is only to identify *statistically significant associations* between a schizophrenia diagnosis and one or more variants within the approximately 1 per cent of the 3 billion base pairs in the human genome considered to vary between any two individuals. Even after excluding known patterns within this 1 per cent, this leaves approximately 10 million variants. Therefore, establishing statistical thresholds to rule out false positives remains an ‘open problem’ (Dudbridge and Gusnanto 2008). Subsequent studies are likely *not* to replicate previous positive findings (Charney 2013), and for each new brief positive finding, any inferred genetic effect will be extremely small, but the best face is put on any results. The largest such study as of this writing, from the Schizophrenia Working Group of the Psychiatric Genomics Consortium (2014), involved nearly 37,000 subjects diagnosed with schizophrenia and 113,000 controls. Conducting over 9 million association tests, the team reported that 108 SNPs (each of which was also present in the vast majority of controls) were statistically significantly associated with schizophrenia. The study was hailed by media around the world as a pioneering discovery, with most reports failing to mention that, taken together, the 108 mutations accounted for only 3.4 per cent of variation on a ‘liability’ scale for schizophrenia. Even setting aside the very high likelihood of false positive findings, the effect of each SNP is so small that it has zero utility for diagnosis or treatment. The Consortium has increased the sample size of schizophrenia-diagnosed subjects from 37,000 to 65,000 (R. Fosse, personal communication, 2016), which should increase the explained variance slightly, but any new SNPs will each have such infinitesimal effect size that the goal of identifying aberrant biological mechanisms will remain ever more elusive. The whole effort rests on the uncritically accepted belief that the classical twin method (developed in the early twentieth century in societies steeped in the ideology of hereditary taint) has ‘established’ that seriously disturbing behaviour *must have* a ‘genetic component’ (Joseph 2013).

Big science is an insider's game. The leading players move fluidly among positions in the major venues of psychiatric power, controlling appointments to decision-making committees, to research review panels and to journal editorial boards. Some are selected to serve on important APA committees, all the while earning money as researchers, consultants or speakers for pharmaceutical companies. Universities thrive on the large grants from the federal government, foundations and big pharma, as do the APA and other organisations such as the 'grassroots' National Alliance for Mental Illness (NAMI). These individuals and institutions, woven together by personnel, money and self-interest, share the goal to portray the vast enterprise as making significant progress to understand and treat madness. Rival scientific efforts barely gain traction because access to mainstream funding is deflected. The size and cost of the studies make them particularly apt to be reported and their (truncated) findings echoed in the media – in turn, influencing professionals and the lay public. The studies are too big to replicate except by the insiders themselves.

Some of these dynamics are also at play in smaller science. For example, academic enthusiasts of what is known in the US as assertive community treatment (ACT) made distinguished careers out of a coercive social control experiment of the 1970s intended to forcibly remove long-term incarcerated mental patients from state institutions and thrust them into the community under the guise of beneficial de-institutionalisation (Gomory *et al.* 2014). Over four decades, the researchers received federal and state funding to create ACT programmes. The same individuals designed the training manuals and tools to ensure that replications cohere to the ACT model, and evaluated their programmes for effectiveness. These insiders thus become the acknowledged experts. They sit on the consensus committees that validate their own treatments as evidence-based practices, ignoring criticism or counter evidence. All this allows them to buttress the status quo and to reinforce the judgement that they are promoting the 'correct' view of madness and its management, reassuring the public that the experts have things under control (Gomory 2013a, 2013b).

Enduring conflicts of interest

There is now a broad recognition that psychiatry and psychiatric research – the engine of mad science – is awash in money that distorts honest enquiry. Overall in medicine, about 25 per cent of practitioners take cash payments from drug and medical device companies and 65 per cent receive routine 'gifts' from them (Pear 2012). Among psychiatric leaders and researchers, the proportion is probably greater. The US Affordable Care Act now mandates all drug companies receiving funds under Medicare and Medicaid programmes to disclose all payments and gifts to doctors and other groups, allowing previously impossible analyses (e.g. DeJong *et al.* 2016; Perlis and Perlis 2016).

The research enterprise should be an arena that prizes free and open enquiry, criticism, independence of thought and unbiased research. Instead, as many have described, psychiatry has become ensnared in a thicket of distortions. In every state, big pharma's payroll includes the most prominent psychiatrists as speakers, consultants, researchers and marketers. It funds the APA and its major conferences; shapes the research agendas of scientists; censors what data may be published and when; manipulates studies to ensure positive results; pays for ghost-written articles; hides its sponsorship of spokespersons and events; forges corrupting ties with universities; attacks critics; floods the professional and public media with adverts for drugs; constrains and manipulates the FDA (and today funds most of its Division of Drug Evaluation); and ensures that expensive but ineffective drugs remain the dominant treatment in psychiatry as they are sought by millions of people (Healy 2012; Jureidini *et al.* 2016). At the cost of dozens of billions

of dollars, big pharma and its allies in the biomedical-industrial complex finance mad science and virtually own a profession (Cosgrove and Wheeler 2013). The entanglement of researchers and clinicians in financial conflicts of interest means that the interests and welfare of consumers and the public are neglected (Whitaker and Cosgrove 2015).

Mad science and the therapeutic state

The preceding sections hint at the bureaucratic and administrative arrangements that employ the classifications, inferences and technologies of the mental health system. These arrangements are simultaneously guided by, and contribute to, mad science. For instance, in the US the federal government's size, power, influence and need for medically sanctioned coercion for controlling troubling (but mostly non-criminal) social dependents, make it the number one funder of mad science as buyer of big pharma's products. The federal Medicare and Medicaid programmes for older adults, the disabled and poor purchase more than US\$100 billion a year of drugs and devices (Pear 2012). With regard to the biomedicalisation of human distress and suffering, the pharmaceutical industry and the federal government function as corporate partners.

The federal government collaborates with the APA on many fronts, serves as shaper and patron of psychiatric research via the NIMH and occasionally utilises the myth-enhancing DSM in its proclamations. Moreover, through regulation and funding of medical and social services in conjunction with the states, and through its public health policies identifying mental health goals, it has sanctioned and institutionalised the disease model of madness. Through policies governing Medicaid, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) and, more recently, mandating both public and private health insurance programmes to offer 'parity' coverage for the mentally ill, the federal government has provided financial incentives to states, hospitals, clinics and providers of human services to interpret distress and inequality as symptoms of brain disease. The rise in rates of mental disability for adults is striking – 250 per cent for adults and no less than 3,500 per cent for children, between 1987 and 2007 (Angell 2011). The offer of insurance coverage for psychiatric help and cash supplements for those in poverty if they are 'disabled' is seductive and exploited by all players in the system (Samuelson 2012).

In California, many low-income people must meet 'medical necessity criteria' (that is, be diagnosed with a mental disorder that leads to functional impairments) in order to receive supports such as housing and personal or family counselling. During the 'great recession' of the late 2000s, the economy stalled, unemployment increased and wages for middle-class families stagnated, record numbers of families lost their homes and non-profits and local and state governments sharply cut services. As a result, millions of adults and children living in relatively precarious circumstances to begin with were under enormous social stress. This stress did not result from brain defects but from defects in economic and social policies. Desperately needing relief and assistance, many of these people were directed to social workers and mental health clinicians who could justify offering help professionally only by first diagnosing them with some form of mental disability or mental disorder to procure payment for the services.

The mechanisms for creating and increasing perceived mental disability are the focus of much of our book *Mad Science* (Kirk *et al.* 2013): confusing the mental illness metaphor with reality, accepting brain disease as the ultimate cause of human misery *sans* evidence, reifying arbitrary DSM categories, sustaining the illusion that safe and effective medications are available and enlisting auxiliary helping professions into the mental health enterprise (Cohen 2010). The government has become a willing full partner in the effort to medicalise human problems and consequently manage an entire socially dependent group whose members cannot – by definition,

not by fact – help their mad behaviour and therefore need a massive bureaucratic infrastructure to care for them.

The troubling conclusion

The interlocking directorate of mental health (government, health corporations, professional associations, academic institutions, organisations uncritically if profitably providing aid, family associations and compliant ‘clients’ themselves) has been achieved. Disease as explanation for troubled behaviour seems just right, and offers a simple and easy to implement solution – control and medicate. Calling the trouble ‘mental illness’ and ‘mental health’ makes it a health care/public health issue, subsidises clinicians and removes much of the financial burdens from the clients. Everyone appears to benefit though treatment options are limited, no validated disease exists and no epidemiological data demonstrates that the incidence or prevalence of mental disorder has been reduced – only the opposite.

Science and the scientific enterprise in mental health have been debased. This has engendered a dogmatic belief system that rests on the usage of indefinable terms like ‘mental illness’ and ‘mental health’ and, thus, can be shaped to fit any current point of view. A multidisciplinary academic tsunami will be required to evolve beyond the medical model and address deeply troubling behaviours and mood states non-medically. Concerned individuals and groups need to reclaim a true science of behaviour that relies on human and social sciences (anthropology, archaeology, economics, ethics, history, law, philosophy, psychology and sociology), with medicine serving as a legitimate but adjunct domain of explanation. Nothing short of an intellectual counter-insurgency needs to be deployed, spearheaded by a massive dosage of critical thinking to better address the tragedies of human existence.

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Racialisation of the schizophrenia diagnosis

Suman Fernando

The term ‘race’ appears to have entered the English language in the early sixteenth century to indicate lineage (Banton 1998). Later, a vague racial awareness of people in Europe (for example, of Jews and Muslims as a special type of ‘other’) evolved into the modern conception of race with the rise of European power and its conquest of the Americas (Omi and Winant 2015). Major figures during the (European) ‘Enlightenment’, such as Hegel, Kant, Hume and Locke, expounded what today would be called racist views (see Eze 1997); and a pattern of ‘race thinking’ (Barzun 1965: ix) linked to *racism* was to engulf Western civilisation from then onwards (Omi and Winant 2015). Since the United Nations Educational, Scientific and Cultural Organization (UNESCO) (1950) declaration of 1950 (*The Race Question*), sociological theories of race have found favour. ‘Race’ is now seen as a social concept ‘that signifies and symbolizes social conflict and interests by referring to different types of human bodies’ (Omi and Winant 2015: 110); and the concept of ‘racialisation’ has developed, meaning that various groups of people are structured as ‘races’ in the manner that Europeans identified the people they enslaved and colonised as racially different. More recently, the ‘racialisation’ term has been applied not just to groups of people but to particular activities carried out by people. Thus we speak of the racialisation of identity whereby one’s identity is determined (at least in part) by the notion of ‘race’; or of citizenship or belonging where the group one belongs to is seen in terms of ‘race’; or (as in this chapter) when the process of making a diagnosis is determined wholly (or to a large extent) by notions of ‘race’.

Psychiatry and clinical psychology (the ‘psy-disciplines’) developed in the context of post-Enlightenment thinking in Europe during the seventeenth and eighteenth centuries; a feature of both – but more emphatic in psychiatry and so often seen as belonging to psychiatry – is the process of making ‘diagnoses’ as a short-hand way of conceptualising problems of individual thinking, feeling and behaving (for discussion, see Fernando 2010: 48–60). The validity of many psychiatric diagnoses has been questioned (Bentall 2010; Thomas 2014), but it has been argued that it is their medical utility, rather than scientific validity, that justifies the continuing use of diagnoses to denote psychiatric illnesses/disorders (Kendell and Jablensky 2003) and enables their acceptance by society at large. In my view (discussed in Fernando 2010, 2014), psychiatry is better regarded as a socio-cultural system than a medical one; and the system of diagnosis has continued, not for medical reasons but rather socio-political ones. This is best

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exemplified by what has happened to the diagnosis called 'schizophrenia' during the 100 or so years of its existence.

Social construction of psychiatric diagnoses

The philosopher Ian Hacking (1999: 35) argues that it may be liberating 'to realize that something [say, a psychiatric diagnosis] is constructed and is not part of the nature of things, of people, or human society', but what this actually means has to be worked out in any given instance. In the case of 'madness', there is a tension between what is 'real' and what is 'constructed', so it is necessary to negotiate and renegotiate constantly our notion of reality when describing a particular type of madness – for example, schizophrenia. The influence of social forces in the construction of commonly diagnosed categories of mental disorder is not always easy to discern. Political, social and ideological pressures current in society at the time an illness category is first conceptualised are important, but categories do not remain static. For example, homosexuality as a mental illness category disappeared as the psychiatric community became better acquainted with human rights principles; and the illness of black slaves who absconded – drapetomania (Cartwright 2004) – lost credibility once slavery was legally abolished in the US.

Psychiatric diagnoses carry their own special images which may connect up with other images derived from (say) tradition, public media or just 'common sense'. Thus, in the context of Britain in the 1980s – where public images associated 'race' with drug abuse and, therefore, the anger of black youth was attributed to their use of cannabis (Imlah 1985) – the diagnosis of 'cannabis psychosis' arose and was given almost exclusively to black African-Caribbean people (McGovern and Cope 1987). Depression has a long history as an illness category in European culture, going back to the time of Hippocrates (Zilborg 1941). A critical analysis of its more recent history in the psy-disciplines reflects wider issues. For example, Carothers (1953: 148) – one of the many white psychiatrists who claimed that depression was rare among black Africans – attributed his observations to the absence of a 'sense of responsibility' among black Africans. Raymond Prince (1968) notes that, although depression as an illness was reported as uncommon among Africans well into the 1950s, papers began to appear from the time that Ghana achieved its independence in 1957 reporting that depression was not, in fact, rare but common among Africans. In my view, depression was found to be rare among Africans when they were seen as a dependent colonial people (lacking a sense of responsibility), but, once African countries became independent, that particular stereotype lessened in popularity and the syndrome of depression began to be recognised.

In addition to pressures arising from the context in which diagnoses are made, the diagnostic process is affected by many factors totally outside the medical or psychological during the recognition and evaluation of symptoms of psychopathology – and stereotypes play a big part here. American stereotypes of the patient who is perceived as 'non-Western', usually on the basis of colour, are described by Sabshin *et al.* (1970: 788) as: 'hostile and not motivated for treatment, having primitive character structure, not psychologically minded, and impulse-ridden'. Similar stereotypes prevail in Britain derived from Britain's colonial past – for example, the notion of the compliant but stupid Asian woman or the feckless and irresponsible African-Caribbean (Brent Community Health Council 1981). The images of black people as lacking the capacity for insight or for 'somatising' their psychological feelings (reinforced perhaps by their reluctance to divulge these to white therapists), may result in psychotherapists being less likely to accept them for 'talking therapies'. The influence of the 'big, black and dangerous' stereotype in determining diagnosis and treatment in British forensic psychiatry was highlighted in a report of an inquiry into the deaths of three black men in a forensic hospital in the early 1990s (Special Hospitals

Service Authority 1993); and the perceived dangerousness of black people may lead to the excessive use of seclusion or high levels of medication. Thus, it is in diverse ways, often peculiar to the particular society or situation concerned, that racism affects the way that mental disorder is conceptualised – that is, its social construction.

Construction of ‘dementia praecox’ and ‘schizophrenia’ as illness

Post-Enlightenment thinking in the psy-disciplines as they developed in Europe during the nineteenth century was strongly influenced by two main concepts – ‘degeneration’ as a basis for understanding poverty, lunacy and racial inferiority; and the idea of the ‘born criminal’ derived from the scientific study of crime. The former was dominated by Bénédict-Augustin Morel (1852, 1857) and the latter by Cesare Lombroso (1871, 1911), who focused on studying the apparent ‘racial’ variation in the nature of human beings across Italy from north to south. According to Daniel Pick (1989: 50–1), ‘[m]adness for Morel and many of his colleagues could not necessarily be seen or heard, but it lurked in the body, incubated by the parents and visited upon the children’; it was not primarily a theory of madness alone but one which was linked to crime, insanity and race. Also, Pick points out that the concept of degeneration must primarily be understood within the language of racist imperialism in the social and political context of nineteenth-century Europe.

On the whole, French theoreticians internalised degeneration as representing lesions in the brain or the mind, but Lombroso (who believed firmly that the white races represented the triumph of the human species) felt that ‘inside the triumphant whiteness, there remained a certain blackness’ (Pick 1989: 126), implying that degeneration could be located in ‘the other’ – the criminal, the insane and a hierarchy of races that harboured ‘blackness’. The underlying thesis inherent in the concept of degeneration – one later taken up by German biomedical psychiatry and the eugenics of European psychology – was that social conflict, aggression, insanity and criminality were all signs of individual pathology representing a reversal to a racially primitive stage of development, either mentally or physically or both. Although, by the start of the nineteenth century, Europe had experienced economic progress for 200 years, there was a sense of insecurity with regard to the increasing crime rates and the apparent failure to contain the dangers from criminality and insanity. Of this situation, Pick (1989: 11) remarks that, ‘[e]volutionary scientists, criminal anthropologists and medical psychiatrists confronted themselves with the apparent paradox that civilisation, science and economic progress might be the catalyst of, as much as the defence against, physical and social pathology’.

To get a closer grasp of how dementia praecox and schizophrenia came about we need to go even further back to the period immediately after the French revolution, to the early days of what we now call ‘psychiatry’. In the early times of the asylum era, insanity was seen as a reflection of ‘mental alienation’ and the practitioners of psychiatry were called ‘alienists’ (Shorter 1997: 17). At the end of the seventeenth century, a French physician, Philippe Pinel (2010), inspired by ideas of the French revolution, published observations on asylum inmates, calling insanity *démence* (Gottesman 1991: 6) and recommending *traitement moral*. The latter, a term accurately translated into English as ‘psychological treatment’, though it became known in anglo-countries as ‘moral treatment’, invoking a ‘connotation of moralising which the French does not convey’ (Weiner 1992: 727). According to Davidson *et al.* (2010) the moral treatment practised in Victorian England and the US was significantly different to the *traitement moral* devised by Pinel. Fifty years later, Bénédict-Augustin Morel (1852) suggested that some adolescents may have a condition similar to ‘dementia’ which he termed *démence précoce* (literally, a precocious form of dementia). Then, towards the end of the nineteenth century, Emil Kraepelin – foremost among European alienists – adopted

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Morel's diagnostic term to describe a specific illness category, dementia praecox (Kraepelin 1896). Kraepelin saw it as a biologically determined illness generated by organic lesions or faulty metabolism (Metzl 2009), clearly not the way Morel would have preferred. But Swiss psychiatrist Paul Eugen Bleuler (1911) published a very different interpretation of what Kraepelin's dementia praecox patients may have suffered from, postulating a loosening of associations in the mind due to a split (*schizo*) in the psyche (*phrene*), therefore renaming the illness 'schizophrenia'.

Arriving in the US in the 1910s during the post-slavery (so-called 'Jim Crow') era of government-sanctioned racial oppression, the Kraepelinian model of dementia praecox, 'with an emphasis on brain biology fit[ted] easily into existing beliefs that "Negroes" were biologically unfit for freedom' (Metzl 2009: 29–30) and with other racist ideas about black people that characterised plantation slavery in the country. Further, at the time, 'marginalisation' (see Stonequist 1937) was a popular idea in the US to explain social exclusion, crime and poverty (all of which applied disproportionately to black Americans), much as 'degeneration' had been in Europe when dementia praecox was first postulated as an illness (see discussion above). Reformulated by Bleuler as a disorder of personality (rather than biology), when schizophrenia arrived in the US in the late 1920s and 1930s it was linked to mainstream populations of mainly white people. For many years after that, 'American physicians and the general public associated dementia praecox with the [mainly black] marginalized, and schizophrenia with the [white] mainstream' (Metzl 2009: 29–30). Dementia praecox was associated with crime and violence, while schizophrenia was depicted as a disease of white male genius, of 'sensitive people', or of people suffering psychological trauma, reflecting the notion of the Freudian conscious/unconscious binary of psychoanalysis.

Studies of diagnostic patterns in New York and London (Cooper *et al.* 1972), carried out in the 1960s, found that people diagnosed in the UK as suffering from mania or types of neurosis would be diagnosed as suffering schizophrenia in the US. Although one study suggested that in both 'London and in New York there was a highly significant ($p < 0.005$) excess of black patients with hospital diagnoses of schizophrenia' (Cooper *et al.* 1972: 107), no firm conclusions could be drawn on the role played by 'race' in diagnostic processes since the subjects in the studies were predominantly white. There is very little available information on what diagnoses were applied to the vast numbers of black people incarcerated in prisons and asylums, especially in the southern states of the US (Dietrich 2014; Jackson, n. d.). According to Metzl (2009: 54–5), case notes at Ionia State Hospital in Michigan (a northern state) written in the 1940s and 1950s showed that black patients, who today would be seen as suffering schizophrenia, were merely described as being 'paranoid', 'dangerous' and 'psychopathic' or suffering 'moral imbecility' – an apparent resistance to giving black people the schizophrenia diagnosis. However, from the 1960s onwards, 'patients described by doctors as African American, paranoid, delusional, and violent had disproportionately high chances of being diagnosed with schizophrenia' (Metzl 2009: 57). Also, according to Metzl, articles in American psychiatric journals 'applied language connoting aggression and hostility to African Americans during the 1960s and 1970s... [and] doctors and researchers... diagnose[d] the category of black under the rubric of the category of schizophrenia' (2009: 106). In conclusion, Metzl (2009: 109) argues from his research that, 'in addition to the diagnosis schizophrenia becoming racialized [in the 1970s and 1980s] it also became a complex metaphor for race'.

Conclusions

French sociologist Robert Castel (1985: 252, emphasis original) argues that the system of psychiatric knowledge, being,

uncertain of its foundations... [and having] a weak autonomy in relation to other systems of interpretation... is *permeable to non-medical norms*, and ready to reinterpret within the framework of an extra-medical synthesis, representations which have no theoretical relation with medically founded knowledge.

What Castel calls 'representations' are the dominant socio-political values of society in which psychiatry functions. In the case of schizophrenia, these would be the values when the diagnosis was first derived. But diagnoses such as schizophrenia, with a large element of social construction, cannot remain static as societies change; and so schizophrenia has changed over the years as the dominant socio-political context has changed, in line with its political function in society – the sort of social control that the power of 'the state' needs to enforce – and the images implied by the diagnosis. Foucault (1988: 180) argues that 'psychiatrists are the functionaries of social order' and goes on to give as an example how psychiatry was used in the USSR to incarcerate political dissidents – described in the West (Bloch and Reddaway 1984) as the 'abuse of psychiatry', but in reality its *use* (not abuse), 'its true context, its destiny' (Foucault, 1988: 180–1). The groups that psychiatry oppresses in this way (through diagnosis) would be derived from the dominant socio-political context in which it functions – it is not a matter of psychiatrists choosing which groups to control or oppress or even being aware that they are fulfilling a social control function.

The 1960s was the time of civil unrest and the civil rights movement in the US, raising the spectre of black rage (Grier and Cobbs 1992). In the UK, increasing discontent among black people led to 'race riots' (Home Office 1981). Drugs marketed as 'treatments' for schizophrenia arrived during the 'medication revolution' of the 1970s and 1980s (Fernando 2014: 83–9). When the psychiatric system was faced with diagnosing people admitted to institutions under psychiatric aegis – often because they were unsettling the social system and appearing to be hostile and angry – the diagnosis that fitted the situation was schizophrenia. Metzl (2009: 103, emphasis original) describes how marketing campaigns 'played on doctors' racial anxieties in order to promote antipsychotic medication as treatment for clinical and social pathologies'. He shows (with photographs) how advertisements in the *American Journal of Psychiatry* portrayed African tribal masks and that an academic paper published in a reputable journal connected African themes with black psychosis, claiming that black protest may be presenting as psychosis (see Bromberg and Simon 1968). Schizophrenia had, in a very real sense, become racialised while acting as a means of social control. In the USSR of the 1960s, the so-called 'abuse of psychiatry' (see above) was a process for controlling political dissidents who were seen as a threat to the stability of the state. The racialisation of schizophrenia has allowed a similar situation to occur in both the US and the UK with respect to black people.

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Part V

Colonial and global psychiatry

The mad are like savages and the savages are mad

Psychopolitics and the coloniality of the psy

China Mills

In many different parts of the world, at different times, psychiatry has been a tool in the coloniser's box of techniques; differently, although sometimes simultaneously, employed to control, pacify or eliminate indigenous, colonised and/or enslaved peoples. A key role that psychiatry has played as a tool of colonialism is in the reconfiguration of resistance as individual pathology or madness, foreclosing structural analysis of dissent as underpinned by racial and colonial logics. This chapter emerges from the uncomfortable question of whether psychiatry (and the disciplines of the psy) can be both a tool of more traditional colonialism and a form of colonialism itself, and explores the continued coloniality of psychiatrisation. The discussion traces the inter-lacing histories of colonialism and psychiatry and their co-constitutive metaphors of savagery and madness, in order to think through what this means for current forms of global psychiatrisation and for the development of psychopolitical and epistemologically diverse alternatives.

Global psychiatrisation and colonial logics

A number of critiques of global psychiatrisation draw on its similarities to, or enacting of, colonialism. By global psychiatrisation, I am referring to advocacy by the World Health Organization (WHO), national governments and the Movement for Global Mental Health (MGMH) 'to scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries' (Lancet Global Mental Health Group 2007: 87); to the use of psy-expertise from the Global North within humanitarian responses within the Global South (Pupavac 2002); and to the work of many non-governmental organisations (NGOs) within countries of the Global South that act as capillary channels for the export of psy-expertise and psychopharmaceuticals (Mills 2014). While the term 'psychiatrisation' is used in this chapter, the globalisation of psy-expertise and therapeutic culture should not be overlooked.

Critics of global psychiatrisation mobilise colonialism and imperialism in numerous ways. Summerfield (2012: 7), in his critique of global mental health, refers to historical imperialism: '[p]sychiatric universalism risks being imperialistic, reminding us of the colonial era when what was presented to indigenous peoples was that there were different types of knowledge, and that theirs were second rate'. Summerfield cites examples of the way that much research (and also the work of some NGOs) assumes that populations of the Global South

have ‘limited’ and ‘unscientific’ knowledge of mental distress as ‘illness’, and need to be educated through mental health literacy campaigns. While ‘psychiatric universalism risks being imperialistic’ (Summerfield 2012: 7), it was colonial psychiatry that contributed to the universalising of ‘mental illness’. The colonial dilemma of whether the colonised were ‘civilised’ enough to experience madness was resolved with the medicalisation of madness through psychiatry during the second half of the nineteenth century, when social and colonial problems came to be ‘construed in the allegedly impartial technical idioms of medical science’ (Ernst 1997: 166). This German–British biological approach, developed in part through the ‘father of schizophrenia’ Emil Kraepelin’s trips to colonial Java to examine the ‘natives’ (Jilek 1995), assumed the universality of mental illness globally. At the same time, Joseph states that ‘the rise of the technologies of psychotherapy in Europe were crucial to the success of the colonial enterprise and were dependent on racial and ableist hierarchies’ (2015: 1038; Metzl 2009; Roman *et al.* 2009). Thus, psychiatry and colonialism were co-constitutive.

For Pupavac (2002: 494), the therapeutic paradigm taken up by humanitarian organisations that frame refugees as psychologically damaged and pathological (in Kosovo and elsewhere), constitutes ‘an international protectorate whose remit encompasses the supervision of the psychological state of the population [and] entails a far more extensive and intrusive foreign presence than past colonial administrations’. Similarly, for Fernando (2010: 115), the export of psychiatry to the Global South marks a form of psychiatric imperialism that is ‘less obvious’ than military domination, ‘but no less powerful and as destructive to the vast majority of people in the world’. Thomas *et al.* (2005: 27–8) ‘regard the globalisation of biomedical psychiatry as a form of neo-colonialism; it involves the imposition of western values, customs and practices on non-western cultures’. Whereas, for Moncrieff (2007: 192), it is psychiatry that provides the networks for the pharmaceutical ‘industry to colonize more and more areas of modern life in order to expand the market for psychotropic drugs’.

Mills (2014) reads global mental health as a colonial discourse in that it overlooks the political economy of distress through reconfiguring economic and social crises as individual ‘illness’ amenable to individualised forms of ‘treatment’. Summarising critiques of global mental health, Bemme and D’souza (2012) describe how it has been criticised for acting ‘as a top-down, imperial project exporting Western illness categories and treatments that would ultimately replace diverse cultural environments for interpreting mental health’. Some critics mobilise colonialism to explore psychiatry within postcolonial landscapes. Ibrahim (2014) points to the colonial legacy of psychiatric facilities and mental health legislation in Kenya, while Akomolafe (2012) stresses the need to de-colonise understandings of ‘mental illness’ and healing in Nigeria (see also Heaton 2013). Davar (2014) and Siddiqui (2016) map how psychiatry is used to discredit and ‘make vanish’ local, traditional and indigenous forms of healing in India, a process that parallels colonial practices of outlawing indigenous healing systems (although it is worth noting that this is a process that does not pass without resistance).

Other critics trace the interlinking of psychiatry and colonialism in contemporary settler colonies. Roman *et al.* (2009: 19) discuss the ‘medicalised colonialism’ of the First Nations people of Canada, where ‘[c]olonial Western psychiatry and medical professions have been used to advance colonial nation-building and the very definition of civil society – its boundaries between the so-called “fit” and “unfit” citizens’. Cohen (2014: 319) explores how a crisis in colonial hegemony in Aotearoa New Zealand, between the 1960s and 1980s, ‘led to an increased need for colonial psychiatry to pathologize a politically conscious Māori population’, thus mobilising psychiatry ‘as a site of colonial power’. Writing of the current occupation of Palestine, Shalhoub-Kevorkian (2014: 2) explains that, with the inclusion of Palestinian suffering into global humanitarian discourse, it has been ‘apoliticized, individualized, and psychologized. This shift toward individual,

psychological pain masks its collective underpinning, which is promoted by a racial logic of elimination and dispossession.'

Madness and savagery as metaphor: 'they do not now nor have they ever existed without one another'

Some of the above critiques make reference to the ways that psychiatry works as a site of colonial power, or works in similar ways to colonialism in the pathologisation and individualisation of resistance and suffering. Other critiques (above) draw direct comparisons between colonialism and psychiatrisation, where psychiatry is either framed as being 'like' colonialism or as being a form of colonialism. To speak of global psychiatrisation as colonialism is to use colonialism as a metaphor. This is a move that the 'Mad People of Color' manifesto warns against, stating that '[w]hite people's experiences of psychiatry are not "like colonialism"'. Colonialism is like colonialism' (Gorman *et al.* 2013: 27). Colonialism, in this argument, should not be used as a metaphor for other forms of oppression (e.g. psychiatric oppression) because colonialism has specific meanings, which can be evaded if turned into a metaphor. In saying that all who are psychiatrised are simultaneously colonised marginalises the realities of those populations who have experienced both colonisation and psychiatrisation. Furthermore, these evasions constitute "settler moves to innocence", that problematically attempt to reconcile settler guilt and complicity, and rescue settler futurity' (Tuck and Yang 2012: 1). Similarly, Fanon maintained that 'the colonial environment is like no other', that it is an unprecedented situation marked by extreme asymmetries of power (cited in Hook 2004: 11). Thus, Vaughan (1993: 54) questions, '[w]hat, if anything, distinguishes colonial forms of domination from other forms of domination?'

For Tuck and Yang (2012), de-colonisation is distinct and always unsettling because it brings about repatriation of indigenous lives and lands, through recognition of sovereignty. Thus, while there are similarities with other movements for social justice and other forms of resistance to oppression in many guises, there is something specific about colonisation and de-colonisation that may be, to some extent, incommensurable with other movements. Yet, we must be careful here not to slip into a portrayal of colonialism as only one thing. While countries and peoples who have been colonised may share much in common, colonialism has not been the same the world over; neo-colonialism may look different in, for example, India than in a current settler colony such as Canada.

Furthermore, while it may be problematic to use colonialism as a metaphor to describe psychiatrisation – in a way that collapses the two together – it is relevant to trace how both colonialism and psychiatrisation are deeply historically implicated, co-constituted and mutually reinforcing. A key method of mutual reinforcement within both psychiatry and colonialism has been the use of both madness and colonisation as metaphors.

The dominance of evolutionary explanations of colonialism and madness drew comparison between primitivity and psychopathology, comparing 'psychotic patients' with 'primitive people' and framing social and racially coded hierarchies as biological (Heinz 1998). The dog-eared textbooks of psychology and psychiatry are full of parallels drawn between colonised peoples ('savages', 'primitive peoples') and people with 'mental illness'. In his article from 1865, 'Hereditary Talent and Character' (hailed as marking the beginning of modern British psychology), Francis Galton said that European 'civilised races' alone possessed the 'instinct of continuous steady labour', while non-European 'savages' showed an 'innate wild untameable restlessness' (cited in Fernando 1988: 19). In 1951, J. C. Carothers, a psychiatrist in Kenya, said there was 'a resemblance between the African and the leucotomized [lobotomised] European' (Fernando 1988: 26). For Bleuler, the African's denial of theft is like autism (in Heinz 1998); for Lewis, the non-European

is mentally degenerate (in Fernando 2004); and for Freud (2001: 187), there are many points of agreement between the mental life of savages and neurotics, although we must not 'let ourselves be influenced too far in our judgement of primitive men by the analogy of neurotics'.

Thus, disease can both be a metaphor and a condition (Marks 1997): '[i]llness is a powerful political metaphor, and the abusive use of terms like "mad" or "retarded" a common way of discrediting individuals or societies to whom we are opposed' (Littlewood 1993: 257). Here we see madness and savagery being used sometimes as metaphor and sometimes as analogies for each other. This distinction may be important because while analogy says something is 'like' something else – allowing a distinction to be drawn between two concepts – metaphor enables us to understand and experience one kind of thing in terms of another. Understanding something through metaphor can hide aspects of a concept that are not consistent with that metaphor (Lakoff and Johnson 1980). In the 'imagined analogies' of madness and savagery, the psychotic labours under the analogy of the 'primitive' (Heinz 1998: 434) and the primitive are understood as mad, with mental asylums in the colonies justified as being 'citadels of European progress – symbolic strongholds of Western reason standing up against the maddening abyss of Eastern irrationality' (Ernst 1997: 172).

More than discursive comparison, the use of madness and primitivity/savagery as mutually constituting metaphors enabled psychiatrists to use 'techniques of exclusion and extermination developed in the colonies' on their patients (Heinz 1998). For example, the interlacing logics of eugenics and white supremacy can be seen in the fact that concentration camps were refined in colonial Namibia before being used in Nazi Germany; in Germany it was 'insane' and disabled people who first experienced forced sterilisation and extermination (see, e.g. Cohen 2016: 180–1).

While we might resist, with Tuck and Yang (2012), using de-colonisation as a metaphor, it seems that woven into both colonisation and psychiatry are metaphors and analogies of madness and savagery. And so psychiatrisation was shaped by the form that colonialism took and the formations of colonialism relied in part on the tools and models of psychiatry. Shula Marks (1997) asks: 'what is colonial about colonial medicine?' A question we might similarly ask of colonial psychiatry: what makes it colonial? Yet this question overlooks historical evidence that psychiatry has always been colonial. Instead of only demarcating colonial psychiatry (psychiatry practised in colonised countries) as a specific category, we might draw upon the ways that psychiatry was used as a tool of colonialism to better understand the continued coloniality of psychiatry. Global coloniality, which continues after the end of formal colonialism – sometimes invisibly – in the current 'modern/colonial capitalist/patriarchal world system' (Grosfoguel 2010: 73) may be a useful concept here. Coloniality refers to '[l]ong-standing patterns of power that emerged as a result of colonialism, but that define culture, labour, intersubjectivity relations and knowledge production well beyond the strict limits of colonial administrations. Thus, coloniality survives colonialism' (Maldonado-Torres 2007: 243).

To say that psychiatry is 'like' colonialism is to use colonialism as analogy, not metaphor. While there is resistance to using analogy in this way, in fact, psychiatry may be 'like' colonialism because 1) psychiatry has been constituted through colonialism and so has always been a colonial practice and 2) psychiatry and colonialism (even when seemingly operating apart from one another) use similar tools (objectification, alienation, classification, developmentalism, universalism, pacification, elimination). These tools constitute and are built upon the interlacing categories of madness and savagery/primitivity. Thus, Joseph (2015: 1037) argues that,

madness and savagery were/are co-constituted through a confluence of ideas that rationalized forms of violence on bodies of difference deemed worthy of harm or exclusion. They

serve together to shore up notions of civility and incivility; they do not now nor have they ever existed without one another.

These logics and tools have been central for colonialism and psychiatry in their shared projects of the (re)articulation and (re)location of outside structures to being inside people – the naturalisation and biologisation of colonial, racist, sexist, homophobic and ableist hierarchies. Thus, a central tenet that colonialism and psychiatry have in common is the destruction and erasure of alternative ways of knowing, being and doing – what is known differently in different literatures as *cognitive injustice* (Santos 2014), *cognitive enslavement* (Dhareshwar 2010) and the *colonisation of the mind* (Nandy 1983).

While psychiatrisation and colonialism may have at their heart the co-constituting analogies of madness and savagery, it is important not to equate de-colonisation with anti- or de-psychiatrisation. To rethink my own previous formulations (see Mills 2014), it may be impossible to de-psychiatrise colonialism or to de-colonise psychiatrisation, but instead it remains important to understand how both psychiatry and colonialism discursively and materially mobilise the co-constituting metaphors of savagery and madness.

Global norms and weeding out alternatives

Advocates of one of the channels of what we might call global psychiatrisation (in this case, the MGMH) have spoken out against critics who claim that global mental health may operate colonial logics. Vikram Patel (2014: 786), a key figure within global mental health, says that ‘we must not allow the false prophets, hiding behind the duplicitous cloak of protecting the “natives” from a profiteering and self-serving “Western biomedical imperialism,” distract global mental health practitioners from their duty and responsibility to reduce this suffering’. He draws similarities between those who critique global mental health as imperialism and ‘the racist ideologies that led one-time colonial administrators to deny mental health care to the “natives” because they were either perceived to be psychologically immature or had supernatural treatments to deal with their conditions’ (Patel 2014: 783–4).

The ideologies evoked here by Patel hark back to colonial psychiatry’s early encounters with ‘natives’ who were presumed too ‘primitive’ to experience mental illness. This ‘myth’ came into question as colonial psychiatrists came into contact with what they understood as madness among the ‘natives’, which they struggled to reconcile ‘with the colonial precept of Western superiority while providing evidence to support the widely held view that allegedly uncivilized people ought by definition to be less prone to mental problems’ (Ernst 1997: 166). This colonial encounter with ‘native’ madness brought into being the ‘native insane’ (Ernst 1997: 164) as a category of personhood, while simultaneously troubling assumptions of the uncivilised barbarity of natives that were used in part to justify continued colonialism.

Yet, Patel’s evocation of the ‘myth’ of ‘native’ madness is itself shaped by a colonial logic, which further denies racially coded and institutionally racist psychiatric practice and models (Fernando 1988; Metzl 2009). Furthermore, the work of global mental health advocacy attempts to work against, and yet simultaneously mobilises, colonial assumptions of Western superiority of mind through assuming the superiority of ‘Western’ knowledge and the promotion of ‘modern’ bio-psychiatric approaches to mental distress over indigenous healing systems (Davar 2014). For example, the launch of *The Lancet’s* second series on global mental health in 2011 (the first being in 2007) outlines the Mental Health Gap Action Programme (mhGAP) guidelines (specifically developed to aid treatment decisions in non-specialised health care settings in low- and middle-income countries) as follows: ‘[t]he mhGAP guidelines should become the standard approach for

all countries and health sectors; irrational and inappropriate interventions should be discouraged and weeded out' (Patel *et al.* 2011: 1442).

This universal standard, then, comes to be that which all countries – and approaches to distress – are compared to and judged by, with the standard itself determining what can be thought of as 'irrational' or 'inappropriate', and what should be 'weeded out' (Mills 2014). Here the populations of low- and middle-income countries are predetermined to fall short of the norms imposed by a universalising global standard – itself a cultural construction (often of the 'West') (Hook 2012). Thus, in the homogenising, universalising move of applying these psychiatric classifications globally a hierarchy is established, whereby high-income countries will always appear more advanced, in part because the criteria to be met with comes from these countries.

The psychopolitics of colonialism and psychiatrisation

The claim that global psychiatrisation is always colonial and may also be a vehicle for continued coloniality does not necessarily lead to an impasse (Cooper 2016). It seems pertinent here to draw upon the work of those who know psychiatry and colonialism well – those who have experienced both. At the centre of this should be the activism and research of those who differentially identify as psychiatric users and survivors, mad people and/or as antipsychiatry, and particularly work that analyses intersections of madness, race and colonialism (e.g. Gorman 2013; Kanani 2011; Tam 2014).

Another key resource here is the sociodiagnostics and psychopolitics of the anticolonial revolutionary and psychiatrist Frantz Fanon. In *The Wretched of the Earth* (1961), Fanon denounced the colonial practice of psychiatry that manifests a concern with the brains of the 'natives' over the structural conditions of colonialism. Fanon (1961: 245) gives the example of how, during colonisation, 'the lay-out of the cerebral structures of the North African' was seen as responsible for the supposed laziness, inaptitude and impulsivity of the colonised, when, in fact, these signs may be symbols of resistance, where laziness marks 'the conscious sabotage of the colonial machine'. Psychiatry in the colonies thus worked to reconfigure colonial hierarchies and social inequality as 'natural' through coding them as genetic dysfunction or as located in the 'neurologically primitive' brains of the 'natives' (McCulloch 1993: 39; Heinz 1998). This enabled colonialism to remain uninterrogated because 'medicalised explanations for dissent' are 'far preferable [to those in power] to economic and political analyses that might find colonial practices to be culpable in African unrest' (Mahone 2006: 250).

More specifically, a central way in which psychiatrisation has functioned alongside colonial projects has been to pacify resistance (and naturalise oppression) through reconfiguring dissent and distress as 'mental illness'. For example, in British-colonised East Africa, to imagine a future free from the colonisers was framed as a symptom of mental illness (Mahone 2006); analyses of oppressive social conditions are/were overshadowed by concern with the psychology of the 'natives' (Mahone 2006; Vaughan 1993).

Thus, psychopolitics explores the psychopathology and psychic life of colonialism and coloniality, without collapsing into single universalising Eurocentric and colonial narratives of psychologisation or psychiatrisation (Adams 1970; Fanon 1986; Shalhoub-Kevorkian 2014). Such narratives fail to recognise the different ways of knowing by which people across the globe provide meaning to their existence, and thus often operate by destroying this epistemological diversity through the telling of single stories that claim to be universal. Both colonialism and psychiatrisation could be read as performing this epistemicide (Santos 2014). Psychopolitics helps us make this move through its connection of 'private troubles to social problems' (Bulhan 1985: 240) and its constant shifting between the socio-political and the psychological, a continuous

‘to- and fro-movement, whereby the political is continually brought into the register of the psychological, and the psychological into the political’ (Hook 2012: 17; Lebeau 1998), never dissolving the two or abandoning one register in favour of the other. Psychopolitics may also enable us to grasp how epistemologies of the south and of the psychiatrised in the Global South mobilise the local to challenge and resist a single approach to mental health and well-being that claims to be global. The fight against a single global norm and its capacity to destroy diversity could be a way for diverse anticolonial and anti- or critical psychiatry/mental health movements to retain their particularities, while simultaneously establishing some threads of mutual intelligibility for joint mobilisation.

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Therapeutic imperialism in disaster- and conflict-affected countries

Janaka Jayawickrama and Jo Rose

This chapter is based on our field research and applied projects in disaster-, conflict- and uneven development-affected Western Darfur (Sudan), Nepal and Syria. We have been collaborating with local organisations and communities in these countries and the information in this chapter is derived from our discussions with these communities and practitioners. Through the case studies, this chapter discusses and explores three critical issues that appear to be missed by most international agencies delivering mental health interventions in humanitarian crises – namely, knowledge imperialism driven by medicalised mental health approaches; the implementation of irrelevant mental health relief interventions; and the inability of medicalised mental health approaches to deal with ongoing conflicts and disasters. Overall, the key question that emerges within this chapter is: are medicalised mental health interventions rooted in European and North American culture and knowledge systems appropriate to non-Western societies?

Throughout this chapter we refer to a range of concepts. Table 24.1 contains the core concepts and how they are defined and understood in this chapter.

The growth of western mental health interventions

Contemporary medicalised mental health approaches are fundamentally based on the emergence of science through the European Enlightenment. Western science attempts to understand human suffering within neutral, impartial and objective frameworks to introduce universally applicable approaches (Bracken 2002). In this process, human suffering has become a scientific problem to be solved, with no acknowledgement of traditional, cultural and religious explanations to life (Illich 1975; Jayawickrama 2010). The globalisation of medicalised mental health approaches creates a disparity between ideology of the West and the rest of the world.

According to European and North American mental health experts such as Briere (2004) and Kessler *et al.* (1995), disasters and conflicts belong to a larger set of potentially traumatic events. In this argument, the overall epidemiology of trauma and post-traumatic stress has been considered important. Further, most of what is known about the mental health consequences of disasters has been derived from studies of specific groups of victims, workers or the communities in which they live. However, most of these case studies are from Europe and North America (Kessler *et al.* 1995). There is a missing link with regards to understanding the traditions, cultures and religions

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Table 24.1 Explanation of terminology

<i>Term</i>	<i>Explanation</i>	<i>References</i>
Disasters	Caused by natural events such as floods, tsunamis and earthquakes that affect social, political, cultural, economic and environmental aspects of a society	O'Keefe <i>et al.</i> (1976)
Conflicts	A conflict is commonly of three basic varieties: intra-state, inter-state and trans-state. The commonality of these conflicts can be identified with violence, rape, torture and atrocities against civil populations. Conflict destroys the social, cultural, economic, political and environmental institutions within the conflict-affected society	Bugajski (2011); Collier (1999); Eck and Hultman (2007)
Medicalised mental health	Divided between physical and mental health, medicalised mental health represents the European and North American construct of psychiatric sciences	Jayawickrama (2009); Pupavac (2012); Summerfield (2008)
Psychosocial interventions	Psychosocial interventions have been defined by the International Federation of Red Cross and Red Crescent Societies (2010: 25) as a 'process of facilitating resilience within individuals, families and communities (enabling families to bounce back from the impact of crises and helping them to deal with such events in the future)'. Critics of such interventions argue that these are not relevant to the affected communities and that the fundamental principles are based on Western medicalised mental health approaches	International Federation of Red Cross and Red Crescent Societies (2010); Jayawickrama (2010); Pupavac (2001); Summerfield (1999)
Humanitarian responses	The aid and action designed to save lives, alleviate suffering and maintain and protect human dignity during and in the aftermath of crises and disasters, as well as to prevent and strengthen preparedness for the occurrence of such situations	Adapted from Good Humanitarian Donorship (2003)

that shape people's attitudes, values and general worldviews in other parts of the world. The medicalised categorisation of 'mental health' undermines people's relationships, their kinships (blood ties and affinities) and, to some extent, the social, political, cultural, economic and natural environments within which they are living (Summerfield and Hume 1992).

The ancient medical systems such as Ayurveda or Chinese medicine do not divide mind and body in their approaches to health and illness (Chan *et al.* 2008; Frawley 1996), rather they attempt to examine these issues within their social, political, cultural, economic and environmental contexts. In contrast, the biomedical approach to mental health and illness conceptualises reactions to disaster and conflict as individual experience, with the affected person requiring treatment and support from a specialised medical community. However, Summerfield and Toser (1991) and Summerfield and Hume (1992) argue that medical models are limited because they

do not embody a socialised view of mental health. Exposure to massive disasters, conflicts and other forms of uncertainty and danger (as well as the aftermath) is not generally a private experience, but, instead, takes place in a social setting where those who need help reveal themselves, and the processes that determine how victims become survivors (as the majority do) are played out over time. As Jones (2004: 4) reflected of her experiences as a child psychiatrist among Serbian and Muslim young people who came of age during the Bosnian War in the 1990s: 'after meeting children in Gorazde [a municipality in Bosnia and Herzegovina] I came to believe that humanitarian programmes and mental health professionals were approaching the subject of war trauma and children from the wrong direction'.

However, since the genocide of Rwanda in 1994, there has been a rise of mental health and psychosocial interventions from the West, which have become a common feature of any humanitarian response to disasters and conflicts worldwide (Summerfield 1999). Experts from Europe and North America have successfully argued that such disaster-affected communities are particularly prone to factors associated with mental illness, including poor physical health, loss of motivation and depression (Coddington 1972; Joseph *et al.* 1995; Vogel and Vernberg 1993). In 2001, Pupavac (2001: 358) warned that, 'trauma is displacing hunger in Western coverage of wars and disasters'. According to Tol *et al.* (2011: 1583), 'in total, countries affected by humanitarian crises between 2007, and 2009, received US\$224.3 billion in funding (at 2008 values). At least \$226.1 million was provided for programmes that included MHPSS [Mental Health and Psychosocial Support] activities'. The recent rise in MHPSS as a part of such humanitarian involvement is widely acknowledged and further documented by Jayawickrama (2009), Pupavac (2012) and Summerfield (2008).

Our own experience is that – unlike food, shelter, physical health or protection – affected communities do not request mental health or psychosocial interventions. Amid the urgent requests for food, water, shelter and physical health needs, not once have we heard a request for any form of mental health aid. Why is it, then, that international agencies and donors feel compelled to implement mental health programmes?

Scholars and practitioners such as Kleinman (2006), Summerfield (1999) and Korn (1997) argue that most disaster-, conflict- and uneven development-affected communities are positively dealing with uncertainties and dangers in life without outside 'expert' help. Although there are evidently mental health and well-being-related issues that are perceived by those outside a community, the inside view is that there are traditional knowledge systems, religions, cultures, attitudes and values that address uncertainty and dangers in a sophisticated though pragmatic manner (Jayawickrama 2010).

Against these arguments, however, psychosocial and mental health interventions in disaster- and conflict-affected communities are still popular among Western humanitarian organisations. Although there is an agreement that water and food are the priorities, media and experts always warn that the affected population will be suffering from the mental traumas of war and disasters. For example, on 17 April 2016, the *New York Times* reported that, 'the strongest earthquake to strike Ecuador in decades left the Andean nation traumatized on Sunday, with collapsed buildings in a swath of destruction stretching hundreds of miles' (Ayala and Nicholas 2016). The assumption is that people who are experiencing disasters and conflicts are inevitably traumatised and therefore will require outside mental health interventions. Summerfield (1999) argues that medicalised psychological frameworks that are based on European and North American knowledge systems capture these assumptions. Furthermore, conflicts and disasters are devastating experiences that invoke fear, anger and pain – they are normal reactions to abnormal situations. The mind and body can naturally heal in many of these situations, but this takes time (Lando and Williams 2006). By delivering medicalised mental health interventions, the humanitarian

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agencies are reinforcing the view that the people's reactions are abnormal and need to be normalised. These interventions also neglect the traditional, cultural and religious rituals that have been established through generations of experiences of conflicts and disasters.

As Summerfield (1999: 118) argues, mainstream humanitarian responses need to be examined from a perspective based on the social, cultural, economic, political and environmental contexts of affected populations:

The debate about the effects of war and other extreme experiences on human beings veers in the West towards an individual rather than a collective focus, and towards individual pathology in body or mind. How applicable is this to non-Western populations worldwide? Many of their ethno-medical systems do not logically distinguish body, mind and self and therefore illness cannot be situated in body or mind alone. Social relations are understood to be key contributors to individual health and illness, and the body is thus seen as a unitary, integrated aspect of self and social relations. It is dependent on and vulnerable to the feelings, wishes and actions of others, including spirits and dead ancestors. The maintenance of harmonious relations within a family and community is generally assigned more significance than an individual's own thoughts, emotions and private aspirations. Thus the emphasis tends to be on a socio-centric notion of a person rather than an egocentric one as in the West. Perhaps the primary psychic impact of war for survivors is their witnessing the deliberate destruction of their social, economic and cultural worlds, ones which defines their identity, roles and values.

The following sections of this chapter explore the challenges and issues of medicalised mental health approaches to conflict and disaster through three different case studies. These are case studies where the authors have experience and can offer insights into such interventions in very different crises – namely, the forgotten crisis of Western Darfur; the recent earthquake disaster in Nepal; and the ongoing and extreme crisis in Syria. The authors have been conducting research, education and evaluation projects in collaboration with communities in each of these settings, and the comments provided have been collected through these activities.

The forgotten crisis in Western Darfur

We begin our case studies with an old, forgotten crisis. Western Darfur in Sudan has a long, violent history. Ethnic tensions that had long simmered between nomadic Arab herders and sedentary *Fur* and other agriculturalists began to erupt into armed conflict in the late 1980s. The violence, although bloody, was generally sporadic until 2003, when rebels from the agriculturalists attacked government installations as an act of protest against discrimination. The government responded by creating an Arab militia force – the *Janjaweed* – that began attacking the sedentary groups (Sikainga 2009). Within a year, tens of thousands of people had been killed and hundreds of thousands fled from Western Darfur as refugees or were internally displaced. Despite efforts and interventions to establish peace, by 2007 the conflict had grown to leave over 2 million people displaced. These years witnessed huge humanitarian interventions. In 2006 and 2007 almost US\$1.5 billion of aid was donated to Sudan per year (United Nations Office for the Coordination of Humanitarian Affairs 2016a, 2016b, 2016c). The conflict in Western Darfur has gone through peaks and troughs, but has yet to end. The Sudanese government launched a new Rapid Support Force in 2013, which reached Western Darfur in 2014. Most compared this new Force to the *Janjaweed*, as many former fighters were among its ranks and it operated with tactics that violated both international humanitarian law and international human rights law (Sikainga

2009). Contrasting to the US\$1.5 billion that was provided per annum in earlier years, in 2014 only US\$6.5 million was given in aid to Western Darfur.

In 2005, there were more than 60 United Nations (UN) and international non-governmental organisations (NGOs) delivering psychosocial and mental health programmes in Western Darfur (Jayawickrama 2005). With more than 41 per cent of the population displaced due to the conflict, the humanitarian agencies were claiming that more mental health programmes were needed. However, ten years later there are few to no Western mental health interventions remaining in Western Darfur, with communities questioning whether they are now 'healed' or if the agencies have simply forgotten them. As a traditional birth attendant (TBA) in Western Darfur remarked in February 2016,

Since you were here [in 2005], the mental health and psychosocial programmes have been closing down. Most agencies tell us that their funding is over and leave. We are not sure whether they think that we are all now 'healed' from our mental health problems or the agencies have more important problems to attend in other places. We are, however, still experiencing the same levels of uncertainties and dangers as in 2005.

Furthermore, the local counsellors that were trained by international humanitarian agencies have reported little success. Local people view the counsellors with scepticism and see them as trying to make them pay for a service they do not need. Understandably, these local counsellors have to charge their 'clients' as there are no longer any funded projects. After many years of medicalised mental health interventions in Western Darfur, people remain unaccustomed to talking with 'strangers' about their feelings, fears and emotions, and this reluctance is compounded when people discover they are also expected to pay for such a service. According to a humanitarian worker in El-Geneina (the capital city of Western Darfur) in February 2016,

Some of the counsellors trained by humanitarian agencies are now jobless. They are still trying to provide counselling and charge people for their time. Although there were many mental health awareness projects during recent years, people in El-Geneina still do not believe in counselling. When the agencies were providing free counselling sessions, they used to attend, but now the counselling is for money, no one wants to attend.

In the case of Western Darfur, it is important to ask why the mental health and psychosocial programmes ceased to exist. Is it due to the funding? Or have the agencies decided that the communities in Western Darfur have now been 'cured'? Either way, this raises a deep-rooted problem in the global humanitarian response, which is donor-driven and fails to build on community capacities through collaboration. Humanitarian agencies launch appeals and bids for funding to respond to a humanitarian crisis. Globally, the largest three donors of humanitarian aid are the US, the UK and the institutions of the EU. Evidently, humanitarian responses are dictated largely by these donors and affected communities have no real voice. The real beneficiaries then are all the international staff involved in the humanitarian aid industry, from donors and humanitarian practitioners to researchers and academics.

Appropriateness of mental health interventions in Nepal

The case study of Nepal allows us to explore interventions in a disaster event. Compared to conflict situations, disasters such as earthquakes and tsunamis are sudden and communities have to deal with the effects unprepared. The case of Western Darfur has highlighted a number of critical

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issues including donor-driven interventions and culturally incompatible approaches. However, are these unique to Western Darfur or are there any commonalities across humanitarian interventions?

Landlocked Nepal was the birthplace of Buddha and has an ancient culture that remains embedded throughout the country. According to The World Bank (2015), Nepal has recently halved the number of people living in extreme poverty (as measured by earning less than US\$1.90 per day, and being without access to food, safe drinking water and basic human needs) from 53 per cent in 2003/4 to 25 per cent in 2010/11. Several social indicators in education, health and gender have also improved. However, there remain a number of major challenges facing Nepal, including a lack of investors or stability in the financial sector, poor infrastructure and high child malnutrition rates. This situation is further compounded by Nepal's vulnerability to climate change and disasters.

Since the earthquake of April 2015 – which had a magnitude 7.9, killing more than 8,000 people and injuring a further 21,000 – Nepal has been struggling with delivering humanitarian responses to the affected people. There are many issues around safety and security, corruption and access to communities in the country. Reporting 12 months after the earthquake, Al Jazeera (2016) recently confirmed that the social and physical reconstruction of affected areas had yet to happen. Western mental health experts, meanwhile, have been rushing to examine the effects of the earthquake. The Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings (2015) produced a review of existing information with relevance to mental health and psychosocial support for the area. This report hoped to assist humanitarian and other practitioners in ensuring that MHPSS interventions built on the local socio-cultural context and health system in Nepal (Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings 2015: 10). Agencies such as the United Nations International Children's Emergency Fund (UNICEF), the World Health Organization (WHO) and many other UN and international NGOs were involved in providing rapid mental health and psychosocial support to the affected people. In January 2016, an affected community member in Kathmandu explained his thoughts on these interventions as follows:

This is Nepal and we have many challenges. We are not living in Europe, where even after one-hour power cut, people get upset. We are not like that – our happiness does not come from materials. So, after the earthquake, of course we were worried and upset, but we have our own ways to deal with them – we have our 'healers' and herbal doctors as well as religious practices and traditions. There were two women mental health experts here after the earthquake – they played with children and made teddy bears – this is not our culture. We were amused to see these women making teddy bears.

At the same time, Nepal proved to be another example of how local people themselves responded more appropriately, efficiently and effectively to the disaster compared to external humanitarian agencies that failed to question the necessity for their medicalised mental health interventions. Many local students, young professionals and businesses were the first to respond. They were organised and coordinated in their efforts. A group of students from the Kathmandu University established a volunteer process where the students visited affected communities to listen to them, identify their needs and then coordinate with other local communities and volunteers to deliver appropriate services. For example, a student group designed a new social media application that allowed local people and local organisations to coordinate relief efforts. This initiative by the students can also be seen as facilitating a natural process of mental healing. Communities were

listened to and developed friendships with the groups visiting them; the belief that they were not alone and were important to others who came to help, in itself, promoted the well-being of those affected. Yet the outside mental health experts that were guiding and supporting the local NGOs failed to acknowledge these humanitarian workers. As a local humanitarian worker in Banepa in Nepal commented in January 2016,

To provide mental health support to Nepali people, the mental health experts have to understand our culture and the ways we think – our attitudes and values; how we understand the suffering through disasters and everyday problems. As most of these outsiders do not know us and even do not speak our language, they cannot expect to deal with our inner problems.

Therefore, local initiatives such as listening and helping processes were found to be much more effective and efficient than external mental health and psychosocial interventions such as counselling, befriending and playgroups.

After the earthquake in Nepal, people did not sit back passively waiting for help. They began helping each other. According to a local volunteer in Banepa, speaking to us in January 2016, this is a natural process found in most disaster and conflict situations:

Yes, we had been affected too and you first check your own family are okay but you help anyone else that needs help too. It is our way to help and care for each other. At first, every tremor, you think is this another big one, but then slowly you begin to feel safe again. And as you begin to rebuild and help everyone around you rebuild, you feel good and you start to see that life goes on.

We have found that disaster- and conflict-affected communities are rarely passive or helpless. Families, friends, neighbours and communities begin helping themselves and each other, often with scarce resources. Outside assistance and resources may be needed, but it is important that international interventions are not driven by external agendas that label local populations as traumatised, passive and vulnerable.

Is there a remedy to deal with the ongoing suffering in Syria?

Many humanitarian organisations working with Syrians both in and around Syria are those that have previously worked in Western Darfur and Nepal. There has been a large number evaluation reports on the Western Darfur humanitarian response (Barltrop 2011). One of the emerging themes of these reports is the lack of collaboration between the humanitarian agencies and affected communities. The evaluation reports are also beginning to emerge from Nepal. Does this mean that organisations have adapted their approaches to incorporate these lessons and recommendations? According to most Nepali people it appears not (Buchanan-Smith *et al.* 2016). The case study of Western Darfur offered us insight into the operations of medicalised mental health interventions in a crisis that peaked over a decade ago. The case study of Syria allows us insight into these operations today.

Before 2011, Syria was under emergency law which suppressed its citizens. However, despite tensions and challenges within civic life, Syria enjoyed a relatively high level of education and health services compared to some of its neighbours. In 2011, inspired by the Arab Spring revolutions, a series of peaceful protests began, followed by a crackdown from the Syrian government (BBC News 2011). Army defectors declared the formation of the Free Syrian Army, which

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formed a series of fighting units. Since then the conflict has escalated to become one of the most violent wars in modern history. According to the former UN Secretary-General, Ban Ki-moon, Syria represents the biggest refugee and displacement crisis of our time (United Nations 2016). According to Mercy Corps (2017), more than 11 million people have been killed or displaced. The United Nations Office for the Coordination of Humanitarian Affairs (2016d) claims that it requires US\$7.7 billion to meet the urgent needs of the Syrian population.

Syria is an ongoing conflict – violence, destruction and deaths are happening every day. According to research led by European and North American humanitarian agencies, 54 per cent of Syrian people displaced to Jordan, Lebanon, Turkey and other parts of Syria are suffering from severe emotional disorders (Weissbecker and Leichner 2015). The same report declares that 27 per cent of displaced children face intellectual and developmental challenges. Humanitarian agencies, including the UN, are claiming that Syrian refugees are not just experiencing horrific challenges in life such as rape, torture and displacement, but also suffering from depression, anxiety and post-traumatic stress. These are organisations promoting mental health care for the displaced with the assumption that counselling, psychotherapy and psychosocial interventions are effective treatments with which to help the population. Most approaches to counselling and mental health interventions in Syria by humanitarian organisations are based on analysing the thoughts, feelings and emotions, related to an event that happened in the past. There is no evidence that survivors of violence and atrocities do better if they undergo counselling to emotionally ventilate their experiences (Rose *et al.* 2001). Further than this, however, as discussed by a community leader in Syria in February 2016, ‘talk therapy’ has the potential to deny the political realities of conflict and, instead, label communities as ‘victims’ at risk of mental illness:

Most [external] agencies that are providing counselling and trauma programmes come with mechanisms and tools that are to discuss our feelings and thoughts about past events. Our problem is that violence and danger is happening now – children are having nightmares and even as adults we cannot sleep at nights. In my mind, these are not necessarily mental health problems, but situations that remind us to stop violence. We need political solutions first, then safety, food, housing and other material support. Maybe after some time, we might need to discuss what happened to figure out to prevent future problems like this. But when people label us as suffering from trauma and PTSD, I do not think that is fair to these brave men and women.

Further issues have been raised relating to the cultural inappropriateness of the mental health interventions targeted at Syrians. Syrian refugees in Turkey, for example, have complained that the mental health interventions are trying to separate communities rather than bring them together. As most Syrian people come from collective communities, the approaches of individual counselling, psychosocial programmes or other interventions contradict the attitudes and values that are fundamentally rooted within their community structures. According to a Syrian refugee woman in Turkey in December 2015, these are culturally inappropriate interventions because,

We live as families – not as mother, father and children, but grandparents, uncles, aunts and cousins. We face these challenges and suffering from the war as families. We share our pains, problems and issues. Of course, we are not perfect – we fight, argue and there are some cases of unspeakable things. But we want to be together. The mental health and psychosocial programmes that are offered to us try to separate us as women, children and so on. That is not helpful. As a wife, my problems are affecting my husband and rest of the family.

Disturbingly, there has been a lack of critical reflection on the existing Western mental health frameworks, which appear to be at odds with the people they are aimed at, while reinforcing the Western priorities driving mental health humanitarian interventions in non-Western countries. In January 2016, a frustrated community leader from Syria commented that,

As community leaders in this area, we try our best to help people. Much of the help they need is practical – like accessing a road to take a delivering mother to hospital or make sure that schools are functioning for our children. We all are living in fear and you can be dead any moment. Life is very difficult and dangerous. But what is the point talking about that? We must help each other and try to do our best in these situations.

Conclusion

The current medicalised approaches to mental health represent knowledge superiority that assumes the European and North American way of thinking is correct and that there is no place for local practices, traditions and mechanisms (Summerfield 1999). This chapter has questioned the necessity of stand-alone Western mental health and psychosocial interventions in disaster- and conflict-affected countries. Implementation of these interventions is sometimes irrelevant, as has been the case in Nepal. At other times they are not effective, as is the case in Syria. Ironically, even when these interventions cease to exist – as was the case in Western Darfur – they have left certain frameworks in place such as counselling and psychosocial mechanisms that have created burdens to communities rather than support.

In Nepal, Syria and Western Darfur, what we do not hear in the Western media or humanitarian dialogue is that local people have the potential to help others and rebuild together as part of the healing process – this is, essentially, where people take control over their lives and regain a sense of purpose and belonging. There will be other disasters and conflicts; current approaches to mental health or psychosocial services in emergencies merely aim to parachute ‘treatment’ to one-off events and take the ownership and responsibility away from affected communities. The Western knowledge imperialism and donor priorities that drive inappropriate and ineffective mental health interventions in conflicts and disasters must cease. Collaboration and engagement with communities and, where possible, governments to deliver context-specific, culturally appropriate interventions that are needed as identified by the affected communities themselves is the only option if humanitarian aid is to be appropriate and effective.

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ProblematISING Global Mental Health

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The emergence of the field of Global Mental Health (GMH) in the last ten years has had a significant influence on the orientation and development of discourses around mental health in the Global South. GMH can be conceptualised as a set of initiatives that promote the evidence-based ‘scale up’ of mental health services in the Global South, to improve human rights of people with mental health difficulties and their access to care (Jain and Orr 2016). The field emerged in the context of growing epidemiological research on the global burden of disorders, including their economic burden in treatment costs and loss of economic output, and in the context of a series of international reports on mental health provision (Desjarlais *et al.* 1995; Lancet Global Mental Health Group 2007; World Health Organization 2001). A key moment was the launch of the 2007 Lancet Global Mental Health series (Patel 2012), which set out an agenda for action to address the ‘burden’ of mental disorders. Linked to this was the emergence of the Movement for Global Mental Health (MGMH), driven by key architects of the Lancet series and supported by key international mental health institutions such as the Institute of Psychiatry, the London School of Hygiene and Tropical Medicine and the World Health Organization (WHO). MGMH rests on two pillars: improving access to care by closing a perceived ‘treatment gap’ between the availability of services and the number of people needing such services, and addressing the human rights of people with mental disorders (Patel 2012). MGMH encompasses a coalition of mental health professionals, policy-makers and service users and carers, and now comprises 200 institutions and 10,000 individuals.

In the past ten years, GMH has emerged as an academic discipline including postgraduate courses, a growing body of research studies, associated academic publications and international conferences. A key aspect of GMH has been the emphasis on evidence, supported by a series of studies to build the case for mental health interventions and thereby facilitate policy efforts.

With the development of GMH as a discipline and of MGMH, a growing number of critics also emerged, questioning some of the fundamental assumptions underpinning both the discipline and the movement. The critiques centre on the following three broad themes:

1. Universality of mental disorders: critics argue that psychiatric categories deployed globally may not reflect lived realities (Das and Rao 2012; Mills and White 2017) and that these categories are Western impositions and not universally applicable (Fernando 2014; Mills

2014; Summerfield 2008). The discourse of psychiatric disorders as an ‘epidemic’ drawing on global burden data has shaped particular approaches to interventions in GMH, generating demands for ‘urgent’ public policy responses. This ‘urgency’ is used to justify the resort to universal categories;

2. What types of evidence are shaping GMH/MGMH interventions: an important critique of GMH relates to the structural mechanisms (funding, publishing) that privilege particular forms of ‘evidence’ (such as randomised control trials) and minimise the value of other forms of evidence and knowledge (for example, qualitative and ethnographic data) (Jain and Orr 2016; Mills and White 2017). This relates more broadly to the question of what is seen as valid ‘evidence’ (Ecks 2008);
3. An over-reliance on technical interventions within GMH discourses: the focus on particular forms of ‘evidence’ generates a reliance on particular forms of ‘intervention’ in GMH discourses – technical approaches such as psychopharmaceuticals and easily measurable forms of psycho-social intervention. This lack of attention to a multiplicity of approaches limits the space for alternatives, facilitating a ‘monoculture’ of approaches to addressing mental health (Davar 2014) and giving limited consideration to the social and cultural determinants of mental health (Das and Rao 2012).

It is important to note the growing multifaceted and multi- and interdisciplinary nature of GMH. A field largely dominated by psychiatry and epidemiology, a focus on disease has faced resistance as described above, leading to vitriolic debates (Bemme and D’souza 2012). In recent years, scholars – including social scientists, mental health practitioners and experts by experience – have offered other perspectives that have sought to move beyond these divides by: examining the ‘functioning’ of GMH (Bemme and D’souza 2014); exploring the contributions of ethnographic methods and medical anthropology to understand GMH and its projects (Jain and Orr 2016); considering the contribution of more marginal mental health disciplines to GMH (Orr and Jain 2014); problematising the role of user/survivors in GMH (Swerdfager 2016b); and opening up new aspects of the role of human rights in GMH – for example, the role of the UN Convention on the Rights of Persons with Disabilities (Davar 2012; Read *et al.* 2009; Stavert 2017; Transforming Communities for Inclusion: A Trans-Asia Initiative 2013). This interdisciplinary work has potential to advance understandings of global mental health, shifting the very basis of GMH towards a discipline that encompasses a range of voices and disciplines and constitutes a ‘(re)claiming’ of the ‘GMH’ label.

In view of these arguments, GMH has recently been dominated by a ‘hostile intellectual climate’ characterised by deadlocked intellectual exchanges. We suggest that this impasse might be overcome by reorientating the underlying principles of GMH from a developmental and epidemiological approach which frames mental illness as a burden/treatment dichotomy, to an ecological framework in which experiences of mental ill-health are understood in terms of suffering and care. This, in turn, might provide GMH with an important opportunity to rethink the sustainability of its approach.

Global Mental Health from the bottom-up: engaging with people and communities in the design of services and interventions

The development of MGMH and the evolution of GMH as a discipline position it as a largely top-down venture. The critiques summarised above would support this. Over-dominance of bio-medical psychiatric knowledge, emphasis on technical interventions and the exclusion of diverse sources of evidence all illustrate how particular forms of knowledge and expertise shape MGMH

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and GMH as a discipline. We do not dispute the importance of the aims of MGMH and the framing of GMH as a discipline. Improving access to care and support for mental health difficulties and ensuring the human rights of those with psycho-social disabilities are important objectives. However, the relative absence of the voices of the individuals and communities who are the ‘objects’ of interventions limits dialogue between different forms of knowledge in the design of services. Such a dialogue and a bottom-up approach are crucial if responses to mental health difficulties are to be appropriate and relevant to local concerns (Jadhav *et al.* 2015; Kirmayer and Pederson 2014). Moreover, a wider reorientation of GMH depends on the presence of a diversity of voices and disciplines (Jain and Orr 2016).

Central to developing this bottom-up approach and dialogue is the advancement of community engagement agendas towards genuine co-production in which experts by experience play central roles in commissioning, designing, implementing and evaluating responses to psychological distress. Issues of citizen engagement and community participation have been much discussed in health and development discourses and there is an established link between community participation and improved health outcomes (Rifkin 2014). Moving towards a co-production approach as core to GMH requires a consideration of power inequalities that shape relationships between professionals and communities (Campbell and Burgess 2012), including the limited voices of experts by experience in such discourses (Swerdfager 2016b; see linked commentaries from Cohen 2016, Jain 2016 and Swerdfager 2016a). Bridging these inequalities requires recognition of the diverse knowledge and experience that communities bring in relation to their own lives and the potential of these to reshape mental health care.

The community competence framework applied to GMH by Campbell and Burgess (2012: 389) provides an approach to engage with these power differentials (for an application of this framework, see Burgess and Mathias 2017). Community competence is defined by Campbell and Burgess (2012: 389) as ‘the ability of community members to participate effectively in efforts to promote prevention, care, treatment and advocacy’ through three dimensions. The first relates to community member’s knowledge – their ability to recognise psychological distress and seek appropriate support. This dimension is crucial, as a key challenge in GMH relates to the relationship between dominant biomedical psychiatric conceptions and a range of local understandings of psychological distress (Campbell and Burgess 2012). The disciplines of cultural psychiatry and medical anthropology offer the potential to inform dialogue around understandings of distress (Jain 2016; Kirmayer and Pedersen 2014). However, critics question the impact of cultural psychiatry on practice in low-income nations (Jadhav 2004) and the discipline’s commitment to user/survivor perspectives (Swerdfager 2016a, 2016b). Enabling the dialogues that would ensure the embedding of user/survivor perspectives in service design and delivery would be supported by the second dimension of the community competence framework: access to ‘safe social spaces’ that would allow integration of different forms of knowledge (for example, local and medical knowledge). These spaces would provide opportunities for critical engagement around the social and cultural factors that shape distress, in turn challenging responses and examining how the impact of distress might be addressed, leading to a more ‘politicised response’ by community members and wider alliances. The third dimension is partnerships and relates to local awareness and the ability to access external support and resources. An important aspect of this approach is the idea of ‘receptive social environments’ – that, along with building community capacities and voice, it is crucial to build environments in which powerful actors can listen and engage with the less powerful. Both the second and third dimensions highlight for us the important shift needed within GMH in how people are perceived towards a view of individuals, families and communities as having capacities and assets which can shape their own well-being. An emphasis on the narrative of patients and community is an important step to reframe the underlying principles of

GMH and its services/interventions around the suffering and care needs of people/community in vernacular terms, leading to culturally valid solutions (Jadhav 2009).

Towards an ecological approach to global mental health

While the use of participatory approaches focusing on patients' narratives and expertise within service design and delivery may yield important positive outcomes (such as better therapeutic engagement, increased adherence and/or enhanced clinical management), it may also be an essential step in rethinking the conceptual underpinnings of GMH. Notably, such an approach may challenge the discipline's indiscriminate use of reductive psychiatric diagnostic categories in framing and justifying its objective of addressing the burden of mental 'disorders'. Indeed, an emphasis on the validity and complexity of patients' suffering would require a shift from a medical approach in which 'disorders' are treated, to a more humanistic form of care. This novel focus may allow for a broader understanding of the topology of human suffering. Contrary to conventional psychiatric formulations that emphasise 'social stressors [which have] an impact on the psyche' (Jadhav *et al.* 2015: 12; Kleinman *et al.* 1997), one's narratives and experiences of suffering may thus be situated within a wider framework encompassing socioeconomic and ecological dimensions (Jadhav *et al.* 2015). This 'ecology of forces and factors' (Jadhav *et al.* 2015: 13), acting with variable directionality 'on and by the people suffering and those around him and her' (Jadhav *et al.* 2015: 12), recognises the ways in which 'asymmetric interactions between people, the environment (wildlife, climate, agriculture), and institutions governing both, generate socially toxic landscapes that are actively counter-therapeutic' (Jadhav *et al.* 2015: 13; Jadhav and Barua 2012).

If suffering is to be culturally understood as something shaped by the wider ecologies in which it occurs, so can notions of well-being and recovery from mental ill-health. Increasingly popularised in the Global South (Patel *et al.* 2011), the latter have been deployed by the MGMH as universal constructs, while becoming progressively 'packaged' into tools (Grover *et al.* 2016) to allow for their integration within the service-driven agenda of the discipline. This is despite various scholarly calls to critically appraise the cultural validity of such concepts (Bayetti *et al.* 2016; O'Hagan, 2004) and multiple service-user critiques of their recent 'instrumentalisation' (Recovery in the Bin 2016; Rose 2014). Building on participatory approaches, the operationalisation of the notions of well-being and recovery using an ecological framework may address such critiques. People and/or community narratives may provide insights as to the range of inter-linked forces and factors shaping individual and collective well-being and recovery, while simultaneously producing a map of crucial local resources used by these actors to foster well-being and support recovery. Taken together, this would allow for the much-needed development of locally rooted and culturally valid models of these concepts, while furthering our understanding of their spatiotemporal nature (Bayetti *et al.* 2016). These models are an important prerequisite in providing alternatives to Western medical and psycho-social methods of addressing suffering and in elevating GMH principles to achieve better care.

More than theoretical constructs, we suggest that it may be possible to modelise these ecological frameworks by using participatory methods such as community-based system dynamics (CBSD). Through a series of group consultations, CBSD aims to render explicit the subjective perceptions that participating individuals have in regard to a complex problem (Hovmand 2013). This allows for the modelisation of this problem through an 'explicit engagement with [its] causal mechanisms' (Trani *et al.* 2016: 3). Such a process may, in turn, reveal the 'interconnections and dependencies that may not be apparent from an external view' (Trani *et al.* 2016: 9), including the feedback relationship existing between the various elements contributing to

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the investigated problem. Additionally, this modelisation exercise enhances one's grasp of the 'the dynamic change in system behaviour over time, as well as nonlinear relationships' (Trani *et al.* 2016: 3). Such a method might thus present a good opportunity to use individual and community narratives to understand the wide range of factors and complex relationships shaping those ecological models. This may allow stakeholders to better 'identify issues and prioritize interventions' (Trani *et al.* 2016: 3), thus resulting in policies and programmes better tailored to address the complexity of the local issues they aim to tackle. More than a useful method for policy-makers and academics to model complex issues, it also enhances communities' ability to identify issues and 'engage with practical problem solving' (Trani *et al.* 2016: 3). Notions of ownership, capacity and, ultimately, sustainability are therefore intrinsic to this method.

Implications for the future of global mental health

The notions of ownership, capacity and sustainability remain glaringly absent from GMH and its discourse. As it stands, GMH inherently configures individual and community suffering as the sum of various 'problems' solvable through the intervention of interlocking agencies. This places individuals as passive recipients of services, rather than as resourceful actors capable of using assets and existing resources to own and decide how to achieve their desired mental health outcomes. Moreover, the rhetoric of 'urgency' underlying GMH's 'epidemic' approach to human suffering has so far limited the discipline's ability to reflect on its sustainability and that of its endeavours.

We suggest that incorporating the approaches and models previously detailed would allow for a radical, yet positive change of this current configuration. Starting at an individual level, participatory approaches inherently reposition people as having assets and capabilities that can be deployed to develop the coping skills and strategies required to obtain the health outcomes they seek. Rather than being the recipient of an intervention and/or service, patients and users are empowered as integral and active actors in their care. This validation of people's expertise and narratives regarding their suffering and/or well-being may increase their engagement with services while challenging the pervasive stigma of being labelled with a mental illness. The increased social inclusion and renewed sense of citizenship which would result from this change would, additionally, allow a greater access to and use of local resources and infrastructures. At the community level, this would lead to a lower level of dependence on novel services and interventions as individuals become better able to identify and rely on their existing resources and infrastructure to maintain and/or improve their well-being. Our suggested approach thus moves away from the tokenistic 'service-user engagement' currently advocated by GMH (Patel *et al.* 2013) to systematically building competency and resilience in individuals and communities.

Additionally, these changes would have important ramifications at the level of mental health policies and services. Indeed, to make the above vision a reality, the planning, commissioning and design of services must go beyond the current 'problem-service paradigm' (The Holy Cross Centre Trust 2013) in which layers of interventions and services are financed to address a specific 'problem' and obtain a predetermined outcome. Contrary to this paradigm, the person-centred, asset-based approach advocated here intrinsically trusts people and communities to determine what outcomes mean for them when addressing their mental health. What a good outcome might mean for them and 'how it relates to the wholeness of their life rather than just their problem' (The Holy Cross Centre Trust 2013: 15) might vastly differ from the outcomes that services think they should deliver in response to the problem they have been commissioned to address. It is essential for GMH to recognise and address this discrepancy by supporting innovative services positioned as 'learning organisations' (Bayetti 2013), capable of 'co-producing'

multiple outcomes defined by, and relevant to, users and patients within the context of the local ecologies in which they operate.

Rather than depending on traditionally rigid and codified mental health interventions, such services will necessarily adopt flexible, holistic and tailored approaches to best meet the demands and needs of their users, even if such an approach involves 1) supporting people to access and use other resources than the service itself or 2) achieving outcomes normally outside of the remit of mental health services. This is particularly relevant in resource-scarce contexts, where services' willingness to work towards outcomes traditionally outside their remit will intrinsically foster inter-sectoral collaborations and lead to 'better value for money' investments. Furthermore, supporting people to access and use existing resources may reduce the unnecessary duplication of similar solutions capable of delivering comparable outcomes, thereby freeing resources (human and financial) to be redirected to other needs. We believe that this approach will encourage services to engage with the community they serve at a richer and deeper level. This, in turn, would provide services with a more intricate understanding of and ability to successfully help communities. For example, services may become increasingly able to understand and predict the impact of evolving local ecologies, in turn providing communities with insights on how to respond to future challenges.

The latter raises important questions as to the sustainability of GMH, both as a discipline and a set of policies and services. To perdure and stay relevant, GMH must show an ability to evolve and provide answers to the challenges posed by other 'global' phenomena, such as neoliberal capitalism and global warming. The impact of these events on the future stability of our economies, social fabric and socio-political and ecological systems is now undeniable (Klein 2015) and raises profound questions as to the effect that these changes will have on the well-being of people and communities. The predicted increase in human displacement and migration, air pollution, incidence of water- and vector-borne disease and resource scarcity and competition accompanying increasing global temperatures (Environmental Protection Agency 2016) stand as troubling examples of changes that will unquestionably increase the suffering of global communities and worsen their mental health. Moreover, the impact of these changes is likely to be felt unevenly by communities across the world, with the most vulnerable populations, inhabiting the Global South, bearing the brunt of their effect (Mendelsohn *et al.* 2006). More than an opportunity, GMH therefore has a *responsibility* to engage with these global events and account for their impact within the development of policies, services and interventions. Unfortunately, the current nature of GMH has not only disconnected it from local realities but appears to distance it from its actual 'global' calling.

Conclusion

This chapter has proposed ideas to shift the current GMH paradigm by incorporating some of its existing critiques. Based on a bottom-up approach engaging community and patients through real co-production, this new paradigm recognises these actors as assets with capabilities – experts in their own care and suffering. This new power dynamic resituates the importance and power of personal narratives of suffering by acknowledging the wider ecological framework from which they originate. As such, this proposed approach challenges GMH current service design and delivery in multiple ways. Novel approaches recognising the importance that local ecologies play in community suffering and well-being may, indeed, not need to be 'scaled up', since these peculiarities might disappear (for a critical discussion of scaling in global health, see Adams *et al.* 2016). Furthermore, such an approach may encourage GMH to think of services and interventions able to deliver multiple outcomes, so as to address the wide array of social and ecological

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factors at the root of individual and community suffering. In turn, this would challenge GMH's 'silo' thinking by forcing the discipline to account for the growing role of other global trends in shaping the nature of these 'ecologies of suffering'.

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Part VI

Critical approaches to therapy

26

A sociology of and in psychotherapy

The seventh sin

Peter Morral

During an interview with a newspaper journalist (Ghomeshi 2009), the Canadian poet, songwriter, singer and perennial sufferer of depression and anxiety, Leonard Cohen, commented on self-absorption:

to talk about oneself in a time like this is a kind of unwholesome luxury. I don't think I've had a darkest hour compared to the dark hours that so many people are involved in right now. Large numbers of people are dodging bombs, having their nails pulled out in dungeons, facing starvation, disease... [W]e've really got to be circumspect about how seriously we take our own anxieties today.

What Cohen is alluding to is the narcissistic tendencies of people living in Western and Westernising countries in which personal betterment, not only materially but psychologically, is celebrated as a highpoint of human actualisation (Baron-Cohen 2011; Lasch 1979). Such psycho-individuation is, however, situated in a particular culture and promulgates certain social organisations. I contend that, along with other 'sins', the enterprise of psychotherapy is a substantial sponsor and beneficiary of this key element of cultural narcissism. I also contend that there is a reflexive relationship between the self and society, personal problems and social issues, muddled minds and messed-up society. Furthermore, to sort society and mend the mind means addressing both, rather than one or the other, though the former is more likely to dispatch the latter than the other way around. Moreover, the concomitant contention is that practitioners and academics have a social responsibility to take action as part of their professional role. Psychotherapists – as well as sociologists – and their institutions have an ethical onus to engage in the discourse(s) and implementation of societal improvements at the clinical and collective levels.

These contentions form the four sub-sections of this chapter under the headings 'the seven sins of psychotherapy', 'psycho-social reflexivity', 'the world is in a mess' and 'social responsibility'. This sociologically mindful critique is imbued with scepticism not cynicism. The intention is to be both deconstructive and constructive. Thereby, the chapter concludes with suggestions to enable the 'social' to enter both the psychotherapeutic enterprise and the practices of psychotherapists. This, therefore, is an attempt to render a sociology 'of' and 'in' psychotherapy focusing on the paramount 'seventh sin'.

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I use ‘psychotherapy’ as a generic term for counselling and psychotherapy, and ‘psychotherapist’ for those who are trained in either, acknowledging that there are actual or asserted distinctions between and within these two groupings (Australia Counselling 2016; McLeod 2013). The term ‘psychotherapeutic enterprise’ refers to the combination of practitioners, their practices and principles and organisations, as a social institution (albeit a diffuse and fractious one). ‘Madness’ is used in social science as a loose synonym for what became classified, through the process of medicalising psychological distress, as mental illness/disorder (Morrall 2017; Scull 2011).

The seven sins of psychotherapy

In the book *The Trouble with Therapy: Sociology and Psychotherapy* (Morrall 2008) I propose that the psychotherapeutic enterprise today exists in a primitive form, characterised by dysfunctionality, arrogance, selfishness, abusiveness, infectiousness, insanity and deceit. My use of the phrase ‘primitive form’, however, indicates that I am not against psychotherapy. In this chapter, I concentrate only on the most imperative impediment to the professional evolution of psychotherapy as a profession, the seventh sin. That is, psychotherapy is inherently ‘asocial’ and thereby markedly futile, as well as distinctly unethical. Consequently, what I am for is a psychotherapy which reflects on its sins and enables its evolution as a sociologically informed and sociologically performing occupation to enable its expertise and proffer genuine beneficence. The thesis in *The Trouble with Therapy*, therefore, is sceptical not cynical, and deconstructionist but not destructive. In its call for social responsibility it is indulging in sociological optimism (Holmes 2016).

Some considerable time has elapsed since the publication of *The Trouble with Therapy* and related publications, but I propose that these ‘sins’ remain apposite. I will summarise each sin below (which correspond to chapters 2–8 in the book), before expanding on and updating the seventh.

Dysfunctionality

The depiction of the psychotherapeutic enterprise as a unified and valuable social institution, peopled by caring and empathic practitioners operating mainly if not wholly for the good of their clients continues to be the presented narrative of its institutions and practitioners. But the enterprise of psychotherapy has a long history of conflicts and rivalries which have, to date, not been resolved. Moreover, choosing a particular therapy, whether it is cognitive-behavioural, psychodynamic, humanistic or one of the scores of their derivatives, remains a lottery, as does choosing a therapist (who may favour one perspective or have a bent towards the epistemological irreconcilability of eclecticism). Therefore, the claim that therapy is a deeply dysfunctional discipline can still be made.

Arrogance

Psychotherapy has been steadily attempting to legitimise its practices through the use of traditional social and natural scientific means without a convincing epistemology. Such a critique, which arises from the well-established field of study known as the ‘sociology of knowledge’ (Mannheim 1936; Stehr and Meja 2005), as well as from within science itself (as evidenced, for example, by the debates around the question of quantum physics, see, e.g. Gross *et al.* 2013; Vedral 2010), highlights the political and procedural vagaries of science and, especially, the ‘scientific fallacy’ that reality can be identified and explained. This naive ‘scientisation of psychotherapy’

(Morrall 2008) has increased markedly with the advance of cognitive therapy and the rise of neuroscientific/geneticist efforts to explain the mind as an outcome of the biology of the brain.

Selfishness

There is an overwhelming focus on the 'self' in psychotherapy (as well as psychology and psychiatry). This focus on the individual, his/her mind, brain, personal history, emotions, thoughts and behaviours ignores or underrates the impact of society on human performance. Moreover, although individualism and freedom are publicised and defended (at times by armed conflict) there is today remarkable – and culturally induced – similarity in terms of how so-called individuals are seemingly free to be fashioned into consumers and ones who indulge in collective binging on whatever media, corporations and governments may render as entertaining, esteemed, healthy, deviant or threatening.

Abusiveness

Sporadically, cases of direct abuse of power (sexual, emotional and physical) by psychotherapists towards their clients have been recorded. However, such events, while serious, seem to be few and far between. In contrast, the indirect abuse of power in the form of unequal and undisclosed influence pervades the psychotherapeutic relationship, despite claims of equality and empowerment. Specifically, the psychotherapist's professional status, specialist knowledge, therapeutic bent, situational control and normalising effect versus the client's psychological vulnerability configure a type of passive-active relationship akin to that found between doctor and patient in the sick role.

Infectiousness

A basic goal of the psychotherapeutic enterprise has been to achieve the occupational status of a fully fledged profession similar to medicine. Yet too much therapy runs the risk of becoming poisonous in a similar manner to how the profession of medicine has been accused – at times, by its own practitioners – of infecting society with its worries and wares. That is, medicalisation has its equivalent in psychotherapy, a social process I describe as 'therapyitis'. Medicalisation has enabled the power and professionalisation of medicine but has undermined self-management regarding health and detracted from social solutions to ill-health. Likewise, therapyitis is enabling the professionalisation of psychotherapy while undermining self-management and detracting from social solutions to 'problems in living' – to adopt unconventional psychiatrist Thomas Szasz's (1972) phrase – which manifest in the mind.

Insanity

Despite being in the business of madness, psychotherapists are remarkably ill-informed about the intra- and cross-cultural histories, interdisciplinary debates and myriad epistemological depositions surrounding that subject. Comprehensive knowledge about madness is absent from most psychotherapy training courses and textbooks. Given the well-worn, as well as contemporary advances in theoretical and empirical understanding emanating from sociology and neuroscience/genetics (and an amalgam of both) it is 'insane' for psychotherapists not to embrace this knowledge – if only to ensure accurate opinion of their clients' psychological state and to seek further specialist assistance if necessary.

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Deceit

The final arraignment – from a sociological viewpoint, the most formidable – against the psychotherapeutic concerns its integral deceit. The aims and practices of psychotherapy are directed towards an outcome of improving psychological well-being, whether this is measured apocryphally or (allegedly) scientifically. While many modern-day psychotherapies positively further happiness, no mainstream approach deviates from at least attempting to help their clients become more tolerably miserable. The concepts and strategies of the vast majority of psychotherapists point only to the individual's psyche (and occasionally his/her soma), when all psychological distress has a connection with the collective. Humans are social beings and society indelibly and elementally imputes the human mind with both misery and happiness.

Psycho-social reflexivity

Bestselling and prestigious textbooks on psychotherapy written by practitioners and used to support the training of psychotherapists, as well as those in practice, make scant reference to 'the social' (see, e.g. Burns and Burns-Lundgren 2015; Cooper and Dryden 2016; Douglas *et al.* 2016; Dryden and Mytton 2016; Malocco 2015; VandenBos *et al.* 2014). Where the social is mentioned, the tendency is for the micro-level or (at best) the middle (or 'meso') level of analysis to be conceded. The latter may involve recognition of the family, work, intra-societal multicultural contexts, interpersonal power and gender roles, utilising so-called 'social therapy' and variations on the theme of eclecticism or pluralism which contain components of sociological commentary. Granted, there are a few exceptions at the introductory level (see, e.g. Feltham and Horton 2012) and a number of macro-level texts and articles which address the social context of psychotherapy (see, e.g. Pilgrim 1997; Spong and Hollanders 2003).

Contributions from neuroscience to basic psychotherapy literature are increasing (see, e.g. Warren 2014), while meaningful and penetrating sociological input is not. Rarely is there any substantive delving into the wider contexts of political, economic, cultural and global structures and processes which can and do impact severely on the way of life of individuals, including their psychological state and their biology. This absence of the examination of the social is replicated in psychotherapeutic training courses, whether these are orientated towards psychoanalytical/psychodynamic, humanistic or cognitive and/or behavioural therapies, or an integration of these styles (see, e.g. Australian Institute of Professional Counsellors 2016; King's College London 2016; New York University 2016; University of Cambridge 2016; University College London 2016).

The sociologist C. Wright Mills (1959) points to the connection between 'private troubles' and 'public issues', forwarding that however we perform as individuals (what we feel, how we act and what we think), our social experiences and environments shape that performance. Seemingly exclusive personal states such as happiness, self-identity, volition, desire, empowerment, madness and misery are linked inexorably to social factors. What Wright Mills and others from a variety of disciplines (for example, the psychoanalyst and philosopher Erich Fromm (1955) and the medical anthropologist Cecil Helman (2007)) acknowledge is that this connection is not unidirectional. That is, there is a reflexive interrelationship between individuals and society and between personal and social pathologies. Individuals are 'free' to operate how they wish, but this freedom is conditional on how their society operates. How society operates is conditional on what individuals, either separately or grouped, decide to think, feel and act. Thus, individual volition and societal pressure are in a push-and-pull myriad of complex arrangements which is problematic to untangle.

Moreover, individuals are also involved in a similarly multifaceted interplay with their biology. Their neuro-genes, brain anatomy and neurochemistry knot with their psychological dispositions and societal experiences. Neuroplasticity, along with the interplay between the psyche and society, furnishes the notion of the mutable bio-psycho-social being affected by both nature and nurture (Rose and Abi-Rached 2013).

A certain degree of miserableness and anxiousness is realistic given the persistently fragile and, ultimately, fatal condition of human life and dalliance with ecological disaster in which humanity is presently engaged. Indeed, John Stuart Mill (2001), the nineteenth-century British utilitarian philosopher and Member of Parliament, posited that dissatisfaction was a higher human quality than satisfaction. Humans have consciousness and a conscience. Awareness of their intellectual and moral capacity, together with comprehending their vulnerable existence, leads to a striving to understand and change the world in which they live. Such striving may culminate with a symbiosis of happy individuals and a 'happy' (that is, egalitarian and moral) society, but the journey towards that end is – and must be – replete with mindful restlessness, not serene mindfulness.

For Mill, those humans who have the highest intellectual ability and moral positioning are the most discontent. Superior thinking and honourable principles mean that contentment, let alone happiness, cannot be gained from only fulfilling primary human needs (hunger, food, shelter and sex). Nor can fallow and routinised employment, religion and what Fromm (1955) considers 'dumb' popular entertainment offer the psyche satisfaction. Hence, psychological distress could be construed as indicating the functionality (rather than dysfunctionality) of an individual's mind and connection to (rather than dislocation from) society. This is not to disregard the terrible suffering from severe modes of madness, but by-and-large those with such 'illnesses' or 'disorders' are not the target client group of psychotherapy.

Hence, the psychotherapeutic enterprise's mission to manage misery and commend contentment can be construed as harmful to personal and social evolution. The psychology of 'positiveness' can be condemned as a professionalised illusion. The world is in a mess, and the mess matters to the mind and, therefore, should matter to the mind-menders. There are reasons to be cheerful, but also justifications for a psychological, societal and biological reflexive 'nausea' because of the mess.

The world is in a mess

The Director-General of the World Health Organization (2009), Margaret Chan, recently admitted that, '[t]he world is in a mess, and much of this mess is of our own making... We have made this mess, and mistakes today are highly contagious'. The United Nations (2016) lists over 30 serious public issues across the world, some of which involve disadvantage, death and destruction on an enormous scale. Society, whether considered to be now global, globalising or remaining partitioned along the lines of (for example) mammon or religion, is replete with injustice, inequality, new and old diseases, financial crisis, criminality, armed conflict and extreme brutality, some of which threaten the sustainability of humanity (Worldwatch Institute 2015). Moreover, nature is being messed up by humanity, with global warming and related ecological disasters predicted if the present trajectory of industrial expansion continues; total ecocide is a possibility (Gore 2006; Higgins 2015; Monbiot 2006, 2016).

The divide between the world's most wealthy and the most impoverished affects detrimentally the latter's mental and physical health, longevity, infant and maternal survival, education and employment opportunities and risk of fatal and non-fatal violence (Dorling 2015; Marmot 2016; Wilkinson and Pickett 2010). The reduction in material and health inequalities is prone to increase happiness within countries (Ehrenreich 2007; Ferrer-i-Carbonell and Ramos 2012;

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Layard 2006; Wilkinson 2005). It is therefore conceivable that equanimity between countries could further global gladness.

Globally, homicide counts for at least one and a half million deaths each year (United Nations Office on Drugs and Crime 2014). Most homicides occur in low- and middle-income countries and most of the victims are poor (Centers for Disease Control and Prevention 2015). Since 2015, deaths from terrorism have increased by 80 per cent, with only 69 countries not affected by at least one act of violence attributed to 'terrorists' (Institute for Economics and Peace 2016). Poverty and income inequality are the key constituents in determining whether a particular part of the world or region in a country has a high risk of fatal and non-fatal violence (United Nations Office on Drugs and Crime 2014). The human and economic cost of victimhood from murder is enormous, with hundreds of millions of primary and secondary victims dead or mentally and physically damaged and such communities destabilised (Amnesty International 2016; Morrall *et al.* 2011, 2013; Wilkinson and Pickett 2010).

Furthermore, there is evidence that widespread public issues can be linked to private troubles, some of which can be fatal. For example, the 2008 global financial crisis has been linked to a rise in the diagnoses of depression, anxiety and behavioural disorders, as well as alcohol abuse and suicide in the Americas, Europe and Southeast Asian countries. It has also been linked to an increase in infant mortality in sub-Saharan countries (Rajmil *et al.* 2014; Van Hal 2015; World Health Organization 2011).

Alongside these debasements of society – and arguably what is the supportive structure of global/globalising society or, in contrast, what is railed against by those in alternative partitions – are the engulfing and interlinked cultural processes of covetousness, consumerism, commodification and corporatism. Most areas of human life have already become reconfigured by corporations as commodities to be coveted and consumed, including well-being, sex, walking, eating, friendships, communicating and death. The profit ethos of big business is fomenting a worldwide culture of materialism, commodification, consumerism and narcissism (Bakan 2005; Rushkoff 2010, 2016). The enterprise of psychotherapy is a major stakeholder in the global commodification of problems in living, with an increasing market share in the consumption of professional help and the coveting of 'the self'. The pejorative prediction of a 'culture of therapy' by sociologist Frank Furedi (2003) appears to have been apposite.

Social responsibility

The writer Edmond Burke is, allegedly, responsible for the famous quote: 'all it takes for evil to triumph in the world is for good men [and women] to do nothing'. The mess in the world should be of serious concern to the enterprise of psychotherapy. This, I portend, is because, first, these are social calamities far outweighing the overall negative effects on society (and thereby individuals) of many of the tribulations for which psychotherapists provide a service. This is not to diminish the meaning of and suffering from private troubles, but to argue that they need to be set alongside those social issues which are presently unheeded or not heeded enough. Second, the private and public cannot be untangled, no matter what the tribulation or calamity. The 'emotional-offsetting' of public issues by addressing only private troubles is not only ineffective, but also counterproductive (Tischner, personal correspondence). While the world burns the psychotherapeutic enterprise cannot merely fiddle with the aftermath. The enterprise of psychotherapy has a social responsibility to deal with the essential causes of a malfunctioning global society.

While there are a few sociologically aware/politically active psychotherapists (Andrew Samuels is one example), psychotherapy organisations (such as Psychotherapists and Counsellors

for Social Responsibility (PCSR)), texts (see, e.g. Nick Totton's *Psychotherapy and Politics* (2000) book) and journals (see, e.g. *Psychotherapy and Politics International*), most of the enterprise avoids social engagement and is not sociologically aware/politically active or, where it is, it is then initiated by other disciplines such as psychology (see, e.g. the Climate Psychology Alliance (CPA)). 'Social responsibility' implies that not only charitable agencies but all social organisations (whether commercial or professional) have a duty to society beyond and, perhaps because of, their initial *raison d'être*. In some cases it is precisely because of this *raison d'être* (for example, profit-making, the extraction of natural resources, corporatism, education) and its side-effects (for example, ecological damage, dehumanisation) that social responsibility should be indulged. However, this is not to sanction 'offsetting' but to introduce, at worse, balance and, at best, substitution.

My suggestions for the foundations of socially responsible psychotherapy include:

1. All psychotherapy training curricula/conferences to include sociological knowledge which can be applied to enact social change;
2. The de-coupling of psychotherapeutic practice from the commercialisation of human (un)happiness and the focus on the self to be coupled with understandings of the social;
3. The setting up of alliances embracing psychotherapists, sociologists, psychologists, health/medical practitioners, scientists and humanitarians to determine specific tactics aimed at moving humanity from social atavism towards social actualisation.

Conclusion

Private troubles are public issues and *vice versa*. All clients of psychotherapy, whatever their psychological distress, are reflexive psycho-social and biological beings, as is the therapist. Psychotherapy should reflect this reflexivity. Crucially, the psychotherapeutic enterprise should reflect on the mess in the world and pay penance for its seventh sin of psychotherapy – ignorance about and/or ignoring of this mess – by formulating and implementing socially responsible actions aimed at mending the mess which may also help to mend minds.

Leonard Cohen died on 7 November 2016. In what was to be one of his final interviews (Remnick 2016), he reviewed his life and referred to his gratitude for what he had: 'I have all my marbles, so far. I have many resources... So I am extremely blessed'. Those of us with our 'marbles' and many 'resources' may also feel 'blessed' should we act to make a better world.

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Marxist theory and psychotherapy

Ian Parker

This chapter examines how psychotherapy either contributes to the circulation and expansion of capital or enables us to envisage another world beyond capitalism. The first part traces the reactionary role of psychotherapy by way of two transformations of capitalism since the end of the nineteenth century, concerning reification and emotional labour. The second part then considers psychotherapy as a practice which functions as part of the super-structure of society which has a reciprocal influence on the economic base. It is concluded that, for there to be any chance of a liberating form of psychotherapy, it is necessary to link therapeutic practice to the wider socio-political struggles against the individualising tendencies of capitalism.

Alienation and surplus value

There is no way of resolving the contradiction between individual one-to-one treatment and collective mobilisation. Both are necessary and, in some form or another, both always will be. Our task here is to work at that contradiction and understand it a bit better. This is a contradiction that is becoming increasingly important because psychotherapy is itself becoming a potent social force, even a political force. Millions of people engage in some kind of psychotherapy, either directly as clients, through counselling or self-help training or vicariously – hearing their friends talk about it, reading about it or watching programmes about it. The disappointments and failures of the left movements in the last half-century have led a number of old activists into therapy, sometimes training as therapists themselves. And there is emerging inside the left, partly also under the impact of feminism, what I would call a ‘therapeutic sensibility’, with a concern about how to include different voices in debate and the discussion about ‘safe spaces’ in our organisations being an expression of that therapeutic sensibility. We care about peoples’ feelings now, and increasingly do that, whether we like it or not, in a therapeutic way.

There is an issue about distress that I want to briefly remark on but then leave as an assumption that we can take for granted: that this miserable political-economic system, capitalism, intensifies distress. It is one of the characteristics of capitalism that ‘surplus value’ is extracted from us when we sell our labour power. This surplus value is profit, and that is how it appears for

those who employ us and sell the products of our labour. But the process by which this surplus value is extracted from us is hidden. We do not enter into an explicit contract with an employer to work for our wage and then spend more time working for the employer's profit, to produce surplus value. That hidden aspect of everyday exploitation at work is bound up with, and necessarily entails, alienation.

We are alienated from our own creativity as the products of our labour are stolen from us, Marx points out. We are alienated from each other as we compete to sell our labour power, we are alienated from our own bodies that we treat as mechanisms, fearful that they will break down and we will not be able to work and survive and support our loved ones. And, Marx notes, we are alienated from nature as such, experiencing it as threatening rather than as part of who we are as human beings. I want to leave aside the debates about whether distress is a direct consequence of alienation and about possible biological bases of mental distress. What we can be sure about – and for Marxists this is axiomatic for our politics, something that drives us to protest and seek to overthrow capitalism – is that these conditions of exploitation and oppression make us sick, drive us mad and all the drugs in the world will not make us happy. Or, at least, they might make us feel happy, but it will be a kind of false individualised happiness that separates us one from the other and that covers over the emptiness and misery of alienated conditions of work and life.

The key question for us Marxists is this: what role does the practice of psychotherapy play in the circulation and expansion of capital? That is, how does psychotherapy enable the production of surplus value so that, whether we like it or not and despite our best intentions, we participate in a phenomenon that today helps keep capitalism going, even makes it thrive? And the flipside of that question, of course, is this: what might there be about psychotherapy that also makes it a force to undermine capitalism and give us more strength to overthrow this political-economic system? Is there something about psychotherapy which anticipates the kinds of relationships we want to experience after capitalism and which even empowers us now to bring that other world into being? These are two sides of the question concerning the reactionary and progressive faces of psychotherapy. This is not to overplay psychotherapy as an apparatus of social control or as liberating practice. But while we are discussing psychotherapy as Marxists, let us ask those questions of it.

For us Marxists in a particular tradition of anti-Stalinist politics, seeking to learn from the authoritarian and bureaucratic mistakes of the past and from other movements of the oppressed, there is something else we need to keep in mind as we ask those questions. We know well that Marx's own analysis of capitalism was partial. He himself was clear that the first volumes of *Capital* (which focused primarily on production) needed to be elaborated further to encompass consumption and to ground those analyses in the histories of colonial expansion. Marx (1867) begins to do this even in *Capital Volume I (Capital: A Critique of Political Economy)*, touching on women's labour and child labour and then on the place of Europe in a rapidly globalising world. Marxist ecosocialists take that analysis further to emphasise that capitalism is a system of social relations. We see the human being as more than the reduced 'individual' of classical nineteenth-century political economy or the isolated psychological mechanism of this twenty-first century; we see ourselves as, in Marx's (1888) words, an 'ensemble of social relations', a particular kind of ensemble that cuts us off from our own nature and from nature as such. And, learning from feminism, we appreciate better that the single isolated individual attempting to be master of nature and of other human beings is also stereotypically masculine. Our alienation from each other and from ourselves that gives rise to so much distress is bound up with either the push to be in control (to be a man) or to be subordinate and passive (to be feminine, to be more like how we are told women should be).

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These deeper and more open ecosocialist and feminist developments of Marxist politics already connect in some way with the project of psychotherapy. They connect in the sense that we are concerned as we have always been with overthrowing the state and seizing the means of production, at last making society democratically accountable and transforming society. But we are also concerned with the nature of social relations in which there is a necessary, ineliminable element of illusion, misunderstanding, fantasy and emotional confusion, even pain, about what it is to work or not be able to work, to be a man or woman, to fear nature or want to return to it. These issues also return us, at the same time, to some of the fundamental starting points of Marxism itself in the writings of Hegel, to the anguish we suffer as human beings, what capitalism does with that suffering and what we can do with it.

Hegel's formulation of the issue was something Marx attempted to ground in a critique of political economy so that we could better grasp it collectively and this formulation is still striking today as a diagnosis of what we face in psychotherapy: Hegel (1977: 187) says that '[s]peech and work are outer expressions in which the individual no longer keeps and possesses himself within himself, but lets the inner get completely outside of him, leaving it to the mercy of something other than himself'. This is alienation; something of ourselves is taken from us and appears to us as an external force, out of our control so that we are at the mercy of something that was within ourselves but has become something other than ourselves. This kind of operation is not merely ideological, not a mistake, but rather is a function of the organisation of social life under capitalism. For Hegel, and for some psychoanalysts, this is an underlying universal philosophical diagnosis of the unending tragedy of the human condition. Marxists, however, focus on the particular ways in which this process is materially grounded and subject to transformation, the way it changes and the way that we might ourselves change the way it operates. We assume, and this is the basis of our politics, that it will change in different ways depending on whether our activity is confined to an individual level or whether it is through collective action.

There is good historical evidence that collective action does actually empower people such that they feel healthier and happier as human beings, they realise more of their potential as beings that are, indeed, an 'ensemble of social relations'. Outside such times of revolutionary transformation and self-transformation, however, we are back to the question of individual activity, limited steps that we might take to keep ourselves together, stop ourselves and others from breaking under the strain of living under this inhumane system; and so we come back to psychotherapy and the role that it plays under capitalism.

Reification and social relations

Something has happened as capitalism developed over the centuries, became a global world system and today appears to be all-powerful to the point where it is difficult to imagine that there could be an alternative to it. Here already we see a first transformation of capitalism. In the early stages of capitalism there was an intensification of what some Marxist writers called 'reification'. For Marx himself, reification referred to the process by which we are able to abstract something from our experience to be able to conceptualise it and examine it in more detail. When we analyse capitalism or imperialism or patriarchy, for example, we 'reify' it so we can grasp its nature as a material and symbolic process independent of us, which then sets the conditions in which we work and think about ourselves. Reification gives us critical distance from reality so we can begin to think and work together to change that reality. But reification also operates in our everyday uncritical engagement with the world, with other people and with ourselves when we treat social relations as if they were things to be manipulated or, worse, things that experts with knowledge way beyond our grasp can manipulate. Here reification is mystification and, to

return to that quote from Hegel, it then makes what was an expression of our creativity, from within ourselves, turn into ‘something other’ than ourselves so we are its mercy. We can see this distortion of our relation to ourselves and our own creative capacities worked through in different spheres of activity.

Our abilities are turned against us so that we are turned into objects rather than subjects of our own lives. Marx (1867) famously argued that what distinguishes the worst of architects from the best of bees is that the architect is able to construct an image of what they want to build in their imagination before they build it in reality. Marx emphasises here the human cognitive capacity to think through consequences of our actions, something which means that human behaviour is always mediated by thought. However, that cognitive capacity then becomes reified under capitalism, so that it is assumed to take place inside each separate individual mind. Then the most we can hope for is that we can better think about how we might adapt ourselves to reality instead of working out together how to change it. In the worst of cases, and when it is reduced to this level of individual mental functions and as part of an agenda of social control to get people back to work, it takes the form of cognitive behavioural therapy (CBT) (House and Loewenthal 2008). The danger here lies in the way this therapy is abstracted from social relations and when it only operates as a reification of those cognitive capacities Marx was drawing attention to.

In one of his more romantic passages, Marx (1843, emphasis added) argues that a future post-capitalist society will see the human being reclaim their capacity for self-creative activity; in those conditions, the human being ‘will *move around* himself as his *own* true *Sun*’. Religion, he says, is only ‘the illusory *Sun* which *revolves around* man as long as he does not *revolve around* himself’. This holistic cosmic metaphor inspires some of the more humanistic strands of Marxist politics. In place of an alienated world in which we are subject to so many different kinds of separation, torn from each other and from our true nature, there is the hope that we will be reunited with each other and with who we always really were – that the end of capitalism will see us live authentically at last. This hope for a better world however, a vision of equal, loving relationships which we aim for and aim to build even if we know consciously and rationally that it may never be attainable, is itself distorted, reified in a most peculiar way in some forms of psychotherapy and in psychotherapeutic ideology. The promise is that you do not have to wait for this to happen in a future post-capitalist world; instead, at the very same moment that you are told to give up any hope to change the world, you are encouraged to believe that you can change yourself. You will be whole and united as an individual self, but in a world that is still divided.

The twist on the process of reification that Marxists notice then takes another turn, both in some forms of CBT and in some forms of humanistic therapy (House and Loewenthal 2008). Now, not only does ‘the inner get completely outside’ so that we are at its mercy as something other than ourselves, but we are convinced that this reified thing – and here is the twist – is inside us. This treatment of something inside us – thoughts and feelings that we cannot control – is part of a reifying practice in psychotherapy that is part of the emerging process of what is called ‘psychologisation’ (De Vos 2012). Our human capacities that we exercise along with other human beings in social relationships (because we are more than individuals, because we are an ‘ensemble of social relations’) are treated as things, objects that some psychotherapists help us to work on, out of our control but, we are told, things that can be managed.

Here we are building up a picture, an analysis of how psychotherapy functions in the service of capital, part of the process by which people can be good workers, accepting that there are aspects of their lives (including their internal lives that are outside their immediate awareness, outside their control) that can be offered up for surplus value to be extracted from them and realised as profit by their employers.

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Cognitive and emotional labour

One of the remarkable things about human labour power is how it produces value. Marx shows us that this value is divided under conditions of capitalist production into ‘exchange value’ (that is, the kind of value that we get as products of our labour are traded with each other as commodities) and ‘use value’ (in which we experience their direct and immediate importance to us). Labour power itself is then also separated into use and exchange value. Not only are these things of value turned into objects of exchange, commodities out of our control, completely outside ourselves, our labour power is itself also harnessed to work processes that are deeply divisive, out of our control. Here we come to a second transformation of capitalism. If the first transformation in the early years concerned the role of reification, the second transformation involves cognition and emotion – that is, exactly the stuff of psychotherapy.

Capitalism after the Second World War saw the rise of the service sector. Today, most economic production and consumption around the world is governed by the needs of the service sector, the provision of marketing, leisure, health and so on (Mandel 1974). One of the characteristics of the service sector is that there is a privileging of intellectual labour over manual labour (that is, the ‘cognitive’ element comes to the fore) and the other is that there is an increasing emphasis on the customer experience and, therefore, the ability of the worker to tend to that – to care for the customer. Not accidentally, this rise of the service sector sees the re-entry into the workforce of women – women who were always present as workers in the early development of capitalism in the nineteenth century, but now women valued as women workers rather than only as bodies with agile limbs and nimble fingers (Marcus 1974).

Women who had been divided off from the world of work and consigned to the home to tend to the family, to care for children and their men-folk, now became a source of what has become known among feminist researchers as ‘emotional labour’ (Hochschild 1983). Recent management discourse has quite cynically drawn on this kind of analysis to quantify and then persuade employees that when they work for a high-status organisation they are receiving an ‘emotional salary’ as well as actual money. That is, we can understand how stereotypical ‘feminine’ capacities for care and an apparently natural intuitive understanding of the needs of others came to be seen as valuable to capitalism. Those capacities (which are actually more closely connected to our human nature as an ensemble of social relations – beings who develop our potentials in relation to others) are ones that many men have been taught to be suspicious of and to keep under control, but now they become a source of value. In that process of apparent reconnection with an aspect of our nature as human beings, this emotional labour power is itself instrumentalised, treated as something that can be useful for others, turned into something outside our control; it is reified.

There is a consequence here for some of the other alternative approaches in psychotherapy that I have not mentioned so far. On the one hand, the cognitive behavioural therapies and humanistic or person-centred therapies often avoid the idea that there is something else beyond immediate awareness, something more deeply hidden in our experience that we might call ‘unconscious’. One of the lessons of a Marxist analysis of capitalism as a regime devoted to the extraction of surplus value and as necessarily entailing alienation is that there is something beyond awareness, outside consciousness. That is why psychoanalysis has been attractive to many Marxists, if not as a therapy then at least as an analytic framework (Kovel 1988). It promises a deeper analysis of what is hidden from us. But, on the other hand, there is a danger here. The historical separation of feminine capacities for emotional care from more masculine task-oriented abilities was played out in a social apparatus of the nuclear family that assumed an important role under capitalism.

The trap that many forms of psychoanalysis fell into was to idealise the family and the separation between the role of the mother and father so that the attempts to describe the ‘unconscious’ as something beyond awareness also had the effect of ‘familialising’ it. That would be making it fit with our idea of what a family should be as a haven in a heartless world, rather than as a little prison for those raised inside it to be good well-behaved workers as daddy was (Engels 1884). The idea that most men are ‘obsessional neurotic’ and that most women are ‘hysteric’ is part of this picture, as is the fake-feminist idea that obsessionals are obedient slaves and hysterics are rebelling against the system (Parker 2011). Then the danger is that psychoanalytic kinds of psychotherapy that appear to give a deeper analysis simply end up operating at a deeper ideological level.

In a variety of different contradictory ways, therefore, much psychotherapy not only adapts people to capitalism – encourages them to feel comfortable with it, happier with it – but operates as a moral force. This moralising aspect is most obvious when we notice that most psychotherapists believe that their clients will be happier when they are like them. It then makes sense to treat psychotherapy not merely as part of the ideological ‘superstructure’ of contemporary capitalist society but part of the economic base. Marx (1863) made the important point that capitalist production not only ‘creates an object for the subject, but also a subject for the object’; that is, capitalism not only makes peculiar artificial kinds of commodities for us, but it also makes us into peculiar artificial kinds of subject who will enjoy consuming them. Capitalism functions as a material force that creates us as particular kinds of being, separated from each other and now cultivating emotional labour power so that we can better function as the kind of subject from which surplus value can be extracted.

Conclusions

These critical reflections on the role of psychotherapy under capitalism must also necessarily for Marxists lead us to the question as to what is to be done with it. We can approach this question by reflecting on how practices that are often side-lined in simplistic readings of Marxist theory on the ‘superstructure’ actually function to modify the economic base. Psychotherapy is a case in point and here we find a positive role for it as part of revolutionary politics. Marx (1863) himself explicitly referred to the way that specific forms of what he called ‘spiritual production’ exercised a ‘reciprocal influence’ on material production. Something of that kind of reciprocal influence is at work today in the case of psychotherapy. Psychotherapy today is a form of ‘spiritual production’, and that is how many practitioners and clients treat it. It becomes for them a complete worldview. But rather than just condemning it as a worldview or an ideology, I think we should step back and reflect on how it might be functioning as such.

I also am bearing in mind some of the transformations of spiritual production in different parts of the world, where religion has been transformed from being a reactionary force that ratifies forms of social inequality into a ‘liberation theology’ that makes present in peoples’ lives and experience another possible better world beyond capitalism (Kovel 1988). This is where psychotherapy may be reconfigured as an experience of self-care and care for others so that it speaks against an alienating destructive social system and lays the basis for resistance to it. To do that, however, this more liberating face of psychotherapy would need to link practitioners with clients collectively organising themselves, would need to take an explicitly political stance against attempts by the capitalist state to use it for purposes of adaptation and would need to break from the enclosure of emotion in which only those who can pay can expect to get help. There are political movements that are working on each of these three questions now, such as the journal and discussion forum *Asylum: Magazine for Democratic Psychiatry* (see asylumonline.net), which

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links practitioners and clients, the Psychotherapy and Counselling Union (see pandcunion.ning.com) to argue against adaptation and the Free Psychotherapy Network (FPN) (see freepsychotherapynetwork.com) to provide services at little cost. When they connect with psychotherapy, Marxists should also actively be involved, theoretically and practically, working with subjectivity at an individual and collective level to transform it.

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A feminist critique of trauma therapy

Emma Tseris

In comparison to the overt forms of harm that continue to be perpetrated within mental health systems (for instance, electroshock, restraint, seclusion and forced medication), it is understandable that some feminists have praised trauma therapy for its approach to working with women presenting to mental health services. For example, proponents of trauma therapy cite the deep interest shown by trauma therapists in women's biographies, in comparison to psychiatry's lack of interest in diverse social contexts (Lindorfer 2007). In addition, trauma workers have argued that there is a strong distinction to be made between a pharmacological response to distress and trauma therapy's emphasis on meaning-making through listening to clients' stories (Dillon 2010). For these reasons, trauma therapists claim to offer a radically different understanding of how women who have experienced gender-based violence can be respectfully responded to by mental health workers, in comparison to a traditional psychiatric response based on diagnosis and medication. Drawing on critical feminist scholarship, this chapter takes a different approach to discussing the influence of trauma therapy, offering instead an examination of the socio-cultural conditions that may sit behind trauma therapy's immense rise in popularity within psychiatric contexts. It will argue that trauma therapy has gained traction within mental health services *not* because of a sudden interest within psychiatry in feminist activism, but rather due to the ability of trauma therapy to reduce complex social justice issues into psychological symptoms, which are then thought to be curable through expert mental health treatment. Therefore, it is necessary to be cautious about the increasing popularisation of trauma therapies, due to their involvement in labelling female survivors of violence with a mental health disorder, at the expense of paying attention to the behaviours of the – usually male – perpetrators of violence against women. In this way, trauma therapies often participate in reproducing, rather than disrupting, the tendency within psychiatry to de-contextualise women's distress from its social and gendered context.

The trauma concept

In an article about the pressing need for training in trauma-related material to be incorporated 'across all professions', Courtois and Gold (2009: 18) argue for an acknowledgement of 'the ubiquity of trauma in human experience and the variety of posttraumatic reactions and disorders identified as occurring in its aftermath'. Despite rigorous scholarship contending that the notion

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of trauma is a culturally specific and historically recent concept (Summerfield 2001), such commentaries concretise trauma as a material ‘fact’ of the aftermath of distressing events. Accordingly, Courtois and Gold join a multitude of therapists and researchers who increasingly draw upon the concept of trauma as a commonsensical description of the effects of abuse and other overwhelming experiences, whereby the aftermath of violence is understood as a predominantly psychological experience (Whelan *et al.* 2002).

The trauma concept is often presented as a marginalised and under-utilised concept within the mental health arena (see Bateman *et al.* 2013). However, the trauma concept has gained enormous traction and attention within mental health services in the past quarter of a century. Indeed, the notion that traumatic psychological and neurobiological changes occur within individuals following the experience of overwhelming stressors – including, but certainly not limited to, rape and other forms of gender-based violence – has taken a central place not only within mental health services, but more broadly within the Western cultural imagination (Bracken 2002; Fassin and Rechtman 2009). In response, a search for simple and reproducible models of ‘trauma intervention’ has become an international enterprise, referred to by some as the ‘trauma industry’ (Afuafe 2011). Therefore, arguments about the reality of an epidemic of ‘trauma’ and the need to increase the funding and resources given to trauma interventions are not neutral arguments based purely on scientific advances, nor can they be explained as being driven purely by the altruistic intentions of helping professionals. As stated by Young (1995: 5), the notion of ‘trauma’,

is not timeless, nor does it possess an intrinsic unity. Rather, it is glued together by the practices, technologies, and narratives with which it is diagnosed, studied, treated, and represented and by the various interests, institutions, and moral arguments that mobilized these efforts and resources.

While some critiques of the ‘trauma industry’ have argued that individuals who claim a trauma history are making illegitimate claims and do so in order to ‘blame others for their problems’ (see Dershowitz 1994), it is possible to critique the ‘trauma industry’ without contributing to victim-blaming discourses or a culture of disbelief that have so often affected the lives of women attempting to seek help related to their experiences of male-perpetrated violence. For example, a sociological analysis has the capacity to examine the processes whereby the popularisation of the trauma concept has suited the professional interests of therapists through enhancing the scope of their authority and perceived expertise. Moreover, the trauma concept performs an important political function. As noted by Withuis (2010: 322), the pervasiveness of the trauma concept has resulted in a one-dimensional view of a trauma survivor, who is defined by a cluster of symptoms and who no longer has a gender, race or class identity: ‘[b]y declaring everyone a potential PTSD-sufferer,’ she states, ‘the question of what exactly causes traumatization and for what reasons frightening situations have different outcomes in different periods and cultures and for different people, disappears from view’.

The idea that trauma is a universal phenomenon, whereby everyone is equally ‘at risk’, consequently has the effect of erasing an analysis of the social – and gendered – conditions that underpin both the perpetration and experience of violence. Essentialising claims, such as Levine’s (1997: 2) renowned assertion that ‘trauma is a fact of life’, de-contextualises distress from its social context, effectively ‘obscuring the *reasons of state* that made it possible to humiliate, torture, and rape’ (Beneduce 2016: 275, emphasis original). Although not the focus of this chapter, discourses pertaining to the trauma experienced by war veterans, victims of natural disasters and indigenous peoples function in a similar way: by focusing on psychological damage, a discussion about the actions of governments and the harm caused by global social inequality is able to be neatly

side-stepped. Even more concerning, notions about the overwhelming effects of trauma have the capacity to erase acts of violence altogether, so that it is the mind-altering effects of trauma that seem most frightening, not the material and social conditions that have preceded and caused the distress. For example, the back cover blurb to Cori's (2007) self-help book entitled *Healing from Trauma* promises to enable readers to:

Understand trauma and its devastating impacts; Identify symptoms of trauma (dissociation, numbing, etc.) and common mental health problems that stem from trauma; Manage traumatic reactions and memories; Create a more balanced life that supports your recovery; Choose appropriate interventions (therapies, self-help groups, medications and alternatives); Recognize how far you've come in your healing and what you need to keep growing.

This passage reflects a mainstream approach to trauma therapy, which paints a picture of extreme symptomatology, with almost no attention given to the origin of the problems that are being named. Also evident in this excerpt is the contemporary, broad usage of the term 'trauma', which has come to be commonly used to describe both the psychological disorders caused by exposure to violence and the injurious event itself – for example, 'exposure to trauma has caused her to experience trauma symptoms'. The effects of this circular use of language support the invisibility of patriarchal dominance, as no reference is made to violence or oppression as the source of the problem (Gilfus 1999). Indeed, 'trauma' has also been used by some authors to describe the psychological effects of *inflicting* violence (see Litz *et al.* 2009). The lexicon of trauma therefore de-politicises gender-based violence: survivors of *abuse* become survivors of *trauma* and interventions for *violence* are reduced to interventions for *trauma*, leading to an ahistorical and de-contextualised understanding of the lives of women survivors of violence.

Trauma and women's narratives

Although trauma therapies are not homogeneous, they usually privilege the telling of stories as the means through which 'recovery' can occur, often requiring survivors to revisit the minutiae of an abusive past, in order to repeatedly process the traumatic material (see, e.g. Cohen *et al.* 2000). At the same time, trauma literature is imbued with discourses of client autonomy, as it 'strives to work collaboratively with survivors, inviting them to participate in treatment planning and encouraging the empowerment of the individual' (Clark *et al.* 2015: 9). The focus on meaning-making and linking current distress to past biographical details is a source of pride for many trauma therapists, who emphasise the differences between a trauma-informed approach and the conventions of psychiatric diagnosis. Storytelling, however, does not occur as a neutral exercise: as McFarlane (in Costa *et al.* 2012: 86) notes, '[s]tories are extremely powerful... But our stories are also a commodity – they help others sell their products, their programs, their services – and sometimes they mine our stories for the details that serve their interests best'.

Thus, the use of narratives within trauma therapy does not, in and of itself, support the advancement of the rights of women, nor does it necessarily result in the overhaul of a psychiatric worldview into a framework that accounts for issues of social context. When women are encouraged to seek therapy (as they so often are), the 'professional' conversation that ensues does not occur in a social vacuum, but is immersed in the therapist's biases, which may be informed by patriarchal norms and values (McLellan 1995). Trauma therapies, for the most part, continue to utilise a language of 'treatment' whereby the mental health worker maintains control over the therapeutic process (Tseris 2013) and many trauma therapies do not offer a transformed view of the role of psychiatry, as they simply combine a talking approach with a conventional

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pharmacological response, rather than replacing it. Furthermore, several trauma therapies continue to readily use the language of diagnosis (including, but far from limited to, post-traumatic stress disorder (PTSD)), thus rendering women as mentally ill and naming their purposive coping strategies and responses to violence as dysfunctional (Burstow 2005). As noted by Lowe (in Proctor 2008: 239), 'it is one thing to offer clients a voice within a professional therapeutic discourse, but it might be quite another thing to allow them a discourse of their own'. The sweeping claim that trauma therapy offers an empowering space for women to tell their stories may act to obscure the multitude of ways in which trauma therapists maintain the capacity to define and analyse women's experiences. In other words, if women's narratives on their own are to be valued, then why is there a need for an ever-increasing number of 'trauma experts' to filter women's experiences through the lenses offered by psychiatric diagnostic frameworks? In fact, utilising a language of 'collaboration' may serve to heighten the power dynamics present within therapy, by hiding the imbalance that continues to be present between therapists and service users (Proctor 2008).

A proliferation of 'techniques'

The past decade has seen a vast wave of new trauma therapies entering the therapy market – examples include trauma-informed yoga, mindfulness meditation, eye movement de-sensitisation and reprocessing (EMDR) and 'neurobiofeedback', among many others (Holleran Steiker 2015). Such therapies compete with one another for prominence as the most 'evidence-based' response to trauma and the 'choices' that are now available to 'traumatised' clients have been widely celebrated. Nevertheless, a preoccupation with the various *techniques* of trauma therapies has distracted from a discussion about the similarities shared by the majority of trauma-informed approaches – in particular, their reductionism and their role in the maintenance of a status quo agenda. Despite the claim that trauma therapies attend to social context, therapy is highly limited in its capacity to examine broad social phenomena; while a discussion about an individual's history and circumstances, families and other local networks is possible, it is rare for therapeutic endeavours to engage in a broader conversation about the need for social change (Morrall 2008). This limitation is particularly relevant to the most recent trauma approaches, which have focused on particularly individualistic responses to distress including 'brain repair' and behavioural techniques. As the majority of the 'new wave' of trauma therapies are not informed by a critical feminist framework, there is frequently very little, if any, scope available within them for discussion about the social and material resources that women may require in order to achieve a state of 'well-being' – the focus instead is on the results that can be achieved through sheer determination and individual resilience, in the hands of an expert therapist (Moloney 2013).

Furthermore, due to its reliance on hegemonic masculine and Western values, the rigid understanding of competent personhood that is drawn upon by many trauma therapists to describe psychological wellness is in need of critique. For instance, examples of the goals of trauma therapy include the development of autonomy and the elimination of a fear of being re-victimised (referred to by Briere and Scott (2015) using the stunningly pathologising term, 'compulsive self-protectiveness'). Such notions of trauma recovery are predicated on a very narrow view of how the safety of women can be understood. Women who receive therapy after violence are not transported to a postfeminist society; rather, they continue to live within cultures that are embedded in patriarchal relations. Experiencing a lack of safety should not be viewed as a 'disorder' but as a realistic worldview within the context of patriarchy (Burstow 2005). There is also a gendered component to the types of responses made by survivors of violence that are positioned as symptoms requiring intervention. For example, the idea that traumatised women experience

‘mood lability’ reflects and perpetuates cultural stereotypes about the problematic emotionality of women. Expectations for abuse survivors relating to their long-term engagement with therapy then act as affective labour tasks assigned to women, with the idea that they will become autonomous and responsible individuals as a result (Arthington 2016). In this way, women who have experienced violence are paradoxically positioned as dysfunctional people who are charged with the active management of the traumatised self. This positioning supports neoliberal political strategies that aim to manage individuals, while simultaneously avoiding responsibility for their well-being (Binkley 2011). In this way, trauma therapy is involved in the concealment of the gendered power relations that affect the lives of women who have survived abuse on both an interpersonal and a socio-cultural level.

Finally, despite their differences, the majority of trauma therapies also share the notion that traumatic events harm people by causing severe and long-lasting psychological difficulties; while this narrative of ‘deficiencies’ proved to be vital to the political work of second-wave feminists attempting to position violence against women as an issue worthy of public attention, it has also been extremely useful to trauma therapists who are attempting to justify the need for their services around violent events (Joseph 2011). There is now a significant body of literature that critiques the problem-saturated view of a trauma survivor, investigating instead the various ways whereby women resist and show strengths in response to abusive relationships (Wade 1997). Nevertheless, this more optimistic picture of the possibilities of growth and resilience in the context of violence needs to be read carefully. First, the capacity of such concepts to fundamentally shift the assumptions underpinning a client–worker relationship is inherently inadequate as, of course, ‘talk of “positives” and “strengths” requires the existence of “negatives” and “weaknesses” for these concepts to make sense’ (Harper and Speed 2012: 8). Second, too much attention on individual acts of resilience distracts from questions about the need for structural change relating to gender equality and poses a barrier to a discussion about what a socially just response to women who have experienced violence could look like.

Concluding reflections

It has not been the aim of this chapter to criticise individual mental health workers who are utilising trauma therapies, especially those who are attempting to build a paradigmatic ‘bridge’ between the constraints of psychiatric thinking and an acknowledgement of the gender politics that underpin women’s experiences of distress (see Herman 1992). As has been noted, the trauma concept is a salient concept within Western contexts and it can be used pragmatically to draw attention to marginalised issues – including gender-based violence – that are, from a critical perspective, in need of serious consideration by mental health workers. In this way, the trauma concept has the capacity to validate and ‘legitimise’ the distress that might be experienced by women after violence and, when used strategically, it has the capacity to combat the significant problem of the psychiatrisation of women. However, as this chapter has argued, trauma therapy also has the worrying ability to quickly transform the social issue of gender inequality into a private ‘dysfunction’ within individual women. Such ‘therapisation’ of social justice issues privileges a micro-analysis of women’s psycho-emotional worlds (Ecclestone and Brunila 2015) at the expense of a critical mental health perspective that focuses on a comprehensive analysis of power relations.

Cultural hegemony is not a zero-sum game (Hall 1996); trauma therapy enables psychiatry, on its terms, to incorporate small components of feminism, while maintaining its paramount status and core assumptions (Holmes and Papps 2013). By focusing on the notion that violence against women causes neurobiological and psychological harm within survivors and by claiming

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that experts can be called upon to heal these ‘traumatic wounds’ mental health workers send a very particular message to both service users and the broader community: the problem of male violence is ultimately located inside the minds of women. Consequently, the actions of men who perpetrate violence against women, along with the characteristics of patriarchal societies that support and condone gender-based violence, remain under-examined. Therefore, while it is important to acknowledge that trauma therapy can, in particular contexts, be inspired by feminist ideals – including building supportive communities and working towards the financial empowerment of women (Goodman and Epstein 2008) – contemporary iterations of trauma therapy are largely involved in obscuring the relationship between women’s distress and gender inequality. It is vital that critical mental health activists and scholars examine the various ways in which trauma therapy contributes to a patriarchal agenda of invisibilising male violence against women and re-establishing cultural motifs about the madness of women (Ussher 2011). Only then will it be possible to explore more practical, creative and subversive responses to the distress experienced by women survivors of violence which extend outside the confines of the therapy room.

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A journey into the dangers of orthodoxy from the former director of the Freud Archives

Jeffrey M. Masson

This is a personal story, a glimpse into one of the key episodes in the history (or post-history) of psychoanalysis, and a cautionary tale. What happened to me when I found certain documents in Freud's desk in his London house has resonance far beyond my own case. That is why I am telling it here. For those of you interested in a more radical (not to say eliminationist) approach to therapy, it may prove useful, remind you of similar events, even in your own life, or simply instruct you more about the history of a central idea in psychoanalysis.

Let me begin right smack in the middle of this tale: in 1980 I went to see Anna Freud in her Hampstead home on Maresfield Gardens. I went in my new capacity as Kurt Eissler's chosen successor to the Freud Archives. Some of the documents were housed in Eissler's apartment, some in the Freud house in London and most of them in the Library of Congress. This was my first visit to the house after convincing Anna Freud to allow me to edit the entire Freud/Fliess letters. This document was already in print, by Anna Freud herself and others, called *The Origins of Psychoanalysis. Letters of Wilhelm Fliess, Drafts and Notes: 1887–1902* (see Freud 1954). But, as Anna Freud explained in her preface, some 169 letters had been left out of this edition on the grounds that they were personal or did not advance our knowledge of the history of psychoanalysis. That was, of course, a subjective opinion, shared by Marie Bonaparte and Ernst Kris, who edited the volume with Freud's daughter.

I disagreed with this decision and explained why to Anna Freud. I was honest enough to tell her that my main interest centred around Freud's abandonment of what he called 'the seduction theory', namely, the sexual abuse of children by adults. I believed he was wrong and had made a mistake – one with enormous consequences for women and children – when he decided that the accounts he heard of sexual abuse were in large part fantasy, especially if they involved a father and a daughter. While I thought Freud made a tragic error, my first interest was to attempt to discover just why Freud changed his mind. In 1896, he believed such accounts were real. A few years later, he said he had made a mistake (Masson 1984). How did he arrive at this conclusion? The historical documents we had at our disposal until then did not permit a clear answer or, indeed, any answer at all. How, after all, does one decide that somebody is fabricating (for whatever reason) an account of sexual abuse or abuse in general? Circumstantial evidence? A confession? Improbability? Freud had written to Fliess about his change of heart, basically stating that it was simply too difficult to believe such events could be so frequent (Masson 1985).

I was hoping that looking at the unpublished letters in German would give me a deeper and better understanding of the events leading up to Freud's change of mind. Anna Freud and I spoke of this over several days, and she tried to convince me I would find nothing of scientific or historic interest. I tried to convince her of the contrary. In the end we agreed to disagree, and she very generously and honourably allowed me to continue my research in her own house.

The first thing that led me to believe I was on to something important was when I sat down at Freud's desk – the very desk he had used in Vienna, which he brought with him to London and where he worked for the short time left to him before he died in 1939. I opened the top right-hand drawer and, lo and behold, I found an extraordinary treasure-trove of letters, all unpublished and all dealing with the very topic I was most interested in – child sexual abuse (CSA). I mention that here because, while I have already published this fact (see Masson 1984), to my knowledge no psychoanalyst has raised the issue of what significance this had. If Freud kept these letters so readily available to him, there must have been a reason. I confess I do not know the answer, but I am persuaded that there must be one. I invite you to think about it.

A brief interruption is called for here: when I arrived in London, I was a fully trained clinical psychoanalyst, a member of the International Psychoanalytical Association (IPA). But just barely; I had graduated in 1979 from the Toronto Psychoanalytic Institute, but there were hard feelings. My teachers did not approve of my focus on trauma in general, and in the sexual abuse of children in particular. They felt I was regressing to Freud's initial 'error' and they made no secret of the fact that they disapproved of my lack of medical knowledge (which they blamed for my ignorance of the central importance of fantasy). In retrospect, I am surprised they even allowed me to graduate. My own analyst, Irvine Schiffer, while fond of me personally (too much so) was not supportive of my interests (for full discussion, see Masson 1990). Nor was anybody else. Perhaps, I often thought to myself, I am simply wrong? Well, time and documents would tell. Time led me to San Francisco, where I became a member of the San Francisco Psychoanalytic Society. My introduction was a paper I wrote with my late ex-wife, Therese Claire Masson, on the centrality of trauma. It was, surprisingly, published in the IPA's official journal, *The International Journal of Psycho-Analysis* (see Masson and Masson 1978). I say 'surprisingly' because it was received in San Francisco with open hostility and anger even from colleagues with whom I was personally friendly (including Edward Weinshel and Victor Calef, senior psychoanalysts at the time).

But the documents I found in Freud's drawer told a story that was radically different from the one we were told as candidates and which was the one officially accepted by all psychoanalysts from the beginning until the 1980s. It read to me as if Freud was haunted by the history of child abuse within psychoanalysis and could not give it up until his death. But even more important for me than this evidence from Freud's workplace were the letters I was – thanks to Anna Freud – permitted to read. These were the unpublished letters from Freud to Fliess during the period when he was 'inventing' psychoanalysis. I remember showing one of these letters to Anna Freud and exclaiming that it was, in my opinion, the single most important letter Freud had ever written, and a deeply heartfelt plea for the protection of children from sexual abuse *after* Freud was supposed to have abandoned his theory of seduction. So it was not only a beautiful letter, it was also important historical evidence for Freud's continued belief in the importance of child abuse. The mystery of why, then, Freud ultimately changed his mind, only deepened. When I asked Anna Freud for her opinion she said to me: 'because he was mistaken'. I told her then, and I still believe, that she was entitled to this opinion and I was entitled to my own – which was different, but surely this document was of enormous historical importance and should be published, allowing others to make up their own minds. She disagreed, but said she would permit me to

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publish this and all the other letters, which I did in 1985 with Harvard University Press (see Masson 1985).

Perhaps naively, given my own experience in my training in Toronto, I thought these issues would be debated by historians and psychologists and the matter would eventually be settled in a scholarly manner. I was wrong. I was vilified for taking an interest in this topic by virtually all of my colleagues in the world of psychoanalysis. Had it not been for the many feminists who came to my rescue (including Louise Armstrong, Judith Herman, Catherine MacKinnon, Kate Millett, Florence Rush, Diana Russell and Gloria Steinem), I would have thought I was totally in the wrong.

But it was not the personal aspect that astonished me (because I knew that Freud had suffered a similar ostracism, as did Ferenczi after him – ironically from Freud himself – and later Robert Fliess, the son of Freud's closest friend to whom he wrote the letters in question), but the fact that these documents were not being taken seriously by other scholars. After all, it was not every day that 163 unknown letters by Sigmund Freud himself saw the light of day. If my interpretation of these letters was false, fine, then let us come to different conclusions. Nor was I wedded to my thesis as to why Freud eventually caved in to society's reluctance to accept the reality of abuse. I believed he found that it was too isolating and that he seemed to be going against the grain and against all his colleagues; he was young, still ambitious (rightly so considering his remarkable intellectual capacities) and did not want to be thrown to the wolves before he had even begun to build a career. As I say, I may be wrong. This is only a hypothesis. I would be glad to hear others. But, at the time, the focus seemed to be on my motivation rather than the historical documents that I had published and commented upon (as if to confirm their appreciation for my efforts, the IPA and their affiliates subsequently removed me as a member of their organisations and I was later fired from the Freud Archives; see Masson: 1990: 203–4).

Undoubtedly this was a sensitive topic. For one, Freud had already pronounced on it and no psychoanalyst wanted to be in opposition to the master, especially on something as central as trauma. For another, there was zero recognition of the reality of child sexual abuse until the 1980s, whether it was in society in general or in any of the psychological disciplines. It was not as if the Jungians, or the clinical psychologists, or the psychiatrists were prepared to recognise this reality. There was only the people – mostly women – who had experienced the abuse and a few feminists willing to stand by them. It was a lonely time and a low point in intellectual history.

Things have changed considerably, I am happy to note. Today, when the Catholic Church is accused of hiding the perpetrators of abuse, nobody uses the excuse that the victims are merely fantasising. I believe that particular idea has been permanently relegated to the dustbin of poor ideas. But it was a powerful idea in its time, and stood for many decades as the single most cited explanation for why a girl would accuse a man of child abuse.

But what I would like you to think about is this: what are the implications of this story for the wider world of therapy? I cannot pretend I have not thought about this myself. Some of you will be aware that I wrote a book called *Against Therapy* (1994), the title of which pretty much sums up my thinking – I was not asking for radical changes to be made to psychological therapy, I was asking for its abolition. Or rather, I was trying to make an intellectual case for why therapy as we had had it for the last 100 years, was something that needed critical attention. I was not convinced then, and still am not, that there are elements of psychotherapy worth preserving. Yes, in theory it is very nice to have a wiser older person listen to your problems and speculate on how you could best solve them or learn to live with them. But I am convinced that this simple scenario is extremely rare; what happens, all too often, is that the therapist tries to impose his or her own views onto your life experience (see, e.g. Masson 1994; Morrall 2008). Sometimes this

might be helpful, but all too often, in my opinion, it is fraught with danger. After all, suppose you have strong left-wing views and your therapist does not. Will he not attempt, even at a very subtle level, to convince you that you are wrong? No, almost all therapists will say, a well-trained therapist leaves his own views out of the picture. But is this even possible? Even Freud, after all, was very worried about what he called ‘the countertransference’ – that is, the feelings evoked in the therapist by the patient (see, e.g. Freud 2001: 9–55). They must be ‘overcome’ he thought. But can they be? And, if so, how? I have not seen evidence, in all my many years of knowing therapists of all stripes, that this is common. Alas, the opposite is more likely to happen: therapists, being human after all, give in to their emotions; this may sometimes help a patient, but can, more likely, harm them (see, e.g. Masson 1994; Moloney 2013; Morrall 2008).

I still, today, some 40 years after my psychoanalytic training, attempt to dissuade people from entering therapy. I warn them that it will be very difficult to know in advance whether this particular therapist has their best interests at heart or, even if they do, whether they are capable of helping them. Are they even capable of forgetting their own views for the hour? I think even this simple task is up for debate, perhaps because it is not so simple after all. We are all flawed humans and when we encounter other flawed humans we are most likely to help them when we are not in a professional relationship with them. There are so many things people can do short of therapy – being outdoors is a healthy alternative, seeking like-minded friends (even those who will not consider therapy), dancing (the later you start, the better for your brain!), learning a new musical instrument (ditto), a new language (ditto), bonding with a dog, cat, bird or other animal or going back to college – in short, any ‘real-life’ activity that allows you to be involved with others without the ills of hierarchy.

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