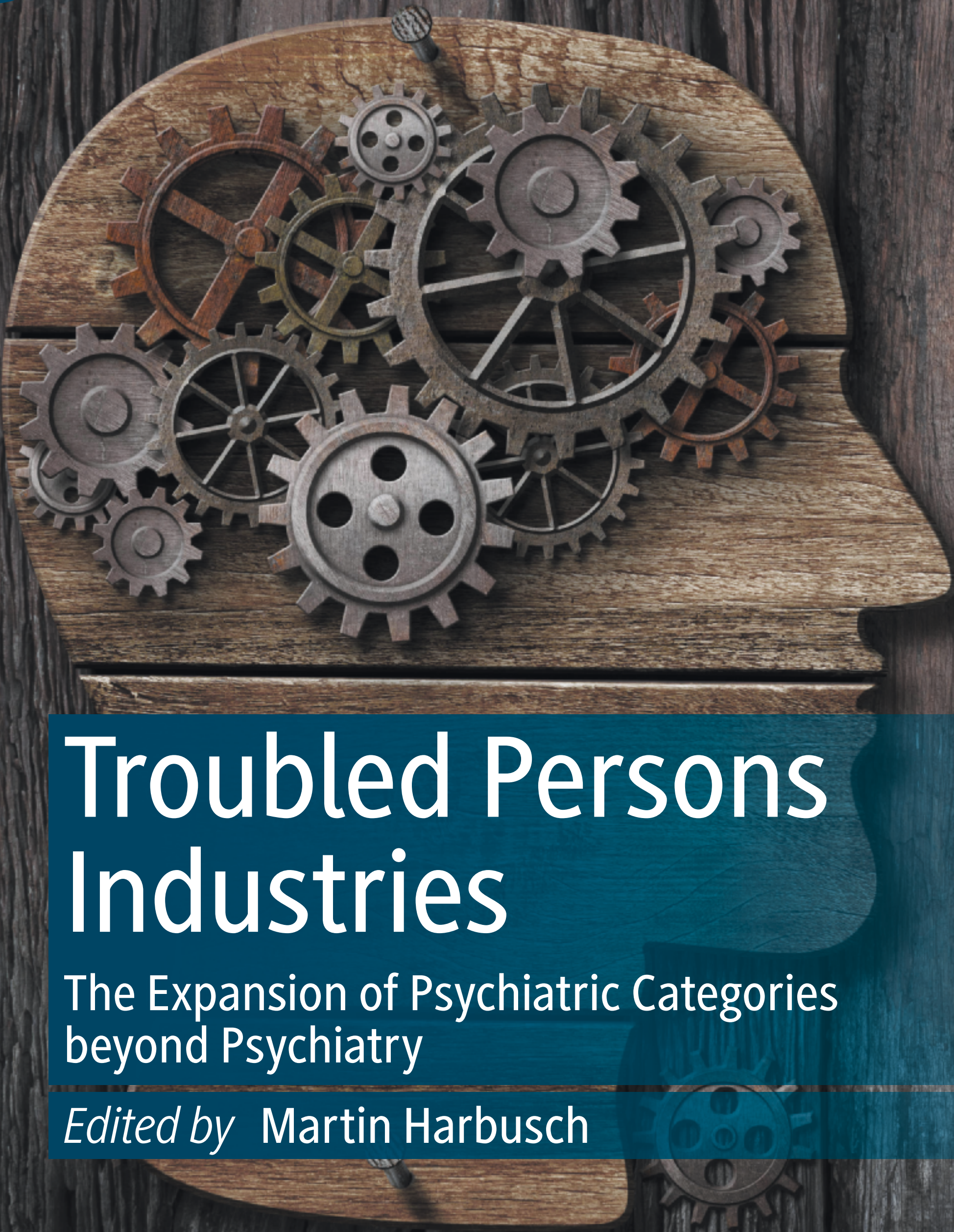

Troubled Persons Industries

The Expansion of Psychiatric Categories beyond Psychiatry

Edited by Martin Harbusch

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Foreword

New Zealand actor and playwright, Rob Mokaraka stood on the stage, and pleaded with his rapt audience. “We’ve got to shine a light on this taniwha.[1] We need to bring it out of the darkness and into the light,” he implored. Mokaraka used the mythical taniwha to evoke the dark world of depression and mental illness. His creative work is devoted to suicide prevention, and to consciousness raising amongst, notably, stoic men, who lock in the taniwha, lest it escape and reap imagined irreparable harm.

Mokaraka is right to promote awareness of repressed emotion. He is right to say that we need to “bring people out of the darkness and into the light.” We have to talk about mental health. A lot. In the right circumstances. Not all the time though…

Last year, I was in my shared office, when two first-year students poked their head in the door, visibly upset, looking for my office mate. I recognised them from the class I teach, in which they were students as well.

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[1] Māori: a supernatural creature, cunning and sometimes terrifying, variably a guardian or a fierce adversary, usually hiding in the depths of the ocean. https://teara.govt.nz/en/taniwha.

“I am sorry, Kim’s not here. What’s up? You don’t look so good.” I said. One of the girls was weeping, the other looked grim.

“We’ve got our first tutorial presentation for Kim’s class in an hour,” wailed one the weepy one. “I’ve got no idea what to do. I am so anxious!”

I invited them in and offered tissues.

“How much is this presentation worth?” I asked

“Five percent” sniffled one of them, through her tears.

They explained that they were the first in their group to do a presentation, and they weren’t sure what it was supposed to look like. They didn’t know if they knew enough to do it well. They thought that five percent sounded like a lot. They were nervous.

I sent the weepy one out to wash her face, and when she came back, I talked to them about being nervous. I asked them if they’d ever played sports, or done creative performances. “You know how you’d get butterflies before, right?” They did remember. “Think of this as the same.” I prompted, telling them about the inverted-U model of arousal that I recalled from my undergraduate days in Physical Education. They gathered themselves, embraced their nerves as best they could, and did their presentations.

But this is not the end of the story. Their experience prompted me to write to all of my first-year students, inviting them to think about butterflies. What words can we use, I asked, that will explain our emotions without pathologizing them. Can we be nervous without being “anxious”? I wondered. I was to continue this conversation by asking if they could think of other words that could normalise the processes of not knowing, discovering, exploring, worrying: all parts of the process of learning. They didn’t have to refer to how they felt as being “confused,” “totally lost,” and “stressed.”

The two students I had comforted came back to me a few days later. They had also read my messages to the class. Things had gone passably well. “Thank you, thank you!” one of them said. “Neither of really had the words to describe our emotions.”

Their experience was one of the expansion of the psychiatric discourse into the experience of everyday emotions. Its negative impact on their university learning journey and on their life in general was multiple. Firstly, it prevented the students from recognising their emotions as helpful to their performance. Secondly, it cast them as victims of pathology, rather than as subjects with agency in relation to the challenge at hand. Finally, it led them to propagate their emotions and reengage with them in future occurrences in a way unlikely to empower them.

They live in a world which gets more and more practiced at, as Mokaraka recommends, "shining a light on the taniwha," yet, with only limited benefit. While, on the one hand, the recognition of depression, anxiety and of a range of other psychiatric disorders technically, should bring benefit to those who suffer from these pathologies; on the other, the impact of this increased awareness of mental illness has not resulted in improved outcomes. The more we talk about it, the more we diagnose it. And, at the same time, the ever-expanding use of these terms pathologises emotion, like the "loss of sadness" in favour of "depression" about which Horwitz and Wakefield have written (2007).

Even while this is an unwelcome discursive turn, I am loath to see this transformation of normal emotion into pathology as a project of medical, or even of industrial, imperialism. Zola claimed that the medicalisation of the 60s was the result of the over-reliance on the expert (Zola, 1991). I will extend that premise to say that the discursive landscape of emotions is the result of the over-reliance on the *now-assimilated tools* of the expert, that is to say, the diagnosis.

Diagnosis is an important way of understanding the world. It breaks up the continuum of nature into manageable parts. A diagnosis is more than a label of a natural "fact," it is, rather, the way we organize facts. It is how we decide what parts of our material existence we want to include under a particular umbrella. The diagnosis then provides an overarching structure to the experience of illness: it explains, provides access to a treatment, and predicts the future.

In the case of twenty-first-century mental health, the language of emotion has given way to diagnostic terminology, and with this shift come the industrial machinations of medicalisation. With the shorthand of diagnosis, it's far easier to connect algorithmically to the next step. Put "Anxiety" into your browser search engine and you'll be immediately directed to self-help, mental health organizations, the anxiety trust. You'll be given lists of treatments; potential psychotherapeutic techniques and services; and lists of diagnoses like phobias, social anxiety disorder, school phobia, agoraphobia, and selective mutism. Put in "nervous about a test" and you'll get a whole different flavour: "use tunnel vision," "call it excitement," and "try a hand massage."

By using the language of mental health, and calling my students' emotions "anxiety" instead of "butterflies" we have created a space in which young people are set up to see themselves as vulnerable and in need of intervention. We also limit the avenues of succour available to these students. They turn to counsellors, doctors, and therapists; rather than to friends, elders, and spiritual guides.

While Mokaraka's aims are valorous, and the destigmatization of mental health problems is an important priority of our era, this book will reveal how the pendulum may have swung too far, focussing the student view inward to a deficient self, rather than towards a self with wide-ranging ways for engaging with their worlds.

The critical essays in this volume make a welcome addition to critical scholarship exploring how to strike that balance. How can we at the same time recognise the importance of well-being and mental health, without tipping our people (young and old) over into a culture of victimhood and pathology? This book will use sociological critique to make visible the limitations of psychology as well as its strengths. Above all, it will empower critical voices.

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References

Horwitz, A., V., & Wakefield, J., C. (2007). The loss of sadness: How Psychiatry transformed normal sorrow into depressive disorder. Oxford University Press.

Zola, I. K. (1991). Bringing our bodies and ourselves back in: Reflections on a past, present, and future “medical sociology”. Journal of Health and Social Behavior, 32(1), 1–16. Retrieved from http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Citation&list_uids=2007758.

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1

Introduction: Are We All Mad Here? The Normalization of "Trouble" in Everyday Life

Martin Harbusch

A studied look into the history of psychiatry shows a discipline which has experienced constant change over the past century (cf. Shorter, 1997; Foucault 1965). The complexity and paradigmatic diversity of the perspectives involved, as well as the constant reformulations of the proffered definitions and concepts, make it seem almost absurd to speak about psychiatry as if it were just one discipline. Aside from common reference points for categorizing and treating "disturbed" behavior, different therapeutic and psychiatric schools throughout the history of the discipline bore little in common and, at the beginning of the twentieth century, experienced difficulties not only in drawing internal lines and establishing boundaries but also in presenting a homogenous and organized image to the outside world (cf. Houts, 2000; Blashfield et al., 2014: 28; APA, 1952: vii).

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Since the 1960s, the unification and systemization of this "polyglot of diagnostic labels and systems" (APA, 1952: v) has been considered a central goal of psychiatric work—especially following the emergence of the DSM (Diagnostic and Statistical Manual of Mental Disorders); this clarification and homogenization of psychiatric thought has, to date, not been entirely successful. This could be read as the failure of the discipline to establish a unified structure and orthodoxy. On closer inspection, however, it is precisely this surviving heterogeneity that engenders adaptability, flexibility, and resilience which in turn allow for a pragmatic openness in the everyday application of psychiatric concepts. This surely is central to the success of psychiatric labels in establishing a beachhead into everyday life, achieving levels of everyday recognition far exceeding that of the jargon and technical terms of most disciplines in both the social and natural sciences. Whether the aspired to homogenization of concepts and applicable labels would truly further psychiatric interests, or whether this pursuit is essentially a staged battle taking place on the front stage of the discipline, is question worth considering.

The incompatibility of different psychiatric approaches has fittingly been relegated to the backstage as the simulacrum of uniformity established by the diagnostic catalogs (since the 1960s) took precedence, but it has not truly dissolved. On the contrary: even if the diagnostic manuals appear to the layperson as a uniform catalog of criteria, a closer look behind the curtain reveals the discursive inconsistency of the supporting arguments. This can be seen in the progression and revision of the manuals themselves, in the constantly changing and historically dependent forms and content of psychiatric disorder constructions, in the dependence of disease categories on social situations and social actors that is more often than not stricken from these definitions, in the monetary interests of the pharmaceutical industry in increasing the population which is considered diagnosable, and in the reliance on the banners, trappings, and styles of medicine without a comparable reliance on classical medical evidence (cf. Frances, 2013). Psychiatry has always been, and continues to be, a chimera; one which has always adapted its ideas of social deviance to the social, political, and hegemonic conditions of the age, and from time to time attempting to reconfigure social contexts into psychiatric contexts with understanding, other times with an authoritative, even oppressive, face.

Sociology has developed alongside psychiatry—sometimes in parallel, sometimes in cooperation, and sometimes in direct opposition. It has differentiated itself particularly in its critical perspectives (cf. Cohen, 2019; Pilgrim & Rogers, 2005). It has also not only broadened its theoretical and conceptual apparatus over the past few decades, establishing the expansion of psychiatric illness categories itself as a topic of sociological interest, but also recognizing (and defending) wider social contexts as field being affected by psychiatric perspectives.

Today, psychiatric categories are more prominent and respected than ever in everyday life. They are brought to bear, albeit not uniformly, by countless professional and private actors to describe problematic social contexts. The success of these categories is no longer solely due to the direct work of psychiatrically trained professionals working in psychiatric institutions or therapeutic practice. It also fundamentally relies on the everyday practices of non-psychiatric actors pursuing differing interested—both professional and private—through the use of psychiatric knowledge systems. Gusfield once referred to these actors collectively as "troubled persons industries" (1989), highlighting the important of (psycho)social, governmental, and economic institutions in the everyday reproduction of categories of concern. This term bundles a broad field which has been primarily explored in micro-sociological studies in recent years. These studies have examined how psychiatric knowledge is used in both institutional and non-institutional contexts. They not only reflect on the expansion of psychiatric arguments from an academic to a mainstream category, but they also show the processes of categorical transformation that facilitate broader non-expert understandings or even establish new forms of psychiatric expertise. They further explore the respective institutional advantages and disadvantages that accompany the use of psychiatric knowledge and the institutional and personal consequences that these applications have for all those involved.

The success of psychiatry appears to lie, paradoxically, precisely in the fact that the psychiatric narrative has left the confines of psychiatry and, as it emerges in increasingly more outside contexts, can still command support by psychiatric contexts, actively and passively. In this sense, the current strength of psychiatry is based in contradiction: it maintains its power through its everyday dissolution.

One of the tasks of sociological criticism of psychiatry in the coming years will be to accompany this process and its development, to make its situational achievements and individual consequences visible and empower critical voices. The present volume is an attempt to contribute to this task.

De-contextualization of Social Problems

With the renewed expansion of the categories of mental disorders through the catalog DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), new disorders and new contexts of (self-)attribution have come under the scrutiny of social scientific criticism of psychiatry. In part, contemporary social science perspectives draw on the classics of critical psychiatry and critical approaches generally, which reached their peak in the 1970s. At the same time, these new approaches fundamentally update and expand this discourse, reacting not only to significant changes in the status and structure of psychiatry in the previous decades but also to changes within the social sciences.

Even today, the central arguments of the classical critiques hold up to scrutiny. These arguments focus on how psychological diagnosis seeks to decontextualize social problems by acting as an objectification, naturalization, and individualization under the guise of biologically oriented attribution (cf. Harbusch, 2019: 197f.). Within these psychiatric frames, the causes of social and socially determined "disorders" are seen as lying within individual behavior. The context surrounding a situation which is evaluated as "disturbed" remains broadly unquestioned, the normative and dominant structures nominally defended, overlooked in the shadow of the now putatively disturbed individual. A division is thereby established between the normal and the deviant through distinctly social processes, while this social construction itself is implicitly held to be natural, even inevitable.

At the center of the sociological critique of the psychiatric interpretation of social problems is then the accusation of simplifying the social world and, more significantly, doing so in a way that avoids even the suggestion of a potential rooting of concepts of "health" and "illness" within social, cultural, historical, institutional, situational, or strategic contexts. It is the accusation that the psychiatric worldview is broadly a defense of bourgeois ideas of normality. Biologically framed conceptualizations, having found their way into psychiatric as well as public discourse to a significant degree since the 1980s following the DSM III, exclude more complex interpretations of social deviation from public debate. These interpretations include those represented in the DSM I (1952) and II (1968), which still considered the social embeddedness of disorder concepts. The potent interdisciplinary framing of the (social and/or individual) engagement of opposing actors within social structures for the social negotiation of valid orders of knowledge—which can be a considered a paradigmatic starting point for psychotherapy, social pedagogy, psychoanalysis, political science, history, jurisprudence, sociology, and philosophy—is silenced in favor of, and with the help of, a medical-technical approach. At the same time, social actors continue to make appearances in the diagnostic catalogs of psychiatry, serving as contrasting foils in the lists of disturbed behaviors. However, with the symptomizing of "disturbed" behavioral patterns, all attributions of cause related to social context are removed. In this sense, the underlying psychiatric argument is a sort of sleight of hand which lets the audience marvel at the empty hat, while the rabbit, the purported focus of attention, has long been confined to a cage backstage.

Following for example the listing for ADHD in the DSM V, an individual who "often does not seem to listen when spoken to directly" could be considered to show symptoms of that disorder. In this case neither the individual nor their situational mode of communication are in question, just as the role or involvement of the person making the diagnosis are not considered in relation. The social context of the occurrence and the involvement of additional interaction participations is similarly excluded from the assessment, as is the power relation that allows one person to demand the attention of another, and that forbids this other from *not* paying attention. The question of what "often" means and who can define what effectively establishes a pattern or routine of "often-ness" remain unaddressed, as well as the obvious room for interpretation in identifying behaviors which "seem" to appear in a certain way, as well as the additional vagueness here in terms such as "spoken to directly." These are not the measured results of medical tests, but rather generalized assessments made from very specific, context-rich circumstances, and ones which cannot necessarily be inferred from behavior alone—of any type—in an abstract and situationally independent way, but instead can and indeed must be questioned sociologically. Moreover, these are all questions requiring comprehensive reflection on the situation and its actors (cf. Goffman, 1967) that are, for the most part, simply not asked. Psychiatric narratives to assert interest-driven professional perspectives that may—indeed, *often must*—disagree with the perceptions and understanding of the affected person, and to do so in a way that maintains public legitimacy, require critical consideration and analysis. In medical terms, mental disorders become something abstract, lacking in context and history, something deterministic, even fated, relevant to social life and the individual's very existence within a society only to the extent that these disorders "disturb" this existence. They are seen as only tangentially related to potential confrontations with difficult social circumstances, relationships, or even to the individual's own engagement with the professionally-led "correction" of disturbed behavior. Classical social scientific criticism of psychiatric perspectives has discussed these contexts as processes of institutional attribution steeped in power. This criticism attempted to give a voice to those caught up in psychiatry's unyielding categorical webs. It addressed the objectification of interactional conflicts into categories of illness as a manifestation of institutional structures and hegemonic orders (Cohen, 2016), exposing the pathways that had led to a fundamental distrust of the language games of identifying madness and the independence of psychosocial expertise as early as the 1970s (Illich, 1977).

From a sociological perspective, the categories of mental disorder primarily represent a creation of meaning (Dellwing & Harbusch, 2013). They arise as meaning within a social space and are consequently only reflected as a construction of this space and its actors. Putative disorders are perceived social deviations that only become apparent as such against the background of a socio-historically dependent concept of normality (Frances, 2013; Goffman, 1971). At the same time, in every situation of perception and attribution there are private as well as public actors who play roles in establishing definitions. With their actions, they produce, design, diagnose, treat, pass on, and/or defend broader images of disorder. These actors can be psychiatrists, psychologists, or physicians, all of whom are well positioned to reproduce psychiatric knowledge orders to effectively interpret the situation.

Today, however, professionals from other institutions, as well as individuals in private life, are increasingly utilizing psychiatric disturbance patterns in the interpretation of situations. The main point is that, today, the psychiatric narrative is increasingly visible in professional contexts outside the strict bounds of psychiatry in which pathologizing is also understood as a task within that profession. Psychiatry has been particularly successful with its individualistic explanations of social reality to a great degree because the idea of "mental disorder" has been through various applications been carried increasingly further away from its original professional center, successfully colonizing various territories of everyday social existence. Psychiatric ideas are widely present as explanatory tools and plausible narratives in workplaces, schoolyards, television broadcasts, online forums, and in the homes of concerned parents. They are reproduced at birthday parties and over coffee, in conversations between neighbors over garden fences. With an increasingly visible presence and growing acceptance in the public sphere, psychiatric interpretations and medicalization of life (Illich, 1982) are currently achieving a reach and potency they have never before held. Psychiatric wards are no longer dark, opaque asylums on the outskirts of cities where madness is hidden and treated with the cruelest methods, denying the very humanity of those consigned to "treatment" (Foucault 1965; Shorter, 1997). The lunatics of Western society are no longer considered madmen whose bizarre and self-destructive actions endanger every rational order as well as those with whom they come into contact. Instead, the transformation and expansion of these labels has led to their broad acceptance, establishing these labels as well as those who are labeled as visible within the core of society rather than relegated to real or metaphorical "urban fringes," as medically proven outcomes. In this way, the psychiatric narrative has managed to establish that effectively all members of society can be affected by these labels and the underlying disorders, that everyone is in some way at risk. This refers to diagnosed persons who are caught up in the net of psychiatric knowledge systems, with their numbers rising steadily as a result of both continuously expanding and differentiated diagnostic catalogues as well as the often-stated assumption that most mental illness goes undiagnosed, as well as to "healthy" people who find themselves and their social backdrop increasingly presented in terms of psychiatric terminology (Frances, 2013). This provides the entire population with increasingly new and modern vocabularies and grounds for suspicion against identified and abstract others. More broadly, it influences public narratives and vocabularies—in media formats, everyday interactions, and culture in its broadest sense—in terms of how health, illness, normality, and deviance can be spoken of intelligibly in Western society as well as how related concrete and attributed behaviors are situationally perceived and interpreted. Medicalizations detach complex contexts from their social, political, historical, individual, and/or institutional contexts of origin and transfer them into a one-dimensional representation that fails to recognize the contingency of psychiatric categories as much as it conceals the social character of definitions of social deviance.

Re-contextualization: New Perspectives on Psychiatric Labeling

With the expansion of psychiatric knowledge orders, the social roles that form with and around these orders in the public sphere have fundamentally changed and become amplified. Making these broad developments visible, reconstructing them, and reflexively accompanying them is the challenge facing current critical engagement with psychiatry from a social science perspective, and one that has been taken up on several levels in recent years. There has been a focus on the newer and expanding meanings and consequences of psychiatric narratives for the subject who takes up psychiatric and/or therapeutic narratives on a daily basis and uses them as a reference point for neoliberal self-dramatization. At the same time, with the psychiatric annexation of ever wider social contexts, new demands on existing professional roles have come into view, within professions that have not played major roles in the context of "psychiatry" in past decades.

Recent works examine how psychiatrically organized disease categories are translated into biographical, narrative logic to be applied to those affected and, in this way, become anchored in practices of subjectification (Cohen, 2015). These practices present the subjects themselves both as equal creators and as created, constantly increasing the demand for individual self-optimization. They are creators in that they apply techniques in a pragmatics of the self (Foucault, 2010) in order to be able to understand and develop themselves as subjects—always in the mirror of their environment—both actively and creatively. However, they are also always created by confronting definitional demands of social contexts to which they feel connected. Here, communities and organizations are often seen as instances of subjectification. These groups create meaning for members and non-members and form them to create their own meanings of self in accordance with these organizational frames, but in the process of making subjects through organizational expectations, also allow these subjects to resist and withdraw, make meaning in relation to, but apart from these organizations. In the context of neoliberal demands on self-optimization as well as self-exploiting active subject in times of life-temporal acceleration (Rosa, 2013), psychosocial thematizations appear as an aid for a self-reflection that has become necessary, opposing a tyranny of success.

The more recent social science criticism of psychiatry is characterized in particular by its focus on emergent contexts and role models which have blossomed in light of psychiatric knowledge coming both from institutional as well as individual sources. At the center of these perspectives is the idea that the core psychiatric argument has become detached from psychiatry itself and stolen away to embed itself into new realms.

Even if the actors involved in the critical debate today continue to be concerned with making visible the power-imposing structures that are constructed and attributed on the basis of the psychiatric argument, many participants no longer focus on a total theorization of the psychiatric field. Rather, they refer to the social processes of production, (self-)attribution, and treatment of mental disorders on the one hand, and the social roles and small, everyday situations of individual shaping produced with these categories on the other hand. This particularly helps to emphasize the situational as well as structural opportunities, possibilities, and benefits offered by the concept of mental disorder. Which interpretations are the right ones for the respective situations in this context is a question that sociology cannot clarify without subtly becoming normative.

When Conrad and Schneider (1992), for example, call for a reflexive and critical examination of the social character of the process of medicalization, a process steeped in power and is essentially able to monopolize public discourse, they advocate for a demystification of psychiatry and its positivist understanding of reality, and for a reordered model of deviance that does not formulate itself solely in a dichotomy between illness hand and criminality. In addition to her equally strong criticism of the expansion of psychiatric disease diagnoses (Caplan, 1995), Paula Caplan calls for strengthening the role of the individual in the medicalization process by publicly advocating for the education and emancipation of female patients and motivating them to be courageous and contradict psychiatric attributions. Especially in contact with therapists, perceptions of one's own otherness are reinforced and doubts about the correctness of one's own behaviors are sprinkled into one's self-assessment (Caplan, 1995: 12). Questioning of the "success" of the increased use of medication to treat supposedly mentally disturbed people in a historically informed manner, Robert Whitaker (2010) criticizes the narrative of the "damaged, chemically unbalanced brain" which must be repaired through medication. He recognizes this publicly rehearsed narrative as just that: a "storytelling process" (Whitaker, 2010: 307). By rejecting this narrative, he aims at alternative means to conventional mass medication (Dellwing & Harbusch, 2013: 49). In this indictment of the hegemony of the medical-psychiatric model for solving socially difficult contexts, Whitaker does not stop at an abstract critique, but focuses on the process of increasing psychiatric interventions as an active manufacturing process pursued by politically and monetarily interested groups. The services these groups provide and advocate for have become so firmly entrenched in society that they could not be easily eliminated without replacement. Annemarie Goldstein Jutel's work (2011) decentralizes the idea of mental disorder and focuses instead on the process of its emergence and anchoring. She looks at the role of psychiatric/medical categories in everyday situations and in micro-processes of professional settings in emphasizing the individuality and the specificity of the diagnostic situation. For Jutel, diagnoses are hybrids that operate as connectors between the hiatus of structure and action and aim to bring theoretical constructions to a practical, everyday application. The focus is thus on a complex context of the diagnostic process, which can neither be presented unilaterally as an interest or power-driven divestment of psychiatric knowledge orders, nor as a simple recognition of physical processes.

These critiques (and many others) appear as an extension of a traditional critique of psychiatry and indicate a trend toward a broader investigation of micro-processes. Without giving up the critical connotation, but also without remaining in a pure oppositional position which could possibly further advance a monopoly position of psychiatry due to the demolition of categorical bridges (Pilgrim & Rogers, 2005), the micro-sociological view appears as a path on which an oppositional but also conciliatory social science can proceed in a constructive manner. Perhaps, in this way, it would be easier to seek solidarity with other critical perspectives and professions, because psychiatric criticism today is neither just a field of social science, nor does it concern psychiatric matters alone. At present, (social) educators, anthropologists, educationalists, criminologists, science journalists, psychologists, political scientists, and psychiatrists in particular are also committed to revitalizing the debate.

Public and Social Institutions as Troubled Persons Industries

The actors within the social system, but also those of public institutions, have been drawn into the maelstrom of medical interpretations and, by genuflecting before psychiatry, have placed themselves in a highly paradoxical situation. Today, nurses, social workers, teachers, lawyers, judges, health insurance employees, kindergarten teachers, employees of state institutions, parents' representatives, journalists, and many other groups are identifiable as "sy-professions" (Cohen, 2016: 8) and troubled persons industries. They are framed as "professionals" as well as "lifeworld experts," that is, as people "who have over time acquired an authority on the supposed real nature of humans as psychological subjects" (Cohen, 2016: 8).

In terms of psychiatric sociology, this focus on troubled persons industries calls into question not only psychiatric concepts for describing social realities themselves, but also whether and how the workings and logics of practical application can be reconciled with the logic of these categories and how this actually happens situationally. Practice appears as a multilayered interested organizational, professional, and/or individual context, which takes up, reproduces, transforms, trivializes, exaggerates, adapts, rejects, and/or criticizes elements of scientific knowledge. In any case, it brings them to the logic of their own fields, and with this knowledge, it also centrally co-constitutes their own fields *as a field*. In doing so, however, this shift always means that the knowledge used is stripped of its original, academic context and is "worked down" in the sense of the application situation (Beck & Bonß, 1989: 9). A reconstruction of application situations decentralizes the question of the veracity of scientific results, which for them can only appear as a field-specific, illusory question anyway. Instead, fields and contexts of use, and especially those situations in which elements of one field of knowledge enter the other and/or in which two systems (have to) communicate with each other, take a central position.

To address psychiatry and its institutions as (co-)producers of increased attributions of illness is certainly an important sociological insight; it is also fundamentally correct. However, it necessarily overlooks the everyday contexts of the anchoring of psychiatric vocabularies in everyday discourse. The reconstruction of contexts of use not only make concrete everyday contexts addressable, contexts in which the ideas of mental disorders are carried into people's everyday lives. In addition, and related to this, new actors come into social scientific view who actively build the lifeworld bridge between academic formulas and individual narratives. They are characterized by the fact that in many cases they are academically trained and aware of the multiperspectivity and contingency of professional and lifeworld constructions. At the same time, however, in their work they always remain bound to a logic of the situation, the institutions and also the sensitivities and needs of the clients and, as scientifically trained practitioners, are pragmatically interested in incorporating academic categories into lifeworld contexts. In terms of the everyday use of psychiatric knowledge, they are troubled persons industries because they work much closer to their clients' life situations than clinical or academic actors within psychiatry. As experts, they turn medical constructions into social contexts in their everyday counseling process and use psychiatric vocabularies to devise solutions to the client's problems, seeking a fusion of academic constructions and lifeworld narratives. Here, the difficulty of this mediation is not that experts of troubled persons industries are institutionally and/or monetarily interested, and turn help-seeking people into clients of the welfare system with logics of communication, documentation, and also billing (Bergmann, 2014): that is, it is not that they have a "false face" (McKnight, 1977: 40). The problem lies rather in the fact that they—as McKnight already suspected in the 1980s—are in many cases convinced of the correctness and importance of their interpretations. "The power of service ideology is revealed precisely by the fact that most service providers cannot or may not distinguish this mask from their own face" (McKnight, 1977: 40). Yet the great paradox of the use of pathologizing concepts in troubled persons industries is that professionals, in their search for truth and professionalism, enter a field in which they themselves must maintain their appearance as laypeople. For they work with concepts whose mode of production and background lie outside their expertise. In this way, they make themselves non-professionals regarding the content they use, abandon their own concepts to clarify unclear situations. They become service providers to psychiatry by transforming people into abstracted cases of the psychosocial system that can be treated and managed in a care-oriented and consultative manner. The incipient expansion and differentiation of the social science discussion around the social phenomenon of mental disorder currently shows how broad the disciplinary and everyday fields have become on which psychiatric knowledge orders have begun to poach paradigmatically, sometimes vigorously supported by the resident professionals. And it also shows that the desired homogenization of the psychiatric argument, a homogenization that was supposed to disciple, has become more distant than ever before. This makes the argument about psychiatry much more difficult: Paradoxically, the increasing dissolution of the psychiatric argument into broader untethered contexts makes it more important.

This Volume

The present volume is devoted to the contexts of the use of psychiatric knowledge beyond psychiatry. It is an attempt to trace new empirically oriented social scientific preoccupations with psychiatry beyond psychiatric contexts and to give them a common direction in the term “Troubled Persons Industries.”

Gathered together are international participants in the debate, whose studies show how multilayered the related discussion can and must be. While some participants deal very concretely with contexts of pathologizing and practices of social institutions, others can show how many actors and perspectives contribute to the emergence of the idea of a mental disorder today by focusing on specific “disturbance patterns” and illuminating the sites of production.

Zoe Timimi and Sami Timimi focus on the role and the perspective of teachers in the current process of the increasing pathologization of young people in British schools. On the empirical basis of interviews with teachers, considered important actors in mediating the discourse of “troubled persons,” the authors investigate the underlying beliefs and altered practices of the interviewees regarding mental health problems among pupils. Schools today are intertwined with political discourse and governmental programs and have become key supporters of an individualizing capitalist system which helps in transforming everyday life problems into psychiatric concepts. The article demonstrates that the discursive and conceptual transformation of the concepts of mental health and illness in schools bear serious consequences not only for the pathologized children themselves, but also for the work and self-conception of teachers, who are trapped in a position which is ironically powerful and powerless at the same time. As long as they adapt the medically formed public discourse of putative individual problems teachers maintain their expert status, their authority, and their conceptual power in a troubled persons industry, possibly with quite good intentions. Yet, colonized by this mental health discourse and depended on governmental decisions, they utterly lack in resources to challenge these labels.

In their article *Governing Emotions in School*, **Roberto McLeay and Darren Powell** describe how emotions and the "right" way of feeling and talking about them has gained increased attention in the psychological and social system in Aotearoa New Zealand over the last years. Today it seems to be important for actors of the social system that young people learn to handle and control their "troubling" emotions, if they want to stay healthy and happy. Schools are one of the main institutions which function as troubled persons industries in this context. Mental health programs in schools and the development of educational and institutionalized roles—such as counseling services—are not only catching up to political programs, but also to an increasingly medicalized public discourse which problematizes the emotions of the younger generations under the banner of the idea of public well-being. After a short theoretical discussion on the transformation and development of the concept of emotion, McLeay and Powell show in their paper—on the example of the counselor as psychiatrically trained agent in schools—how complex the field not only in Aotearoa New Zealand is and how much work has to be done within critical sociology to reconstruct the everyday practices in which psychiatric ideas are reproduced in schools.

Charles Marley and David Fryer offer a theoretical re-conceptualization of the rise of ADHD ascription and treatment in a deindustrialized region of Scotland. The aim of their paper is to understand ADHD as a construction of official institutional knowledge on the one hand and specific social practices on the other. Not only do social problems need to be framed as personal problems in order to understand ADHD as a connector for multiple social problem-oriented institutions and to stage it as a local solution for the individual case. There must also be concrete practices as well, which construct young people as affected, "troubled" persons. In their empirical examination, framed in critical theoretical voices, the authors make visible the processes and conditions under which this taking place. They can show very clearly that

ADHD diagnoses not only depend on social and always already interested contexts, but are deeply entangled with contemporarily dominant political and economical discourses.

Stephen L. Muzzatti and Dawn L. Rothe understand universities as neoliberally transformed places which have developed ways to pathologize and disenfranchise undergraduate students over the past few decades. In the tradition of a cult of the "Damaged Self" and against the backdrop of a changing understanding of universities, which increasingly adopt corporate management models, the authors describe this change and conceptionally reconstruct how the lives and the (self-)understandings of professors, staff, and student have changed during this neoliberal turn. While, for students, university is more understandable as a commercial service today, the students themselves—as a vulnerable and easily victimizable group—have become customers for institutions centered around political and monetary interests and troubled persons industries. Emphasizing the reproduction of contemporary neoliberal trends and of public ideas of mental health and illness as well, Muzzatti and Rothe present a comprehensible and lucid argument for understanding universities as part of today's troubled persons industries.

Bruce Cohen looks at the world of work as a context in which psychiatric expansion became more and more widespread as a consequence of the increasing process of neoliberalization in western societies. Looking at the historically changing concept of worker productivity and its expanding foci, first on improvements in work processes and working conditions, and later on the individual worker, Cohen reconstructs how these concepts were loaded with more and more psychological interpretations and evaluations. Initially interested in the improvement of the work process itself, the perspective on work productivity has changed significantly toward an increasing psychiatrization of the discourse today. With reference to new research results as well as with a look into the diagnostic catalogs of psychiatry, Cohen shows lucidly why and in what way every worker today is in danger of becoming entangled in the web of psychiatry.

Alison Fixsen and Anna Cheshire offer a constructionist view of the emergence of a new psychiatric category: Orthorexia nervosa, the medicalization of "extreme" healthy eating. After some thoughts about the process of diagnosing and a theoretical examination of the field of eating disorders, the authors present and discuss interview research that focuses on central actors of this new field: those who self-identify as highly preoccupied with healthy eating, professionals with expertise in eating disorders, and posters on a social media site focused on eating disorders. The paper not only shows how practices of eating come under psychiatric scrutiny in western societies, in which ways the body is framed more and more as an individual, self-controlled project of self-optimization, and how many institutional and social actors are interested and involved in those psychiatric labeling. With their reconstruction of the interview material, the authors also give an internal perspective on this process of emergence, showing how social phenomena come up in life-world contexts and how these phenomena get transformed into psychiatric categories.

Emma Tseris' text *The Psychiatric Surveillance of Pregnancy and Early Parenting* shows how the widespread use of mental health screening tools in perinatal healthcare settings establishes pregnancy as a "high risk" time for the emergence of mental health problems. Pregnancy and motherhood are not only constructed idealistically as very satisfying experiences full of joy and happiness but simultaneously also as times of vulnerability which subject women to emotional distress, public pressures, and exhaustion. These risks are often depicted in formats and with frames that imply solutions involving high levels of micromanagement and a loss of autonomy. Tseris illustrates how psychiatric categories—particularly perinatal distress—undermine formerly dominant ideas of motherhood and transform the experiences of women pre- and post-pregnancy into status conditions which warrant medical attention, intervention, and correction.

Emmanuelle Larocque, Baptiste Brossard, and Dahlia Namian direct our attention to the label of Sex Addiction in a multi-perspective way. On the theoretical base of classical labeling theory and interviews with both professionals within the troubled persons industries in Canada and Australia and self-designated sex addicts, the authors show how a concept emerges to become a widely reproduced and therefore relevant construction in the broader social world. The authors demonstrate with their rich material that on a micro-social level not only the individual involved professional actors follow strategic interests while—for example—they are making meanings, assigning or declining responsibility or defending ideas of normality and control, but also that the powerful assigning process of troubled persons industries is located in everyday life situations, carried out by non-professionals who apply labels to the other as well as the self.

Ruari-Santiago McBride takes a closer critical look to the interwoven relationship between prisons as troubled persons industries and psychiatry. While both institutions were intentionally separated in the nineteenth century, current therapeutical reforms that transform prisons into places of care and support (at least on the front-stage), psychiatry is again deeply implicated in carceral practices and logics. McBrisde shows very convincingly how the contemporary world of the prison is framed as a psychiatric context and how constructions of health and control meet at this point. The article then offers a much deeper empirical look into the lifeworld of prisoners. In an interview-study with inmates, McBride reconstructs their narrated experiences with the carceral-psychiatric complex. Those accounts can paint a vivid picture of practices of psychiatrists in the everyday prison work, of fellow-inmates and their addiction to psychiatric medicals, or of prisoners, who actively try to avoid psychiatric diagnoses. McBride reveals this field as both interesting and terrifying, showing how psychiatric actors' masks of help slip in favor of their controlling power in an open and official frame of carceral control.

William Dolphin and Michelle Newhart deal with the relationship between cannabis use and mental health. On the one hand, the medical consumption of cannabis is framed as helpful by professionals as well as by laypersons, and a growing number of people in the United States are involved in medical cannabis programs. On the other hand, the effects of cannabis use have been classified as mental health disorders since the beginning of psychiatry. During their exploration of this putative paradox, the authors come across a complex, historically changing field permeated by different aspects of privately, publicly, and institutionally entangled actors, interests, and discussions. In doing so, as they walk through the debate, they encounter contexts and practices that demonstrate, as clearly as revealingly, the importance to psychiatric discourses and the surrounding troubled persons industries of framing people as troubled and maintaining control over conversational ways and substances that are able to sustain these roles.

Charles W. Nuckolls looks to Aotearoa, New Zealand against the backdrop of American (psychiatric) discourse. While in the United States, psychiatric ideas are formulated in terms of cultural and especially gender-specific images of individuality on the one hand and sociality on the other, the New Zealand discourse of mental disorders is still strongly guided by the constructions of "race" and "ethnicity." Although Pakeha (European settlers) and Maori constructions of self and other are intertwined, entangled, and to be understood as in a dialectical process with each other, the author's study of psychiatric discourse in Aotearoa, New Zealand demonstrates the ways in which the Pakeha view has become entrenched as the leading perspective in psychiatric programs and in troubled persons industries.

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References

American Psychiatric Association (1952). *Diagnostic and statistical manual of mental disorders*. Washington.

American Psychiatric Association (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). Washington.

American Psychiatric Association (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington.

Beck, U., & Bonß, W. (1989). Verwissenschaftlichung ohne Aufklärung? Zum Strukturwandel von Sozialwissenschaft und Praxis. In U. Beck & W. Bonß (Hrsg.), *Weder Sozialtechnologie noch Aufklärung? Analysen zur Verwendung sozialwissenschaftlichen Wissens*. Suhrkamp.

Bergmann, J. R. (2014). Der Fall als Fokus professionellen Handelns. In J. R. Bergmann, U. Dausendschön-Gay, & F. Oberzaucher (Eds.), *Der Fall. Studien zur epistemischen Praxis professionellen Handelns*. Transcript.

Blashfield, R. K. (1998). Diagnostic models and systems. In A. S. Bellack, M. Hersen, & C. R. Reynolds (Eds.), *Comprehensive clinical psychology* (pp. 57–80). New York.

Blashfield, R. K., Keeley, J. W., Flanagan, E. H., & Miles, S. R. (2014). The cycle of classification: DSM-I through DSM-5. *The Annual Review of Clinical Psychology, 10*, 25–51.

Caplan, P. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide*. Da Capo Press.

Cohen, B. M. Z. (2015). *Mental health user narratives. New perspectives on illness and recovery*. Basingstoke.

Cohen, B. M. Z. (2016). *Psychiatric hegemony: A Marxist theory of mental illness*. London.

Cohen, B. M. Z. (Ed.). (2019). *Routledge international handbook of critical mental health*. Routledge.

Conrad, P., & Schneider, J. W. (1992). *Deviance and medicalization: From badness to sickness*. Temple University Press.

Dellwing, M., & Harbusch, M. (Ed.). (2013). *Krankheitskonstruktionen und Krankheitstreiberei. Die Renaissance der soziologischen Psychiatriekritik*. SpringerVS.

Foucault, M. (1965). *Madness and civilization; A history of insanity in the age of reason*. Pantheon Books.

Foucault, M. (2010). *The government of self and others: Lectures at the Collège de France 1982–1983*. Basingstoke.

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life*. HaperCollins.

Goffman, E. (1967). *Interaction ritual: Essays in face to face behavior*. Pantheon Books.

Goffman, E. (1971). *Relations in public: Microstudies of the public order*. Basic Books.

Gusfield, J. R. (1989). Constructing the ownership of social problems: Fun and profit in the welfare state. *Social Problems, 36*(5), 431–441.

Harbusch, M. (2019). Die Diagnose als Hybrid. Drei Formen der Entzauberung und die (Re)Kontextualisierung psychischer Störungen. In M. Dellwing & M. Harbusch (Eds.), *Pathologisierte Gesellschaft* (pp. 197–227). *Beiheft zum Kriminologischen Journal*, Weinheim.

Houts, A. C. (2000). Fifty years of psychiatric nomenclature: Reflections on the 1943 war department technical bulletin, medical 203. *Journal of Clinical Psychology, 56*(7), 935–967.

Illich, I. (Ed.). (1977). *Disabling professions (ideas in progress).* Marion Boyars Publishers.

Illich, I. (1982). *Medical nemesis: The expropriation of health*. Pantheon Books.

Jutel, A. (2011). *Putting a name to it: Diagnosis in contemporary society*. Baltimore.

McKnight, J. (1977). Professionalized service and disabling help. In I. Illich (Ed.), *Disabling professions (ideas in progress).* Marion Boyars Publishers.

Pilgrim, D., & Rogers, A. (2005). *A sociology of mental health and illness* (3rd ed.). Maidenhead.

Rosa, H. (2013). Social acceleration: A new theory of modernity. New York.

Shorter, E. (1997). *A history of psychiatry: From the era of the asylum to the age of Prozac*. Wiley.

Whitaker, R. (2010). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally Ill*. New York.

2

Psychiatrisation of School Children: Secondary School Teachers' Beliefs and Practices on Mental Health and Illness

Zoe Timimi and Sami Timimi

Much of western media has promoted the idea that we are facing an epidemic of mental illness and psychiatric emergencies in contemporary western society and worldwide and that young people are a particularly vulnerable group. Schools have become a prominent site of concern and focus for this discourse as mental health problems are said to start early in life, thus targeting intervention at people in their early years is perceived an important mental disorder prevention strategy. Drawing on interviews with 19 UK secondary school teachers, this chapter explores changes in their beliefs concerning mental health over the last decade and how this informs changes in their practice. All teachers' felt that

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awareness of mental health and mental disorder had increased and that this has led to an expansion in the numbers of students thought to have mental health problems that required professional intervention. Whilst also documenting an increase in mental health provision within and outside the school system, teachers perceived these services as still woefully inadequate. Teachers identified many behaviours and experiences they previously deemed ordinary and/or understandable as likely mental health problems that required professional expertise they lacked. Teachers have thus been co-opted into becoming agents for the growing market of the troubled person's industry. Rather than preventing mental health problems it is likely that this dominant discourse and the resulting practice are creating them.

Introduction

A summary of global disease burden published by the World Health Organisation in 1996 predicted that by 2020, depression will be the second-leading cause of disease burden globally (Murray & Lope, 1996). This discourse of a rising tide of mental health problems has continued and accelerated such that twenty two years later, on October 10, 2018, the then UK Prime Minister, Theresa May (2018), gave a speech for 'World Mental Health Day' in which she declared that the 'historic injustice' of mental health struggles was 'one of the defining challenges of our time' and that young people face the brunt of this injustice. Today, much of western society shares an idea that we are facing an epidemic of mental illness and psychiatric emergencies in contemporary western society and worldwide (e.g. Patel et al., 2016; Tucci & Moukaddam, 2017), and that young people are a particularly vulnerable group. Schools have become a prominent site of concern and focus for this discourse, as mental health problems are said to start early in life, thus targeting intervention at people in their early years is perceived as an important mental disorder prevention strategy.

Quotes such as "*one in eight people aged under-19 in England have a mental health disorder*" (Campbell, 2018), "*50% of all mental health problems are established by the age of 14*" (Tuomainen, 2018) and "*We are at* *crisis point with child mental health*" (Whitaker, 2018) regularly appear in the media. We hear of a "*striking increase*" (Nuffield trust, 2018), "*sharp rise*" (Campbell, 2018), or even "*crisis*" (Campbell, 2019; Wright, 2019) in the prevalence of mental health problems amongst young people and a lack of services for them, and that "*teachers are overwhelmed by the sheer number of students showing signs of mental health problems*" (Marsh, 2018). However, none of these articles made clear what was meant by the term mental health 'disorder', 'problem' or 'illness'. Whilst there is a prevalent narrative in UK mainstream media of an urgent crises in youth mental health, there seems little discussion about what constitutes a mental health problem, or what the implications of how we define mental health problems might be.

In tandem with this media coverage, mental health has also risen up the UK government education agenda as it has, throughout the last decade, dedicated more time and funding to programmes, initiatives, and support in schools to improve young people's mental well-being. All three major parties in the 2019 UK general election made commitments to increase mental health funding significantly, particularly for young people, including more school-based services. The current focus on increasing investment in Child and Adolescent Mental Health Services (CAMHS) started with the UK coalition government in 2010 (Children & Young People's Mental Health Coalition, 2010). This commitment has accelerated with the government announcing in 2018 that an additional £1.4 billion was being made available to 'transform' children and young people's mental health services with the primary emphasis being increasing training and access that builds upon what is already done by schools and colleges (Secretary of State for Health & Social Care & the Secretary of State for Education, 2018).

A search of multiple scholarly search engines brings limited material that explores teachers' experience of this perceived crisis in youth mental health. What is found echoes the narratives covered in the media; that there has been an "*alarming increase in the mental health needs of youth today*" (Kidger et al., 2009, p. 920). It is thus oriented towards teachers' experiences of, and educational initiatives towards, the growing expectation that schools are more involved in the realm of mental health (e.g.

Ekornes et al., 2012; Franklin et al., 2012). Many of these studies highlight a trend towards rising tension amongst secondary school teachers resulting from a discrepancy between perceived increase in pressure on teachers to attend to mental health issues, often on a daily basis (e.g. Koller & Bertel, 2006; Rothi et al., 2008), and a shared sense of "*worry, hopelessness, and inadequacy*" (Ekornes, 2017, p. 334) when it comes to both identifying and managing mental disorders adequately (e.g. Kidger et al., 2009; Stormont et al., 2011). This is often because of a perceived lack of knowledge about spotting signs, conducting effective interventions, and the time addressing mental health problems can take (Edling & Frelin, 2013). These trends are interpreted as indicative of a need for "*more research into good practice models in the delivery of mental health care in schools*" (Rothi et al., 2008, p. 1217). Like the media discourse, this literature assumes 'mental health' is a concrete entity that can be accurately defined and measured, in a similar manner to physical health, with little coverage of the various critical literature that questions the validity and reliability of current definitions or the problematic outcomes achieved by mental health treatment technologies.

Thus there is no engagement with issues such as 'Medicalisation'. Conrad and Bergey (2015) define medicalisation as a process by which previously non-medical problems become defined or treated as medical conditions. The term medicalisation, originating in sociological literature on deviance in the 60s and 70s, proposes that the classification of certain deviant behaviours or experiences as mental disorders serves to medicalise and thus de-politicise these behaviours (Conrad, 1976; Illich, 1976; Pitts, 1968; Zola, 1972). Critics of psychiatry have explored how the pathologisation of behaviours and experiences can act as a mechanism of control and surveillance (Foucault, 1965; Goffman, 1961), and many concerns have since been raised about the 'over-medicalisation' of society (Bergey, 2017). The widening of the boundaries for many mental disorders, such as depression, has made a wider variety of human emotions and behaviours candidates for being labelled as pathological (Horwitz, 2015; Horwitz & Wakefield, 2007). Increasing pathologisation can also be demonstrated through the increase in the number and range of psychiatric diagnostic categories over the last half century (Bergey, 2017).

Although some scholars have argued that in recent years the dynamics of medicalisation are much more fluid, complex, and multidirectional than previously thought (Clarke et al., 2003), others have suggested that there has been an intensification of medicalisation (Conrad, 2013). A contemporary area of literature that has drawn on the ideas of medicalisation is that of 'therapeutic education' (e.g. Brownlie, 2011; Craig, 2009; Ecclestone & Hayes, 2008; Furedi, 2004; Gillies, 2011). Ecclestone and Hayes, drawing on the arguments of medicalisation scholars, claim that psychiatric diagnostic manuals turn "*once-normal traits such as shyness or feeling nervous about speaking into psychological disorders*" (Ecclestone & Hayes, 2008, p. 7). The notion of an extended pool of behaviours that qualify as cause for concern and intervention is seen as part of the evolution of a therapeutic ethos over the past few decades and is part of a political and social orthodoxy that has been fuelled by a transition in the view of the self, symptomatic of an inward turn in our culture. It is argued that in the past 15 years or so, this therapeutic ethos has seen a significant shift in social policy, reflecting an increasing concern with the realm of emotions in our culture (Brunila & Siivonen, 2016).

More troubling is that despite there being an increasing number of people being treated for mental health disorders, whether this is with medication or psychotherapy, it is not leading to better outcomes; in fact it may be leading to worse mental health outcomes at a population level (Dalal, 2018; Gøtzsche, 2015; Timimi, 2014, 2015, 2021; Whitaker & Cosgrove, 2015). Whitaker (2010), for example, has documented a tripling of the number of disabled mentally ill in the US since the 1980s, as well as finding that the numbers of youth categorised as having a disability because of a mental condition had leapt from around 16,000 in 1987 to 560,000 in 2007. In the UK mental disorders have become the most common reason for receiving benefits, with the number of claimants doubling between 1995 and 2014, whilst claimants with other conditions fell (Viola & Moncrieff, 2016). Real life child and adolescent services show a similar poor record of improving outcomes. A new service configuration for CAMHS was rolled out to all CAMHS services in England and Wales in 2016, for which the pilot sites had found that the service models they used produced rates of 'clinical improvement' from treatment of between 3 and 36% (Edbrooke-Childs et al., 2015).

So it seems that we are living in a time when mental health of the young is being pushed into the mainstream resulting in growing awareness about the ubiquity of mental disorder and a fear of being struck down by psychiatric illness. Yet in this propaganda, from both media and professional bodies, what is not made clear is what is meant when they use terms like mental 'health', 'disorder', 'problem', or 'illness'. Mental disorders are what experts define them to be and, of course, open to wildly differing interpretations because of inescapable subjectivity in the definitions. Worse still there is little reassurance to be gained from the outcome literature that mental health interventions lead to lasting improvement.

The progressive encroachment of the mental health crisis in the young people discourse, together with the rapidly expanding flow of resources to schools for mental health detection, prevention, and promotion, places schools in general and teachers in particular as potentially important actors in mediating this 'troubled persons' discourse. To investigate this possibility, one of the authors (ZT) interviewed[1] 19 UK-based senior practicing secondary school teachers between November 2018 and February 2019, using a semi-structured questionnaire format. Her research sought to investigate teachers underlying beliefs about what constitutes a mental health problem, how this might have changed in the last decade, and how this then impacts on their practice.

The Research

The teachers taught a range of different subjects and all had been teaching for many years. 9 were female and 10 were male. Several teachers who had a specific role related to mental health were interviewed. Topics covered included exploring beliefs on what constituted a mental health problem, current practices around mental health in

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[1] This research was carried out by ZT as her dissertation connected with an undergraduate degree in Human Social and Political Science at the University of Cambridge.

schools, whether these have changed and in what way over the last 5–10 years, and what sort of services were available.

After transcribing the interviews, the data was analysed through several stages of thematic analysis.

From this coding process eight main themes emerged. Not all the themes were directly relevant to the research questions (e.g. teachers' perceptions of changes in parenting), and others were infrequent (e.g. differences in practice between young and old teachers). After excluding these from the final analysis, five themes that were frequent and of direct relevance emerged. These were (1) increasing awareness, (2) definitional issues, (3) the rise of everyday challenges, (4) increasing need for expertise, and (5) overstretched services. These themes fell into two broad sections; (a) Changes in belief and (b) Changes in practice.

Findings

The findings are presented and discussed under the two main section headings of (a) Changes in belief and (b) Changes in practice. The teachers' responses have been anonymised and their real names and locations are not used.

Changes in Belief

This section illustrates how increasing awareness of mental health in the last decade has led to changes in teachers' ideas about what constitutes a mental health problem. The changes include a general normalisation of the idea of mental health suffering, an expansion in the kinds of behaviours and emotions understood as constituting a mental health problem, and how everyday challenges, such as social media and academic pressure, are believed to be causing a worsening of adolescent mental health. The trend towards expanding the numbers and types of behaviours and emotions regarded as indicative of a mental disorder supports a medicalisation hypothesis that an increasing number of problems previously considered outside the remit of health professionals, teachers now saw as potentially indicative of a mental disorder.

There was however a deeper ambiguity in teachers' beliefs about what a mental health problem 'is'. Whilst most teachers indicated that they understood mental health problems as something with a material basis they were also oriented towards more of a social understanding of the origins of mental health problems. They frequently referred to everyday challenges that they believed were causing an increase in the amount of mental health problems experienced by young people. Despite the fact that many teachers oriented towards an environmental model of causation, when it came to responding to these, most teachers subscribed to a more medical model view (as explored in the second section) that relied on 'trained experts' who could diagnose and treat the resulting disorders.

Increasing Awareness and Normalisation

> You see it on the television, there are adverts on the television, and so on, you look at those and see it has become less of a taboo subject. Brian

This quote echoes a consensus shared by all of the teachers, that today there is increasing awareness around mental health filtering down from media and government. Most interviewees referred multiple times to increases in awareness around this topic in wider society,

> Not a day goes by without news, where within youth media mental health is not raised. I think maybe five or 10 years ago, and I will say this hand on heart, there was a lack of understanding of what mental health issues were. Phoebe

Many teachers thought that a decade ago they had the idea that "*only the weird people or mental people had it*" (Imogen). Phrases such as 'less taboo', 'more acceptable', and 'more open' were frequently used when talking about their changing beliefs.

An Umbrella Term

When asked what they thought a mental health problem was, teachers referred to it as a term encompassing a wide range of phenomena;

> It's basically an umbrella term. Anything that is challenging for your mental health or emotional wellbeing. Could be serious psychosomatic… to less life altering (I say less life altering in a very blaze way) like just feeling blue. Imogen
>
> How far do you go with it, there are so many. It's just people's opinion of mental illnesses; everybody has mental health. Claire
>
> Stresses and strains due to ordinary everyday life as you get through each day then there are extra stresses which come from a work schedule, work and the demands of work, the stresses of social life, nowadays even more so there's the stresses associated with the internet and social media . Brian
>
> I think there are a lot of problems at the moment. In general stress, anxiety, and depression are the three I've encountered the most in young people . Marie

The change in ideas about how normal it is to have a mental health problem meant that many participants now understood mental health problems as encompassing a wider range of things than in the past. Eric, talking about someone he knows with diagnosed depression, said that "*five years ago I wouldn't have said that what they experienced is depression.*" Steven identified the main change in his idea of mental health as a growing awareness of "*those lower level ones*" being recognised, rather than just extreme problems such as "*anorexia.*" David described how a pupil, who is usually loud and bubbly, came into his lesson close to exams with a "*face like thunder*" as an example of those kinds of "*low level*" behaviours that he would now recognise as indicators of possible mental health problems.

Teachers often thought that the reason there were more phenomena considered as mental health problems than before, is because we had got better at identifying them and "*students generally feel more able to talk about it*" (Olivia). They felt these problems have always existed, but we just didn't recognise them.

Teachers' understandings of what a mental health problem is, seemed to be dominated by the assumption that it is the outcome of negative experiences resulting from everyday challenges. There was a shared sense amongst all of the teachers that there are two particular everyday challenges that have intensified in recent years; (a) social media and exposure to the Internet from a young age, (b) increasing performance pressures on young people.

Often, teachers saw a connection between new social media technologies and an increase in the general pressure on young people. One feature of life today deemed new and different from the past was that there is no switch-off time and thus people are constantly on the go;

> I think life was very different 10/15 years ago. We are a very constant world, there is no let up, the waters always boiling. When I was a youngster, you could go home and it was a sanctuary almost, life was a bit simpler. Shops weren't open on weekends. But now in life everything is at a high rate all the time, there's no switch off. Olivia

Emerging Awareness of Definitional Issues

Most teachers noted that as their ideas about mental health were becoming more normalised and general, they were encountering difficulties with defining what exactly counts as a mental health problem and where the boundary between ill health and other issues lie. With the increasing prevalence of conversations about mental health in the school setting, came the problem of distinguishing between students who need mental health support and students who might just be a "*stroppy teenager*" (David).

> I think an increasing number of people who, not so much would make up mental health problems, but they see a label or tag and they want to be that. That's a problem as well as you have to sift out the genuine. Eric
>
> It's trying to get that balance where - are they playing the system or are they real…in terms of my understanding of mental health it's a spectrum, and it's really defining when it turns into proper serious issues. Phoebe

> 10 years ago the idea of a time out was unheard of. Some students have had real difficulties with mental health and school has adapted to take those things into account, whereas before we might have forced the child to conform. I think sometimes that's abused by some children. It can be very difficult to identify which is which. James

Some teachers went further to suggest that not knowing how to draw the line results in some difficult dynamics affecting both teachers and students.

> I think that we have a problem where we are identifying students that have an issue where actually it's laziness and a distraction from things outside of school. Leon
>
> It feels a little bit more like a tide turning into students feeling like they can ask to leave lessons when they are just upset about something really minor that happened at break time like falling out with a friend. Marie

Undermining natural resilience, making unnecessary allowances, and clogging up services with people who might not need them at the expense of others were the main negative side effects identified by teachers of definitional and boundary ambiguity about what constitutes a mental health problem.

Changes in Practice

There was a recurrent theme that the teachers' main role was early identification and onward referral. When talking about the increase in awareness around 'mental health', teachers were now getting the message, "*to look for signs, to never ignore anything that makes us worried about the well-being of the student*" (Derek). This reflected a general sense of anxiousness about being attentive to young people's negative emotions lest an early indicator of a possible mental disorder is missed. Teachers often perceived that they are in need of more expert training and felt powerless to manage mental health problems without recourse to specialist mental health 'expertise' and resources, which they felt was lacking both within and external to school, despite the reality being that a considerable expansion in the availability of such services had taken place.

Pre-emptive Measures: Identification, Education, and Awareness Schemes

Many teachers mentioned that there had been a big push towards awareness and education around mental health. Various new awareness programmes were mentioned such as a "*mental health awareness week, mental health awareness day, and stress awareness week.*" (Henry), assemblies about mental health given by both staff and guest speakers from outside agencies, "*posters around school*" (Claire), as well as safeguarding lanyards worn by staff and sixth formers displaying the pastoral and safeguarding staff's contact details.

Teachers often spoke about how safeguarding policies are, "*completely different to what was in place 10 years ago.*" (Derek) and now includes mental health under it. Part of the policy includes training staff "*to be able spot the triggers and signs of mental health issues*" (Henry).

Growth in Pastoral Team and Management

> Five or ten years ago, even three years ago, we didn't have a pastoral support team. Eric

Teachers directly involved in pastoral teams were interviewed. They outlined a growth in assigned members of staff to deal with pastoral issues that encompassed mental health. Other changes included providing extra allowances, specific plans for students with perceived mental health problems, and changes in safeguarding systems to include mental health as one of the main issues to be identified,

> You've got myself as head of student welfare, we've got 5 pastoral mentors for each year from 1 to 7. When I first started I was doing work experience and there was just me and now there are 5 pastoral mentors and it just seems to get bigger and bigger. Claire

The personal allowance plan procedure was also something that many teachers identified as the main method for managing students once they were identified as having a mental health problem.

> It could be that they have timeout cards, they may need an altered timetable. Where there's particular lessons that they really struggle with, we might take them out of those lessons and give them an alternative intervention. They could have later arrival times in the morning. Tina

Some teachers suggested this was a new procedure; however, others said that the allowances systems had been in place for many years but the difference was that more students needed to use it now than ever before.

Expertise, Training, and Professionals

> There was a few articles a couple of years ago that was 'you know education is this, they are letting students down by not identifying mental health issues'. Sorry, I thought we were here for teaching? We're not doctors? We're not registered clinicians. Imogen

All of the teachers, apart from one, referred (often frequently) to the need for specific expertise and training when dealing with mental health problems in schools.

> Obviously none of us are skilled mental health practitioners and would not know how to cure people. Derek

There were varying ideas about exactly where specialist help was needed (whether, for example, in or outside school). All, however, felt that specific mental health expertise was needed to manage/treat students once a mental health problem was recognised.

All the teachers felt that they lacked specific expertise and knowledge that mental health professionals had and therefore had little confidence in their ability to deal with mental health issues. This left them feeling powerless to intervene with students known or suspected to have mental health problems. These teachers spoke about an erosion of their authority to make decisions and be assertive figures with students. For example, Tina spoke about feeling unable to act in ways that she felt were beneficial to anxious students. Her normal technique involved starting with, "*the really anxious kids just pressing buttons, but being part of it [class presentations], and then building up*" and she notes that, "*I've seen it work with kids from year 7 to year 11, but then I get parents saying no, don't even ask her a question. I can't do anything; I'm powerless… because if I did and then something happened, I would be the one hauled over the coals.*"
This sense of a 'you have to be careful' culture was shared by others,

> There's that air of accountability, you don't want to go 'well I've spoken to a student, we had a chat', and then suddenly it's like well this has happened to them now. Steven

A few teachers were more confident about dealing with student mental health problems independently. However, this was voiced in a tentative manner,

> [Speaking about a student he helped independently] He genuinely smiled and walked off… I think it was a couple of weeks later I mentioned it to the pastoral manager and there was a member of senior staff who said 'you should have logged that', but it was dealt with… it wasn't like I'd forgotten about it, I saw them the next day and they were fine, they were happy. Steven

The teacher quoted above felt they should be able to exercise authority over certain decisions, whereas the majority believed that the 'untrained' should leave decisions regarding young people's mental health to 'trained' experts. In addition, it seemed that when a teacher did still believe in their ability to act independently they were concerned about being labelled as irresponsible for doing so. Thus mental health was now being seen in these schools as something that should not be dealt with in an 'ordinary' manner; indeed it could put you at personal risk to do so due to external (e.g. parent pressure or school policy) and internal (personal beliefs about expertise) forces.

Specifically trained and appointed mental health and pastoral team support had grown in recent years in all schools where the interviews took place. At one school they didn't have a specific pastoral team three years ago and they mainly relied on heads of year, whereas now they had three pastoral support officers who are 'non-teaching' members of staff. At another school there were now five pastoral mentors that started two years earlier. Prior to that there was one mentor for every two year groups, but now they have one mentor for every year group. At a third school they had been training staff in emotional support programmes for around four years.

Despite this, teachers still felt that they had a long way to go before they had enough school-based provision, "*We do a bit of training in school, but not to the professional level that they need to be receiving…Teachers do need more training*" (James).

Experts from Where? Barriers of Funding and Resources

Most of the teachers felt there were significant obstacles for schools providing robust systems of pastoral and mental health support. Thus having access to trained expertise external to schools was seen as vital. However, most teachers' emphasised that it was near impossible to achieve both goals of adequate internal and external support. Many teachers referred to the limits on capacity in school, suggesting that there was a general trend towards schools being expected to do more and more,

> I could get on my soapbox with this one for ages. It really frustrates me, I've had them where the parents take the child to the GP and the GP diagnoses depression and they say go back to school and see a school counsellor. And I'm like how do you know we have a school counsellor? How do you know what my waiting list is like? Remy

Teachers also reported that external services that schools work with, such as a county-wide service providing school-based short-term therapy and the Child and Adolescent Mental Health Services (CAMHS), have become greatly stretched in recent years and are now "*woefully inadequate*" (Alice).

> We need more money, more resources definitely. CAMHS could do with more and being bigger. Claire

It was thought that the services are now more overwhelmed due to increased demand with some teachers believing there is no extra funding or even that funding had been cut and that there were, "*things disappearing*" (Claire) and, "*resources have been cut, funding has been cut*" and "*money is at an all-time low*" (Keith).

Mental health services in this county had, in reality, undergone a considerable expansion in the previous three years. A new service that provides short-term therapy for students in the school setting and employed around 50 therapists had started in late 2017. The county CAMHS had also expanded with increased funding and staffing and the setting up of new specialist teams from early 2016 onwards. The new in-school short-term therapy service was set up under the same management structure as CAMHS, but as a separate service, with the hope that such a service will provide early intervention and thus reduce the need for referrals to CAMHS. The county CAMHS service received 4697 referrals between April 2016 and April 2017; 4679 between April 2017 and April 2018; and 4698 between April 2018 and April 2019; in other words no real change in referral numbers after the new school-based counselling service was started. The new in-school short-term counselling service had meanwhile received just over 2000 referrals per year in its first two years, meaning the total number of referrals for mental health treatment of young people had increased by a factor of about 1.5 in the two years since the new school-based service opened.

Thus, there has actually been a wide expansion in specific mental health provision both internally to, and externally of, schools. This contrasts with teachers' perception, where they felt services for mental health were underfunded in school and outside and some even thought that external services had been cut.

The Psychiatrisation of School Children

This research seems to confirm that the current cultural discourse about, and accompanying government policy on, mental health in young people bears an increasingly heavy burden on teachers and provides fertile ground for expanding the numbers of young people deemed to be mentally disordered and the types of experiences and states of mind thought to be indicative of a potential mental disorder. A process appears to have been set in motion with a greater public and media awareness influencing and being influenced by government policy on the importance of identifying and intervening early in mental health disorders, contributing to expanding provisions and more dedicated staff and awareness that further increases the 'mental health problems in the young' discourse. This seems to have left teachers sensitive to this new priority, but confused about what qualifies as a mental disorder that requires attention. They see more problems than ever, yet as services expand both within and outside of school, they seem to feel more powerless to do anything about this. They are often reluctant to intervene in case it gets them in trouble or because they feel it needs special expertise, but are struggling to get enough professional services for their students.

Lack of critical perspectives in media, government policy, or even academic papers in this area, on what sort of a 'thing' constitutes mental health and where/when special expertise might be helpful, coupled with increased sensitivity, leads to an increase in the number of students being deemed to require professional help that the teachers can't provide. More referrals are then made and despite external services expansion, they then have trouble dealing with the numbers of referrals, leading to access problems that may to lead to more media coverage of a 'crisis' in services, thus further increasing the volume of the 'mental illness in the young' discourse and so on. The increasing discourse and media coverage on something deemed a threat to individuals and society at large begins to sound like a moral panic (Cohen, 1972) has emerged about mental health in young people. As discussed in the introduction, such a moral panic and increased medicalisation, which leads more young people to be labelled as mentally disordered/ill, is likely to further worsen rather than improve outcomes at the population level.

Social looping theory (Hacking, 1995), which shares social constructionist theoretical roots with medicalisation, provides a conceptual framework that helps with further understanding how the sense of crisis, definitional ambiguity, and feeling overwhelmed, expressed by the teachers may have developed. A 'looping effect' concept explains how a cycle can develop in which the problem effectively inflates itself. As professional understandings of mental disorders change, people shape their behaviour, experience, and self-understanding in response. By this means, evolving concepts of mental disorder, carried by language, make up new kinds of person. A 'looping effect' means that changing concepts of psychiatric phenomena do not simply, "*slide frictionlessly over an unchanging social reality… but rather they alter that reality*" (Haslam, 2016, p. 4). Thus expanding concepts of mental health problems means they are framed by new language and discourse that shape peoples' behaviour, experience, and self-understanding in response. In effect, "*changing ideas change people*" (Haslam, 2016, p. 4).

There is good evidence that this looping process is effecting how British youth are interpreting the emotional turmoil of growing up. A recent documentary conducted a survey of one thousand young people and found that 68% think they have had or are currently experiencing a mental health problem and of those, 62% think that de-stigmatisation campaigns have helped them identify it (Wright, 2019). It also found that there had been a 45% increase in mental health referrals of under-18s in the last two years. These are dizzying numbers, but not that far off a recent academic paper that, using a child self-report questionnaire methodology, came up with a prevalence figure for mental health problems in 11–15 year olds, of 42% (Deighton et al., 2019).

Weinberg (1997) depicts the 'profound relevance' of social processes and understandings of mental disorder in the organisational settings of treatment centres, demonstrating how "*once assembled as meaningful objects of discourse and practice*," mental disorders "*exercise their own causal influence*" (cited in Hacking, 1999, p. 113). It seems a similar process is happening within the schools where the shifting cultural understanding/definition of what mental health is, is leading to increasing numbers and kinds of behaviours becoming imbued with troubling meanings in current discourse and practice, that in turn can exert a real causal influence over students, thus creating new challenges for both them and their teachers. The teachers are then tasked with responding to this new expanded reality (of what has now become 'mental ill health') and, by confirming this new discourse in practice, discourse and practice reinforce one another.

Haslam (2016) argues that there has been a 'conceptual creeping' in common definitions of mental disorder, such that the concept has expanded and undergone multiple semantic alterations in recent years. Firstly, the concept has expanded 'vertically', meaning it has become quantitatively less stringent (i.e. the threshold for meeting the criteria has become more relaxed). Secondly, the concept has expanded horizontally, meaning that it now encompasses qualitatively more phenomena. This cultural shift was evident in the way teachers spoke about mental health as an umbrella term that now incorporated many different behaviours and problems that arise from everyday challenges such as social media and pressures that all young people are potentially subject to. These widening conceptions influence practice, because what you conceive problems to be relates to how you subsequently manage it. If you see it as everyday 'ordinary' phenomena, it could imply that you can manage it using everyday 'ordinary' approaches. Because there is an ambiguity, even though many teachers had a primarily environmental orientation to causation, they seemed to imagine that particular expertise is required and more ordinary/non-expert practices would be insufficient or even dangerous. So when it came to practice, most teachers' predominant response was that special training and expertise was needed.

This looping effect helps to explain the increasing tension that most teachers reported and also why, despite significant increase in provision, there is a sense that schools and society still have 'miles and miles to go' to even come close to addressing the issue of youth mental health struggles. As more human experiences are deemed to warrant help from a mental health professional that is perceived as hard to obtain, there is increasing pessimism about recovery and the capacity to control the problems felt by both the teachers and the young people concerned. This could result in an enlarged and demoralised population of young sufferers who are perceived to need special expert attention. Thus, one can empathise with teachers who feel they are out of their depth and wish to pass on to people with more expertise. As the looping effect sets in motion expanding concepts of mental health and as these alter social reality, teachers are faced with a triple burden in which they are tasked with (1) being more open about mental health and identifying more pupils with such problems, but (2) feel powerless to intervene and feel a wide gap between need and professional resources, whilst (3) being unsure of who is in 'genuine' need of such specialist interventions.

Conclusion

The above research shows that schools have become an important site for further expansion and marketisation of the troubled persons industries. Teachers as agents within an individualising capitalist educational system help the process of transforming everyday life problems into psychiatric concepts thus further supporting the relentless expansion of this phenomena.

We have presented evidence on how secondary schools' teachers have got caught up in a moral panic about young peoples' mental health to the extent that it is influencing the discourse, culture, and practice in secondary schools. Through processes of medicalisation and social looping there has been a dramatic widening of what gets caught in the 'mental disorder' net. This has led teachers to inadvertently become part of a cultural discourse that is in effect mystifying ordinary reactions to social stress, existential anxiety, performance pressures, and relationship challenges, that would all previously have been considered part of the inevitable, but ordinary, struggles of growing up. The result is that both teachers and students risk becoming alienating from understandable everyday emotions, which they come to fear as something that could be a precursor to deeper problems and that therefore must be addressed professionally and rooted out.

The interacting media and political alarmism about young peoples' mental health provides fertile ground for a 'looping effect' that is taking place in schools and leaving teachers feeling powerless and afraid of more ordinary, low key, interventions that they may have previously been more likely to carry out. The increased pressure to deal with these newly politicised spaces means that problems of primarily socio-political origins are being individualised, shifting pressure to address them away from macro-structural concerns (such as redistributive policies).

Once set in motion the 'looping effect' means that the psychiatrisation of the young effectively inflates itself. Whilst teachers may be acting with the best of intentions, having been colonised by the dominant 'mental health' discourse, they end up playing a vital role in the pathologising process. Of course, teachers want to help their pupils, but the reproduction of psychiatric narratives in such an important context of young people's lives (both in the time they spend in schools and in its capacity to shape their future beliefs about themselves and the world more generally), the lasting, and potentially harmful, impact they may have goes unacknowledged.

The lack of a more critical discourse in both policy and teacher trainings may have left teachers feeling more responsibility, but lacking agency to deal with this responsibility. Teacher trainings would benefit from a change in approach, moving towards empowering teachers to be confident and comfortable with having a more elastic orientation to the problems of their students, such that they feel able to deal with young people's understandable emotional responses and less obliged to initiate professionalised responses.

Greater exposure to mental health critiques would allow them to question many currently taken-for-granted assumptions about the nature of mental disorders, its boundaries, and the outcomes achieved by the real-life services they feel are lacking. However, it must also be acknowledged that, given the dissemination of changing ideas about mental health from wider society, teachers are faced with a challenging scenario in which the nature of a looping effect means that changes in wider cultural conceptions of mental disorder "*will surely affect how the growing numbers of people who fall within this capacious concept see themselves*" (Haslam, 2016, p. 9). This then puts pressure on teachers to do something more drastic such as involving third parties. Thus, although recommendations for teachers' trainings can be made, tackling the problems of medicalisation and social looping likely needs to involve re-structuring and re-framing efforts that extend well beyond the realm of the secondary schools.

References

Bergey, M. R. (2017). The changing drivers of medicalization. In B. M. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 153–161). Routledge.

Brownlie, J. (2011). Not 'going there': Limits to the professionalisation of our emotional lives. *Sociology of Health and Illness, 33*, 130–144.

Brunila, K., & Siivonen, P. (2016). Preoccupied with the self: Towards self-responsible, enterprising, flexible and self-centred subjectivity in education. *Discourse: Studies in the Cultural Politics of Education, 37*, 56–69.

Campbell, C. (2018, July 2). Sharp rise in under-19s being treated by NHS mental health services. *The Guardian*. https://www.theguardian.com/society/2018/jul/12/sharp-rise-in-under-19s-being-treated-by-nhs-mental-health-services.

Campbell, C. (2019, December 4). Mental health: Young people in crisis waiting hours for A&E help. *The Guardian*. https://www.theguardian.com/society/2019/dec/04/mental-health-young-people-in-crisis-waiting-hours-for-ae-help.

Children and Young People's Mental Health Coalition. (2010). *Children and young people's mental health: The policy, the progress made, the challenges*. Zurich Community Trust.

Conrad, P. (1976). *Identifying hyperactive children: The medicalization of deviant behavior*. Lexington.

Clarke, A. E., Shim, J. K., Mamo, L., Fosket, J. R., & Fishman, J. R. (2003). Biomedicalisation: Technoscientific transformations of health, illness, and US biomedicine. *American Sociological Review, 68*, 161–194.

Cohen, S. (1972). *Folk devils and moral panics*. MacGibbon & Kee.

Conrad, P. (2013). Medicalization: Changing contours, characteristics, and contexts. In W. C. Cockerham (Ed.), *Medical sociology on the move* (pp. 195–214). Springer.

Conrad, P., & Bergey, M. R. (2015). Medicalisation: Sociological and anthropological perspectives. In D. J. Wright (Ed.), *International encyclopedia of the social and behavioural sciences* (2nd ed., pp. 105–109). Elsevier Science.

Craig, C. (2009). *Well-being in schools: The curious case of the tail wagging the dog?* Centre for Confidence & Well-Being.

Dalal, F. (2018). *The cognitive behavioural Tsunami*. Routledge.

Deighton, J., Lereya, S. T., Casey, P., Patalay, P., Humphrey, N., & Wolpert, M. (2019). Prevalence of mental health problems in schools: Poverty and other risk factors among 28,000 adolescents in England. *British Journal of Psychiatry, 215*, 565–567.

Edling, S., & Frelin, A. (2013). Doing good? Interpreting teachers' given and felt responsibilities for pupils' well-being in an age of measurement. *Teachers and Teaching: Theory and Practice, 19*, 419–432.

Ecclestone, K., & Hayes, D. (2008). *The dangerous rise of therapeutic education.* Routledge.

Edbrooke-Childs, J., Calderon, A., Wolpert, M., & Fonagy, P. (2015). *Children and young people's improving access to psychological therapies: Rapid internal audit, national report*. Evidence-Based Practice Unit, the Anna Freud Centre.

Ekornes, S. (2017). Teacher stress related to student mental health promotion: The match between perceived demands and competence to help students with mental health problems. *Scandinavian Journal of Educational Research, 61*, 333–353.

Ekornes, S., Hauge, T. E., & Lund, I. (2012). Teachers as mental health promoters: A study of teachers' understanding of the concept of mental health. *International Journal of Mental Health Promotion, 14*, 289–310.

Foucault, M. (1965). *Madness and civilization.* Bantam.

Franklin, C. G., Kim, J. S., Ryan, T. N., Kelly, M. S., & Montgomery, K. L. (2012). Teacher involvement in school mental health interventions: A systematic review. *Children and Youth Services Review, 34*, 973–982.

Furedi, F. (2004). *Therapy culture*. Routledge.

Gillies, V. (2011). Social and emotional pedagogies: Critiquing the new orthodoxy of emotion in classroom and behaviour management. *British Journal of Sociology of Education, 32*, 185–202.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Doubleday.

Gøtzsche, P. C. (2015). *Deadly psychiatry and organised denial*. People's Press.

Hacking, I. (1995). The looping effects of human kinds. In D. Sperber, D. Premack, & A. J. Premack (Eds.), *Symposia of the Fyssen Foundation. Causal cognition: A multidisciplinary debate* (pp. 351–394). Clarendon Press and Oxford University Press.

Hacking, I. (1999). *The social construction of what?* Harvard University Press.

Haslam, N. (2016). Looping effects and the expanding concept of mental disorder. *Journal of Psychopathology, 22*, 4–9.

Horwitz, A. V. (2015). The DSM-5 and the continuing transformation of normal sadness into depressive disorder. *Emotion Review, 7*, 209–215.

Horwitz, V. A., & Wakefield, J. (2007) *The loss of sadness: How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press.

Illich, I. (1976). *Medical nemesis*. Random House.

Kidger, J., Gunnell, D., Biddle, L., Campbell, R., & Donovan, J. (2009). Part and parcel of teaching? Secondary school staff's views on supporting student emotional health and well-being. *British Educational Research Journal, 36*, 919–935.

Koller, J. R., & Bertel, J. M. (2006). Responding to today's mental health needs of children, families and schools: Revisiting the pre-service training and preparation of school-based personnel. *Education and Treatment of Children, 29*, 197–217.

Marsh, S. (2018, August 31). Calls for action over UK's 'intolerable' child mental health crisis. *The Guardian*. https://www.theguardian.com/society/2018/aug/31/calls-for-action-over-uks-intolerable-child-mental-health-crisis.

May, T. (2018). *PM's words at World Mental Health Day reception: 10 October 2018*. https://www.gov.uk/government/speeches/pms-words-at-world-mental-health-day-reception-10-october-2018.

Murray, C. J., & Lopez, A. D. (1996). *The global burden of disease*. Harvard University Press for World Health Organisation.

Nuffield Trust. (2018). *Striking increase in mental health conditions in children and young people*. https://www.nuffieldtrust.org.uk/news-item/striking-increase-in-mental-health-conditions-in-children-and-young-people.

Patel, V., Chisholm, D., Parikh, R., Charlson, F.J., Degenhardt, L., Dua, T., Ferrari, A.J., Hyman, S., Laxminarayan, R., Levin, C., & Lund, C. (2016). Addressing the burden of mental, neurological, and substance use disorders: key messages from disease control priorities, 3rd edition. *Lancet*, *387*, 1672–1685.

Pitts, J. R. (1968). Social control: The concept. In D. L. Sills (Ed.), *International encyclopedia of the social sciences* (pp. 381–396). Macmillan.

Rothi, D. M., Leavey, G., & Best, R. (2008). On the front-line: Teachers as active observers of pupils' mental health. *Teaching and Teacher Education, 24*, 1217–1231.

Secretary of State for Health and Social Care and the Secretary of State for Education. (2018). *Government response to the consultation on transforming children and young people's mental health provision: A green paper and next steps*. Crown Copyright.

Stormont, M., Reinke, W., & Herman, K. (2011). Teachers' knowledge of evidence-based interventions and available school resources for children with emotional and behavioral problems. *Journal of Behavioral Education, 20*, 138–147.

Timimi, S. (2014). No more psychiatric labels: Why formal psychiatric diagnostic systems should be abolished. *International Journal of Clinical and Health Psychology, 14*, 208–215.

Timimi, S. (2015). Children's mental health: Time to stop using psychiatric diagnosis. *European Journal of Psychotherapy & Counselling, 17*, 342–358.

Timimi, S. (2021). *Insane medicine: How the mental health industry creates damaging treatment traps and how you can escape them*. PCCS Books.

Tucci, V., & Moukaddam, N. (2017). We are the hollow men: The worldwide epidemic of mental illness, psychiatric and behavioral emergencies, and its impact on patients and providers. *Journal of Emergencies, Trauma, and Shock, 10*, 4–6.

Tuomainen, H. (2018, October 9). Mental illness: Why help ends at a milestone birthday. BBC News. https://www.bbc.co.uk/news/health-45411901.

Viola, S., & Moncrieff, J. (2016). Claims for sickness and disability benefits owing to mental disorders in the UK: Trends from 1995 to 2014. *The British Journal of Psychiatry Open, 2*, 18–24.

Weinberg, D. (1997). The social construction of non-human agency: The case of mental disorder. *Social Problems, 44*, 217–234.

Whitaker, P. (2018, September 5). We are at crisis point with child mental health—So don't dismiss it as mere teen angst. New Statesman. https://www.newstatesman.com/politics/health/2018/09/we-are-crisis-point-child-mental-health-so-don-t-dismiss-it-mere-teen-angst.

Whitaker, R. (2010). *Anatomy of an epidemic*. Crown.

Whitaker, R., & Cosgrove, L. (2015). *Psychiatry under the influence*. Palgrave Macmillan.

Wright, B. (2019). Documentary reports mental health crisis amongst young people. https://happiful.com/documentary-reports-mental-health-crisis-amongst-young-people/. Accessed 23 December 2019.

Zola, I. K. (1972). Medicine as an institution of social control. *Sociological Review, 20*, 487–504.

3

Governing Emotions in School

Roberto McLeay and Darren Powell

Introduction

The emotions of young people have gained increasing attention, both globally and in Aotearoa New Zealand, through their position within the contemporary notions of mental health and, more recently, wellness. Although it is important to support young people's health and wellbeing, we argue that the attempts to make children's emotions 'well' may work in favour of burgeoning mental health and 'troubled person's' industries'

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(Gusfield, 1989)—but not necessarily the needs or 'wellbeing' of young people. Through a Foucauldian lens, we seek to demonstrate how dominant discourses of mental health/illness and psychiatry (Cohen, 2016) work to re-position young people as 'troubled', re-imagine young people's emotions as 'unhealthy', and re-shape educational policies and practices that relate to the provision of counsellors in schools. While the school guidance counsellor and their role in expanding the troubled persons industry takes centre stage in this chapter, they are just one of a host of individuals and organisations that are part of the troubled persons professions (Gusfield, 1989); those involved in the deployment of tactics and techniques that work to shape young people as 'troubled' in a variety of ways.

'Troubled' Young People and 'Troubling' Emotions

The concept of 'troubled' young people is both complicated and complex, illuminating a deeply social process that draws on and produces specific ideas, thoughts, beliefs, and assumptions about young people and the way they 'should' conduct themselves (and others) in society. While the 'helping professions' aim to position themselves as occupations of 'benevolence'—that work to 'help the 'needy' (Gusfield, 1989)—it is crucial for anyone who engages with young people to explore, examine, and understand the ways young people may be positioned as 'troubled' (and, therefore, in need of curing, fixing, disciplining, or supporting). In the following sections, we seek to demonstrate how the assemblage of emotions with mental health, biomedical discourses, and claims of a mental health crisis, work to position young people as 'troubled', further ingrain psychiatric *ways of seeing* and knowing emotions, and ultimately serve to expand the troubled persons industries.

Troubling 'Mental Health'

> Mental illness in young people is a serious issue worldwide, but is a particular concern in New Zealand. (Mapson, 2013, p. 70)

> Our young people need free and timely access to mental health support. (New Zealand Government, 2019, p. 35)

The mental health of young people has gained increasing attention from journalists, politicians, educators, health officials, and the public—both nationally and internationally—over the past decade. The widespread use of mental health categories and language—such as anxiety or depression—illuminates the successful promotion and proliferation of specific psychiatric *ways of seeing* in society (Cohen, 2016). It is here that the troubled persons industry takes root, as fields that claim benevolence—such as psychiatry, psychology, and public health—also demonstrate a dependence on defining certain populations as 'mentally sick' and in need of their medical attention (Gusfield, 1989). Although we are not attempting to summarise the rich body of literature that has contested common assumptions about mental health (for example: Cohen, 2015, 2016, 2018; Whitaker & Cosgrove, 2015), we encourage those who work with young people to contemplate how particular discourses of mental health have positioned young people as troubled, sick, ill, and requiring specialist services, professionals, and interventions.

Given the strong articulation of health/wellbeing ideals with mental health in contemporary times (See: Ministry of Health, 2017; World Health Organisation, 2020), it is hardly surprising that young people's emotions are problematised as 'troubling'. In short, young people are now assumed to have a variety of 'emotional health/wellness/wellbeing issues' (L'Estrange, 2019). However, as we demonstrate in the following sections, current 'knowledge' about mental health draws on dominant discourses of emotion and produces a particular *way of seeing* emotion; a re-imagining of young people's emotions and mental health.

Ways of 'Seeing' Emotion

The English word 'emotion' first appeared in the 1800s and derived from the 16th-century French word *émouvoir*, a concept relating to the movement or stirring up from within (Watt Smith, 2015). Prior to this idea people already had a plethora of various ideas, thoughts, beliefs and practices; each unique in its description of *movement from within*; each unique to the diverse cultures, languages, politics, and times (Watt Smith, 2015). However, since the conception of science in the sixteenth century, the concept of *a movement from within* has largely been shaped, or rather confined, by a specific group of people—psychiatrists, psychologists and now health 'experts'—with a particular philosophical and theoretical *way of seeing*.

The Anatomy of Emotions

Today's contemporary use of 'emotion' was developed during the seventeenth century by English anatomist Thomas Willis, who theorised that emotion was a result of physical brain functioning (Watt Smith, 2015). Willis' biomedical *way of seeing* emotions utilised a dehumanising perspective, termed by Foucault (1975) as the 'clinical gaze', where humans are seen as merely a body of organs (Petersen & Bunton, 1997). By privileging this *way of seeing*, the idea of 'emotion' shifted firmly towards the positivist paradigm (Crotty, 1998) where emotions were constructed as being measurable, comparable, knowable, and therefore, controllable, objects. Since this time, a number of theories have developed that support Willis' *way of seeing* a *movement from within*—as simply a physically observable, measurable, and knowable response from the body—such as the theory of emotional expression (Darwin, 1872), the theory of basic emotions (Ekman, 1999), and the componential theory of emotions (Scherer, 2005). By drawing on these biomedical theories, mental health 'experts' have continued to conduct research on emotions that measure heart rates, brainwaves, nervous systems, brain physiology, facial expressions, and behavioural responses (Watt Smith, 2015), to further reinforce the idea that emotions come from the body, and can be understood in terms of physical (ill)health.

The re-imagining of emotions as *'physical matter'* demonstrates a warlike tactic, where health 'experts' utilise the clinical gaze to position social objects in the medical 'light' of sickness and health (Foucault, 1975) in order to promote a position of benevolence—'helping' those afflicted with emotional un-wellness. In other words, re-positioning the concept of *a movement from within* to represent the simple functioning of organs provides mental health 'experts' with the opportunity to construct emotions as physically 'unhealthy' or 'sick' objects, which may then require treatments through specific biomedicalised psy-technologies (i.e. psychology and psychiatry). By whittling down human emotion to represent a physical reflex of the body, health 'experts' grant themselves further authority to define social norms and solve social problems. To this end, medical and health 'experts' have succeeded in extending their jurisdiction through confinement (see: Foucault, 1965); producing and promoting a specific *way of seeing* and knowing emotions that supports their own philosophical views and values on the idea of a *'movement from within'*. Furthermore, when those charged with caring for young people in schools (such as teachers, principals, school nurses, social workers, parents, youth mentors, counsellors, and students themselves) draw on ideas of ill/unhealthy emotions, they simultaneously shape emotions as 'troubling', position young people as 'troubled', and reinforce the biomedical authority of the troubled persons professions.

However, the biomedical *way of seeing* a *movement from within*—like mental health—is contested, problematic and not straightforward. For instance, the contestation of biomedical emotions may be problematised through the emotion of nostalgia. Originally constructed—through the clinical gaze—as a medical diagnosis (see: Watt Smith, 2015), nostalgia is recognised today as "a feeling of pleasure and also slight sadness when you think about things that happened in the past" (Cambridge University Press, 2020) and has been noted to increase connection to people and places (Watt Smith, 2015); as well as "help people find meaning in their lives" (Sedikides & Wildschut, 2018, p. 48). Also, sadness—historically recorded as bringing about steadfastness, soundness of mind, resolution of the soul (Watt Smith, 2015)—was once an emotion that one could feel smug with when experiencing it; a concept far from today's notion of sadness—which now has within it an embedded suspicion of 'illness/un-healthiness' that requires 'curing', 'fixing' or 'helping'. In other words, in current times—during the mental health 'crisis'—a young person's sadness may now be re-imagined as a mental illness known as depression (see: American Psychiatric Association, 2013); a psychiatric diagnosis originally constructed to support the acute social claim of 'unjustified sadness' (Watt Smith, 2015), which can then be sent for 'treatment' to be made 'well'. These two examples serve to illustrate how dominant discourses of emotions, as biomedical objects, work to support the troubled persons industry by disregarding an individual's 'subjective feeling' of emotion (Scherer, 2005)—as well as the diverse ideas, thoughts, beliefs, social contexts, cultures, languages, and locations—in favour of directing (through the guise of 'health') how young people 'should' know, understand, and conduct themselves with their experience of a *movement from within.*

Further, through bridging the concept of 'mental health with biomedical discourses of emotions, health 'experts' in Aotearoa New Zealand and internationally have been provided with an opportunity to produce a range of literature that endorses the idea of 'emotional health': the need to 'feel good' (Mindfulness Education Group, 2020b) or 'feel right' (Health Promotion Agency, 2020, para. 1). As a result, young people have become subjects to be trained—indeed disciplined—through technologies such as emotional first aid, managing emotions, building emotional resilience, regulating emotions, developing emotional competence, and learning to be emotionally intelligent. While these concepts sound plausible, they also illuminate the presence of profoundly social and philosophical work that supports the positing of indisputable, positivist, biological 'truths' of emotions—as simply biomedical, mental health, reflexes from a body of organs. Hence, these concepts are privileged and promoted in the fields of health, psy-sciences and education for their assumed ability to 'help', or rather direct, 'troubled' young people to conduct themselves 'appropriately' in society.

Constructing 'Troubled' Young People

While the social/philosophical construction of biomedical emotions works together with theories of 'mental health' to construct a notion of 'troubled' young people, its proliferation requires assembling these, problematic, concepts with claims of severe and extreme consequences—in order to generate a widespread urgency in society to 'deal' with 'troubled' young people and their 'troubling' emotions. Here in Aotearoa New Zealand, public figures—including actors, sportspeople and comedians—have worked themselves into the complex and complicated puzzle of the troubled persons industry by proclaiming the most severe and extreme consequences of 'troubled' young people. For instance, speaking on national television to the concern for suicide—a topic that is categorised widely as a 'mental health' issue—comedian and mental health (and more recently mental wellbeing) advocate, Mike King, escalated a sense of urgency (and promoted his charity) by proclaiming:

> In my opinion, it's [the number of people committing suicide] well over 1700. My personal opinion, I think the coroner should also release the figures of those that they class as death by misadventure where people have taken their own lives… those figures aren't in the numbers… There are lots of things that need to be done. (cited in: Fitzgerald, 2019, 7:29–7:59)

By bolstering estimated suicide statistics, King's claim serves to generate greater public and political alarm, as well as support the idea that Aotearoa New Zealand's annual suicide rates have continued to be among the highest in the world and to date (Paterson et al., 2018; Stubbing & Gibson, 2019). Further, this statement reflects the rhetoric often used to describe young people's 'mental health', which draws on discourses of a crisis to explicitly promote the idea of 'troubled people' who are at risk of impending, disastrous, and extreme consequences.

Similarly, in the following quote from celebrity psychologist Nigel Latta, we can see how the 'shocking' statistics on mental illness are deployed as a rhetorical device to help manufacture a crisis:

> **There's no doubt we have a crisis in youth mental health in this country.** That's not a word I personally use lightly, because it's a word we all hear a lot.
>
> Everything's a bloody crisis these days it seems, but when it comes to our young people, it's actually true: We are 34th out of 41 countries for overall childhood wellbeing. Antidepressant medication being prescribed for under 13 year olds has increased 79.4% since 2006, and 101.9% for teens aged 14-18.
>
> I could go on, there are far more terrifying statistics, but we all know them, and they just make you feel sad, and tired, and hopeless. (Mindfulness Education Group, 2020a, paras. 5–7, bold in original)

Latta's statement makes use of crisis discourses to generate a sense of urgency and reinforces the concept of 'troubled' young people as a way to justify and expand the need for 'benevolent' organisations (such as the Mindfulness Education Group) and programmes (e.g. the *Pause, Breathe, Smile* mindfulness programme) that re-assert their expert abilities to 'prevent' or 'make-well' 'troubled', mentally 'unhealthy', individuals.

Emotions—or rather the biomedical *way of seeing* emotion—also serves to support the rhetoric of a youth mental health crisis, as depression—a mental illness initially constructed from the idea of 'unjustified' sadness (Watt Smith, 2015)—and anxiety—the transformation of the emotion called angst into an illness known as angst-neuroses (see: Watt Smith, 2015)—are often linked with suicide (Stubbing & Gibson, 2019). This complex amalgamation has provided the media with opportunities to promote mental health/illnesses, such as anxiety and depression, as a severe and steadily increasing crisis that has reached new plateaus (Roy, 2018); which, in turn, has amplified the public's concern for 'troubling' emotions and 'troubled' young people. To complicate the subjectivities of young people even further, academic publications, government documents, and the media have articulated how young people's difficult circumstances—such as bullying, divorce, poverty, friendship challenges, domestic violence, and abuse—relate to psychiatric diagnoses of depression and anxiety (and behaviours like suicide or self-harm). This generates another opening to view young people as 'troubled' according to their lived experiences and socio-cultural contexts. By intertwining the concept of 'troubling' emotions with severe and extreme consequences—like suicide or self-harm—and ideas of mental health issues, the 'problems' of 'troubled' young people may be further conflated and certain emotions—such as sadness, angst, anger—are able to be proclaimed as unequivocally 'unhealthy' or 'unsafe'; to the point where they are used in society as 'incontestable' 'predictors' of severe and extreme consequences. Hence, by employing emotional/mental health (and increasingly emotional/mental wellbeing) as a crisis, what can be said, what cannot be said, and who is allowed to be an 'expert' in dealing with the causes of and solutions to the 'problem', are re-worked and re-defined (Powell, 2020). Further, crisis discourses—manufactured both intentionally and unintentionally—work to shape academic and public understandings of young people and provides space to fortify claims of 'troubled' young people through irrefutable 'truths'; which has serious implications for policies and practices that target children.

Foucault (1980) argued that every society has 'regimes of truth' that accept particular discourses and allows them to function as true—the youth mental health 'crisis' is one such regime of truth. While we are not trying to replace one set of mental health 'truths' with another, it is important to recognise how the concept of 'truth' illuminates another complex and complicated way that emotions may be claimed as 'truly troubling' objects of health; and, therefore, young people may be positioned as 'truly troubled' and in need of 'help'. Our point here is that although there is an ease in which these statements are accepted as being certain 'truths', they are also assumptions that continue to be contested, critiqued, and challenged. For instance, the claim of increasing suicide rates in Aotearoa New Zealand is a contested point as Gluckman (2017, p. 2) reported that since 1996, youth "suicide mortality rates have generally declined for non-Māori"; a finding echoed by Snowdon (2017). Similarly, figures recently released by the Chief Coroner indicated a continued decrease of suicides overall in New Zealand, specifically with Māori, Pacific Islanders, and those of European descent (Kronast, 2020). Further, it is also important to acknowledge that the attempts to define 'emotion'—through producing an 'ultimate', 'universal' and 'absolute' claim of 'truth' or rather *way of seeing*—has been noted by scholars as one of the most problematic tasks to undertake, due to the diverse ideas, thoughts and beliefs about emotions (Scherer, 2005; Watt Smith, 2015).

We are not saying here that the loss of a young person's life is acceptable, nor are we saying we should ignore or dismiss young people's experiences of *a movement from within*. Instead, we are drawing attention to how the use of a mental health crisis, alongside biomedical *ways of seeing* emotions, discursively produces 'truths' that work in favour of the troubled persons profession; allowing them to construct emotions as 'troubling' objects of sickness and health, as well as direct societies to position young people as 'troubled' for their experiences. For this reason, critiques of the 'truth' of a youth mental health crisis are critical to this chapter and help us to understand how mental cannot simplistically be understood as some sort of neutral biomedical categorisation of health but is a complex issue that is uncertain, contested, and socially constructed. In other words, a young person's mental health, wellbeing, or emotions are far more than a medical condition to be solved through a variety of interventions. Despite ongoing debates and tensions, emotions—like mental health—are widely acknowledged as a part of the human experience and, as such, provide an ideal target for governing populations, such as young people. After all, if the majority of people experience these *movements from within* then shaping and confining the way *movement from within* is known, felt and seen serves as an excellent way to govern others towards specific ends. Hence, particular *ways of seeing* emotions have been privileged and promoted in society—and certainly in schools—through ideas and solutions that seek to make young people 'well'.

Solutions to 'Troubled' Young People

> For us as a government in the last budget… we put the biggest investment this country has ever seen into mental health, in over a billion dollars; and that's because our goal is to make sure that no matter where ever you live in New Zealand you can get the help that you need. — Jacinda Ardern, the Prime Minister of New Zealand (Fitzgerald, 2019, 6:13–6:31).

The growing concern about a youth ‘mental health crisis’—suicide, self-harm, depression, anxiety, and general struggles in life—has led to the expansion of troubled persons professions in society. Other occupations—such as researchers, computer programmers and marketers—are now also employed to develop, promote, and justify the surge of solutions that seek to identify ‘troubled’ young people and make them ‘well’. In New Zealand, this expansion is made visible through an increase in psychiatric diagnoses and medications prescribed to young people by ‘health’ experts (Bowden et al., 2019), a call for more counsellors and psychologists in schools (Bootham, 2016; Education Central, 2018), the creation of new virtual reality and online technologies to ‘fix’ mental health issues (e.g. Sparx, 2018), and a range of programmes and resources designed to ‘improve’ children’s ‘mental health’ in schools (e.g. Mindfulness Education Group, 2020b) and beyond (e.g. Cure Kids, 2020). Further, the tactical move to reduce the stigmatisation of mental health (Ministry of Health, 2002; Thompson, 2017)—and make it more palatable to the public—has led to the re-packaging of emotional health as emotional ‘well-ness’ or wellbeing—one that is now promoted by researchers, professionals, politicians, media, and celebrities as *the* solution to ‘mental illness’ and ‘unhealthy emotions’. As Mike King claims: “Kids don’t want to go [to counselling] because they are mentally ill, they want to go to stay well… now it’s about taking care of ourselves” (OneNews, 2020, 2:57–3:45). King’s idea of transforming mental health into ‘wellbeing’ reinforces The Mental Health Foundation of New Zealand’s (2020a) strategic assertion that “We [New Zealanders] will not create better mental health within New Zealand by continuing with an imbalanced focus of resources on acute mental health services. Instead, New Zealand must increase its efforts in promoting wellbeing and preventing mental health problems from occurring” (para. 6). Thus, the solutions that have been developed to combat ‘mental illnesses’ have now been transferred into contemporary products of, and services for, ‘better’ wellbeing, and have specific ramifications for young people in schools.

Although these solutions support claims of benevolence and goodwill to ‘help’ others, we share a concern that when claims relating to ‘troubled youth’ “are treated as uncontestable truths, void of any ambiguities and uncertainties … and are uncritically welcomed as a kind of individual and cultural salvation" (Vander Schee & Boyles, 2010, p. 170), they are also uncritically welcomed into schools (as well as homes, hospitals, sports clubs, businesses, and government organisations). Subsequently, no matter whether one agrees with critiques of a youth mental health 'crisis', acknowledging that the causes, consequences, measurements, prevalence, and solutions to 'troubled' youth are complicated, complex and uncertain should force us to question what is happening to children in schools and in the name of 'mental' and 'emotional' 'health'.

Schooling Emotions

While schools are typically recognised as locations for benevolent professions that help young people to become contributing members of society (Ministry of Education, 2007), the increasing presence of mental health 'experts'—such as, educational psychologists, nurses with specific mental health training and counsellors—in schools illuminates how the pathologising of everyday life "not only creeps through social narratives to include children, it now centres around them" (Harbusch & Dellwing, 2019, p. 371). Indeed, schools are now so aligned with troubled persons industries that they regularly invite in an array of organisations and individuals to transform young people, with 'mental' and 'emotional' wellness issues, into 'healthy' contributing citizens (see: Gusfield, 1989). This is unsurprising given the strong historical association between public health imperatives and public schools (see: Gard & Pluim, 2014), as well as the intentional targeting of schools by psychiatric documents. For instance, the American Psychiatric Association's DSM-V (2013) mentions schools 275 times in relation to specific mental health diagnoses (Cohen, 2015); a point that demonstrates how "psychiatric categories [ways of seeing] are shape-shifters changing with their clients and situations" (Harbusch & Dellwing, 2019, p. 371). Further, the close relationship between the interests of public education and public health is not just historical but demonstrated in contemporary contexts by "the ease and regularity with which the work of schools and teachers is assumed by others to be an instrument of public health policy" (Gard &

Pluim, 2014, p. 5). Teaching resources that aim to educate young people about mental/emotional health concepts (see: Fitzpatrick et al., 2018) demonstrate how schools may be guided to serve public health policies. Gard and Pluim (2014, pp. 216–220) also note that the re-emergence of psychology in schools, as an extension of the medicalisation of schooling and the quest to 'make' young people healthy,

> is also another 'colonizing' moment when many members of a particular field of study and professional practice see themselves having a greater influence over what happens in schools … The attention of psychologists will be something that children all over the world will find increasingly difficult to avoid.

The point here is that schools are locations where large populations of young people are trained, through exercises and practices, how to know, see and feel in society; and, as such, produce schools as a docile body (Foucault, 1991a); where dominant discourses of emotions, psychiatric concepts such as mental health, and helping-technologies (like counselling) assemble together in an attempt to govern young people in and through their 'emotions'. In the sections that follow, we demonstrate how the field of psychology—in particular, counselling discourses and technologies underpinned by psy-sciences—attempt to govern young people and their emotions towards certain, yet unpredictable, ends, and fortify the position of the troubled persons professions in schools.

Schooling 'Troubled' Young People

> Schools here and abroad continue to be touted as 'health promoting', that is, an ideal setting in which to link mental health and learning outcomes. (Manthei et al., 2020, p. 6)

> Attending to and caring for the wellbeing of students is an integral responsibility of schools (ERO, 2016), and serves not only as a foundation for academic learning and progress, but also as part of a wider community function. (Hughes et al., 2019, p. 41)

Through bringing together troubling discourses of mental health and wellbeing with 'learning outcomes' for young people (see: Education Review Office, 2016), principals, teachers, deans, counsellors, and support staff are drawn into an assemblage of troubled people's professions that attempt to govern young people's mental health/wellbeing towards greater productivity and achievement in school. Further, the focus on 'mental health' and its assumed connection with economic and academic productivity has provided schools with a new mandate, to promote environments that are emotionally 'healthy' and 'safe' for young people. Education legislation and policies are a key technology of government to make this possible. For instance, Sect. 127 of the Education and Training Act (2020), Subpart 3—Teaching, learning and wellbeing, states that one of the primary objectives of Boards in governing schools is that they must ensure that "the school—(i) is a physically and emotionally safe place for all students" (p. 108). This legislative requirement is reinforced through the Ministry of Education's (2019, para. 5) National Administration Guidelines (NAG5), which reminds the Board of Trustees that they are required to "provide a safe physical and emotional environment for students".

The intentional focus on the emotions of young people, expressed through legislation and policy documents, positions schools as ideal locations for programmes that target young people's everyday experiences of emotion. Programmes that draw on dominant biomedical discourses of emotions and 'mental health' appear to be particularly prevalent—such as New Zealand's *Sparklers* programme, which focuses on using techniques to "help tamariki manage their emotions, feel good" (2019a, l. 9), or overseas programmes like *The Zones of Regulation* (2020), a programme designed to promote emotional control as self-regulation for young people. Unfortunately for young people, mental health programmes in schools often position emotions as 'troublesome' and 'troubling', and therefore, in need of disciplining.

By promoting the 'struggles' of young people and attaching them to biomedically-informed emotion and mental health diagnoses (such as anxiety and depression), psy-professions have succeeded in constructing a wide-scaled examination of 'normalcy' for human emotions—whereby young people may be understood as emotionally 'unhealthy', 'abnormal' and, therefore, ‘troubled’ at any time. Thus, through the use of the clinical gaze, health ‘experts’ and wellbeing advocates are able to encourage school communities to survey young people for ‘unhealthy’ emotions or emotional ‘wellness issues’ (L’Estrange, 2019). Once identified as ‘troubled’, young people are encouraged to be referred by school staff, parents, other young people or themselves (see: Kidsline, 2020) to a range of ‘health’ technologies—such as specialist youth mental health services (see: Healthpoint, 2020), or education programmes that target emotions (see: Sparklers, 2019b)—in order to be ‘supported’, ‘cured’, ‘fixed’ or ‘healed’ of their ‘troubling’ emotions. The call to support emotionally ‘troubled’ young people, as well as the legal and moral mandate to provide emotionally ‘safe’ and ‘healthy’ environments in Aotearoa New Zealand schools, has led to an increasing demand for one particular group of ‘experts’ in mental health and emotional wellness to take action in schools: guidance counsellors.

Shaping Counselling Policies And Practices In Education

Since the ‘mental hygiene’ movement (Gard & Pluim, 2014) and the formalisation of educational guidance in the mid-twentieth century, counselling has been positioned as a foundational technology for assisting schools with young people. The role of the school guidance counsellor has become legitimised and institutionalised across Aotearoa New Zealand secondary schools, in part, through government legislation. For instance, Sect. 77 of the Education Act (1989) dictates that: “The principal of a state school shall take all reasonable steps to ensure that—(a) students get good guidance and counselling” (p. 137). This short, yet influential, section of legislation resulted in a renewed opportunity for counsellors to engage with and shape populations of young people on a grand scale.

The educational mandate to provide a ‘safe’ emotional environment for young people has also presented counsellors with the opportunity to draw on dominant biomedical and psychiatric discourses in order to justify techniques (see: New Zealand Association of Counsellors, 2019a) that 'support' young people with their emotional wellness issues in schools. Further, certain education rationalities, such as removing barriers to those at 'risk' of failing the education system (New Zealand Post Primary Teachers' Association & New Zealand Association of Counsellors, PPTA & NZAC, 2015), have joined with technologies of counselling and the subjectivities of the school guidance counsellor to govern not only young people's emotions and wellbeing, but their educational (and future economic) productivity. Reviews on the 'effectiveness' of counselling in Aotearoa New Zealand secondary schools (Education Review Office, 2013; Manthei et al., 2020)—coupled with the Aotearoa New Zealand government's focus on developing a new health improvement practitioners workforce (New Zealand Association of Counsellors, 2019b) and funding mental health initiatives (Labour, 2018)—have guided school counsellors to justify their roles according to the ideas, thoughts, and beliefs of psy-professionals; further positioning themselves as a professional body that utilises and promotes the dominant discourse of 'mental health' (Hughes et al., 2019). Thus, counsellors who govern young people through biomedical discourses of mental health and emotions are in turn also shaped and governed through the same psychological 'knowledge' and technologies, thus maintaining their current privileged position and *status quo* in society. The precarious stance of being surveyed and bound by the knowledge posited and promoted to young people illuminates how counsellors are simultaneously positioned as both governors and the governed (Foucault, 1991a). Nevertheless, aligning with the troubled persons professions provides counsellors with an opportunity to market their expertise to schools, and for counselling, as an essential technology for 'working' on 'troubled' young people.

Counsellors as Experts

Through the use of policies, legislation, and an increasing concern for the 'problems' of 'troubled' young people, school guidance counselling has transformed and permitted counsellors to be shaped as *the* 'experts' of young people's emotions. President of the New Zealand

Association of Counsellors, Christine MacFarlane (2020, p. 2), articulates the importance of 'expert' counsellors in schools, asserting that: "Of course, pastoral staff have some skills to help students, but it is only the professional school guidance counsellor who is able to meet the diverse needs of today's students". However, while guidance counsellors have a unique position in schools, careful consideration should be given to how the 'expert' title is obtained and executed. By drawing on their expertise in 'knowing' and using specialised skills, knowledge, and understandings of young people's emotional health, counsellors are able to forge alignments between themselves and mental health imperatives that require 'expert' emotional wellness evaluators and analysts. This is further reinforced by the deployment of expert knowledge on palatable concepts—such as young people's 'mental health', 'emotional health' or 'emotional wellness issues'—which ensures counsellors are then able to evaluate young people's behaviours and label particular emotions as being 'unhealthy', 'problematic' and, therefore, in need of 'helping' occupations. Speaking to the 'expert' nature of the counselling profession, former President of the New Zealand Association of Counsellors, Bev Weber, states: "New Zealand dealing with mental health and emotional wellness issues need targeted, trained and qualified support, and counsellors are the right people for that job" (L'Estrange, 2019, l. 13). While positioning counsellors as 'experts' in schools may appear to support the emotions of young people and the construction of emotionally 'safe' environments, it also illuminates the production of bio-power (Foucault, 1975) by attempting to manage a population through the belief of obtaining 'healthy emotions' and reducing 'ill emotions' for life. Further, disciplinary power intermingles with the focus on promoting life and managing illness, positioning the bodies of young people as 'resources and manageable objects' (Petersen & Bunton, 1997, p. 114) that can be "subjected, used, transformed and improved" (Foucault, 1991a, p. 136) for the purpose of maximising and sustaining the financial and economic productivity of the wider body. The contemporary notion of happiness is one useful emotion that illustrates the way health 'experts' may utilise ideas, thoughts, and beliefs about emotions to serve the interests of neoliberalism and economic productivity. Originating from the old Scandinavian word 'hap', happiness describes a *movement from within* that was to be experienced rather than controlled or manufactured, and is embedded in circumstances of chance, luck and success (Watt Smith, 2015). However, over time happiness has come to be re-defined by psychologists as "a state of well-being that encompasses living a good life" (Psychology Today, 2019, p. 1). The intentional shift of attention towards living a 'good' life has led to a multibillion-dollar industry of happiness technologies ranging from self-help books and apps to research studies that promote the idea of obtaining happiness as a way to having (and in some ways, consuming) a better and longer life (Watt Smith, 2015). The continued focus on better life and health has led psy-professions to promote happiness as being valuable for increasing work productivity (Carr, 2011), an idea that many industries have now 'bought' into and profited from (e.g. 100% Pure New Zealand, 2019; Zwilling, 2014). Schools in Aotearoa New Zealand have also aligned themselves with these ideas of 'emotions' and 'productivity', promoting happiness as a means to improve young people's learning and work outcomes (Children's Commissioner & NZ School Trustees Association, 2018). To this end, school guidance counsellors who claim an 'expert' role through promoting the concept of managing 'ill' emotions and obtaining 'healthy', 'positive', emotions—such as happiness—reflect the same shared aims of psy-professionals to maximise the capacities of young people for economic productivity.

Counsellors as Authorities of Knowledge

> 63% of principals identified support for students with mental or well-being needs as a major issue for schools… these young people need help. They need therapeutic interventions such as counselling as psychological services.— Perry Rush, President of the New Zealand Principals Federation. (New Zealand Principals' Federation, 2020, p. 1)

> There needs to be more education around who counsellors are, what they do and why the idea of a mental and emotional health warrant of fitness is a good one. (New Zealand Association of Counsellors, 2019c, l. 16)

School guidance counsellors have become key resources for sharing 'knowledge' of mental health and emotions with staff, children, parents, and the community (PPTA & NZAC, 2015). As an authority of knowledge, counsellors therefore also shape what counts as the 'truth' about young people and their emotions, mental health, and lived experiences. For instance, through promoting the belief of 'unhealthy' emotions as an uncontested 'truth', school guidance counsellors are able to confine (Foucault, 1965) young people from being able to know, understand, and experience their emotions in any other way than a biological reflex from a body of organs; emotions that become 'unhealthy' or 'ill' and require treatment from a counsellor or other psy-science expert. Further, by drawing on and promoting this particular 'knowledge', counsellors position themselves to meet the key performance indicators for employment in schools outlined by the PPTA and NZAC (2015) guidelines, namely the responsibility to 'identify' and address the emotional well-being issues of particular ethnic groups in schools. While the claim to make emotions 'well' may provide counsellors with the ability to embed and extend their expert jurisdiction, promoting the idea that emotions are only reflexes from the body is problematic and misrepresents emotions (Watt Smith, 2015). Thus, school guidance counsellors who utilise and promote the idea of emotional 'health' may dismiss the importance of the social, cultural, and political factors, and focus on more individualistic ways to govern young people to become more docile, productive, and 'healthy'. Moreover, in serving particular 'knowledge' of emotions for consumption in schools, guidance counsellors may guide young people to survey themselves—self-surveillance (see: Foucault, 1991a)—for their own 'ill' or 'unhealthy' emotions; and, thus, direct young people to self-refer to professionals, programmes, and services for their 'troubling' emotions and mental health.

Counsellors as referrers of 'mental health'

> Both studies indicate the broad range of problems that every counsellor must be able to recognise and respond to, whether that means treatment or referral to an outside specialist. (New Zealand Association of Counsellors, 2020, p. 2)

> Counsellors shall refer clients on, where possible, when other specialised knowledge is needed, or when the counselling is not being useful. (New Zealand Association of Counsellors, 2016, p. 7)

A further mandate for the guidance counsellor is to promote specialist services for students with specific emotional or mental health 'issues'. By referring young people to specialists services and programmes that focus on supporting young people to 'deal' with their emotional difficulties (see: Marinoto, 2020; Youthline, 2017), feel good and function well for better learning (Mindfulness Education Group, 2020b), or generally increase their resilience and wellbeing, school guidance counsellors are able to further reinforce the technologies that make 'unhealthy' emotions 'well'. Moreover, referring young people may also serve to benefit the counselling profession, as specialist mental health services and organisations (see: Mental Health Foundation of New Zealand, 2020b)—who trust counsellors to deliver the agreed-upon mental health and biomedical emotion discourses—may, in turn, refer 'troubled' young people to 'expert' counsellors. Referring young people with emotional 'wellness' 'issues', back and forth, between professional, services, and programmes—that are underpinned by similar discourses—illuminates the formation of a symbiotic relationship that is less about the 'health' of the young person and more about engraining *specific ways of seeing* emotions and economics.

Counselling as a Technology of Discipline

Although the PPTA and NZAC (2015) make it explicitly clear that school guidance counsellors do not punish students, examining how power can be exercised by counsellors is critical to illuminating discipline within the school guidance counselling role. Foucault's (1975) notion of disciplinary power—a war-like strategy that utilises techniques of observations, examinations and measurements to train adults and children to compare themselves against an established socially constructed 'norm' (Petersen & Bunton, 1997)—provides a unique opportunity to observe power at work in the school setting. Through utilising and promoting specific 'knowledge' and concepts—such as mental health and biomedical emotions—school guidance counsellors mobilise their privileged status as 'experts' and authorities of knowledge, to re-position themselves in schools as a central technology that surveys young people according to specific psychiatric *ways of seeing*. Young people's emotions—indeed young people themselves—may then become objectified by counsellors and trained under the guise of 'emotional health', 'emotional wellness', 'emotional resilience', 'emotional management', 'emotional competency', and 'emotional intelligence', in order to sustain their work productivity for the benefit of the economy, rather than just for their own 'wellbeing'. Further, the intention of training school communities to re-imagine young people's emotions as biomedical and mental health objects is to further engrain the value of the societal 'norm', as well as emphasise the importance of counsellors who purvey and survey the 'norm'. Hence, disciplinary power exposes the ability of school guidance counsellors to gain prestige in schools and society, as medicine and science enables biomedical experts with a privileged position to define and then intervene in mental health 'disorders' (Petersen & Bunton, 1997).

Conclusion

Despite uncertain evidence about the 'problem' of young people, their emotions, and their 'mental health', a plethora of 'solutions' continue to target young people within and outside of schools. As we have illustrated throughout this chapter, an array of players and programmes have assembled together to bolster the 'troubled persons industries' (Gusfield, 1989) and solve the mental health 'crisis', and require us to question the potential impact on young people. While attempting to make people mentally and emotionally 'healthy' is not necessarily a 'bad' thing, it is, in a Foucauldian sense 'dangerous' (see: Foucault, 1997). These dangers are made visible by the ways in which dominant biomedical discourses of mental health and psychiatry position young people as 'troubled' (or at least at risk of becoming 'troubled'), re-imagine young people's emotions as binaries of 'un/healthy', and uncritically, produce particular types of mental health practices in schools.

In the New Zealand context, we noted how, in part, these discursive practices manifested in and through legislation and education policies that enabled counselling and counsellors to become the 'experts' on young people's mental health and emotions. However, as Foucault (1991b, p. 102) argued, modern government does not necessarily work by the state enacting power from the top-down onto individuals but is undertaken by an 'ensemble' of authorities, institutions and agents, using an array of technologies, tactics and bodies of knowledge, in an attempt to guide individuals' conduct towards definite, albeit unpredictable, ends. In New Zealand, media, celebrities, educational organisations, schools, and others are assembled together to employ counselling as a technology of government—one strongly underpinned by biomedical discourses and psychiatric ideas, beliefs, and concepts—to govern young people's emotions, mental health, and everyday lives. There is still more work for critical mental health researchers to do, especially in moving from analyses that are centred on discourse (such as in this chapter) to those that illuminate how power works to shape the 'actual' spaces, practices, and experiences of those who govern and are governed (see: O'Malley, 2009). As Foucault also acknowledged, programmes of government are resisted, rationales are ignored, and the actual 'living reality' of both the governors and the governed are a 'witches' brew' in comparison to the proposed simplistic, straightforward programmes of government (Foucault, 1991c, p. 254). In this way, to be able to critically examine the 'truths' and philosophical orientations promoted and practised by school guidance counsellors and other 'health' or 'wellbeing' experts, we may better demonstrate how young people may (or may not) be governed by psy-professions, and in ways that may not necessarily benefit their 'emotions' or 'wellbeing'. This brings to light the importance of exploring, contemplating, discerning and judging the ideas, thoughts, beliefs, assumptions and *ways of seeing* that are used to position young people and their emotions as 'troubled'; for the knowledge and *ways of seeing* that are used to claim how and why young people should be made 'well' must, at the very least, attempt to benefit young people *more* than the troubled persons industry.

References

% Pure New Zealand. (2019). *The art of employee happiness: How to create a highly motivated workforce*. http://www.businessevents.newzealand.com/getattachment/incentives/the-art-of-employee-happiness/The-Art-of-Employee-Happiness.pdf

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Publishers.

Bootham, L. (2016). *Call to put counsellors in primary schools*. http://www.rnz.co.nz/news/national/314627/call-to-put-counsellors-in-primary-schools

Bowden, N., Gibb, S., Thabrew, H., Audas, R., Camp, J., Taylor, B., & Hetrick, S. (2019). IDI trends in antidepressant dispensing to New Zealand children and young people between 2007/08 and 2015/16. *The New Zealand Medical Journal, 132*(1505), 48–61.

Cambridge University Press. (2020). *Nostalgia*. https://dictionary.cambridge.org/dictionary/english/nostalgia

Carr, A. (2011). *Positive psychology: The science of happiness and human strengths* (2nd ed.). Routledge. https://doi.org/10.1017/CBO9781107415324.004

Children's Commissioner & NZ School Trustees Association. (2018). *Education matters to me: Emotional wellbeing* (Issue March). http://www.occ.org.nz/assets/Uploads/Emotional-Wellbeing2.pdf

Cohen, B. M. Z. (2015). *Mental health users narratives: New perspectives on illness and recovery*. Palgrave Macmillian.

Cohen, B. M. Z. (2016). *Psychiatric hegemony*. Palgrave.

Cohen, B. M. Z. (Ed.). (2018). *Routledge international handbook of critical mental health* (1st ed.). Routledge.

Coronial Services of New Zealand. (2019). *Provisional suicide figures August 2019 [Fact sheet]*. June, 1–8. https://coronialservices.justice.govt.nz/assets/Documents/Publications/Provisional-Figures-August-2019.pdf

Crotty, M. (1998). *The foundations of social research meaning and perspective in the research process*. Sage.

Cure Kids. (2020). *Mental health starts with our youth*. https://curekids.org.nz/ceo/mental-health-starts-with-our-youth/.

Darwin, C. (1872). *The expression of the emotions in man and animal.* William Clowes and Sons.

Education Act .(1989). (no. 80).

Education and Training Act .(2020) (no. 38).

Education Central. (2018). *Double the amount of educational psychologists needed*. http://www.educationcentral.co.nz/double-the-number-of-educational-psychologists-needed/

Education Review Office. (2013). *Improving guidance and counselling for students in secondary schools.* http://www.ero.govt.nz/assets/Uploads/Improving-Guidance-and-Counselling-for-Students-in-Secondary-Schools-December-2013.pdf

Education Review Office. (2016). *Wellbeing for success: Effective practice March 2016*. New Zealand Government. http://www.ero.govt.nz/assets/Uploads/ERO-Wellbeing-for-success-effective-practice.pdf

Ekman, P. (1999). Basic emotions. In T. Dalgleish & M. Power (Eds.), *Handbook of cognition and emotion* (pp. 45–60). Wiley & Sons.

Fitzgerald, K. (2019). *Mike King surprised suicide figures aren't higher*. http://www.newshub.co.nz/home/politics/2019/08/mike-king-surprised-suicide-figures-aren-t-higher.html

Fitzpatrick, K., Wells, K., Tasker, G., Webber, M., & Riedel, R. (2018). *Mental health education and hauora: teaching interpersonal skills, resilience and wellbeing*. New Zealand Council for Educational Research.

Foucault, M. (1965). *Madness and civilization a history of insanity in the age of reason*. Random House.

Foucault, M. (1975). *The birth of the clinic: An archaeology of medical perception.* Vintage Books.

Foucault, M. (1980). The confession of the flesh. In C. Gordon (Ed.), *Power/knowledge: Selected interviews and other writings, 1972–1977* (pp. 194–228). Pantheon Books.

Foucault, M. (1991). *Discipline and punishment*. Penguin.

Foucault, M. (1991b). Governmentality. In G. Burchell, C. Gordon & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 87–104). Harvester Wheatsheaf.

Foucault, M. (1991). Questions of method. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality* (pp. 246–258). Harvester Wheatsheaf.

Foucault, M. (1997). On the genealogy of ethics: An overview of work in progress. In P. Rabinow (Ed.), *Michel Foucault: Ethics, subjectivity and truth: The essential works of Michel Foucault* (Vol. 1, pp. 253–280). The New Press.

Gard, M., & Pluim, C. (2014). A future without limits. In *Schools and public health: past, present, future* (pp. 206–223). Lexington Books.

Gluckman, P. (2017). *Youth suicide in New Zealand: A discussion paper*. Office of the Prime Minister's Chief Science Advisor, April, 1–14.

Gusfield, J. R. (1989). Constructing the ownership of social problems: Fun and profit in the welfare state. *Social Problems, 36*(5), 431–441. https://doi.org/10.2307/3096810

Harbusch, M., & Dellwing, M. (2019). Fluid politics: Reclaiming critical studies in psychiatry as a progressive issue. *Symbolic Interactions, 43*(2), 370–373.

Healthpoint. (2020). *Waitematā DHB Marinoto child and youth mental health services*. http://www.healthpoint.co.nz/public/mental-health-specialty/waitemata-dhb-marinoto-child-and-youth-mental/

Health promotion agency. (2020). *Is it depression/anxiety?* http://www.depression.org.nz/is-it-depression-anxiety/

Henry, D. (2019). *New Zealand suicides in 2018–19 highest since records began*. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12262081

Hughes, C., Barr, A., & Graham, J. (2019). Who comes to the school counsellor and what do they talk about ? *New Zealand Journal of Counselling, 39*(1), 40–70.

Kidsline. (2020). *Home*. http://www.kidsline.org.nz/Home_312.aspx

Kronast, H. (2020). *New Zealand's suicide rate drops to three-year low*. http://www.newshub.co.nz/home/new-zealand/2020/08/new-zealand-s-suicide-rate-drops-to-three-year-low.html

L'Estrange, A. (2019). *The government has just demonstrated its lack of understanding*. http://www.nzac.org.nz/publications/media-releases/the-government-has-just-demonstrated-its-lack-of-understanding/%0APosted

Labour. (2018). *What we're doing in Mental Health*. http://www.labour.org.nz/what_we_re_doing_in_mental_health

Macfarlane, C. (2020). *School counsellors can affect positive and significant change, NZ ' s first study shows*. http://www.nzac.org.nz/assets/Uploads/Press-release-Research-counselling-in-schools.pdf

Manthei, R., Brent, G., Tuck, B., Agee, M., Crocket, A., & Blanchard, N. (2020). *Evaluating the effectiveness of counselling in schools*. Ministry of Education.

Mapson, R. (2013). Seclusion under the Mental Health (Compulsory Assessment and Treatment) Act 1992. *The New Zealand Law Students' Journal*, *3*(1), 70–87. http://www.nzlii.org/nz/journals/NZLawStuJl/2013/5.html

Marinoto. (2020). *Guide to CHOICE appointments*. Waitematā DHB.

Mental Health Foundation of New Zealand. (2020a). *Addressing issues in our mental health*. http://www.mentalhealth.org.nz/home/our-work/page/17/10/addressing-issues-in-our-mental-health-system-a-position-paper

Mental Health Foundation of New Zealand. (2020b). *In crisis?* http://www.mentalhealth.org.nz/get-help/in-crisis/

Mindfulness Education Group. (2020a). *Lending my support to providing pause, breathe, smile in all NZ schools*. http://www.mindfulnesseducation.nz/lending-my-support-to-providing-pause-breathe-smile-in-all-nz-schools/

Mindfulness Education Group. (2020b). *Pause, breathe, smile mindfulness in schools*. http://www.mindfulnesseducation.nz

Ministry of Education. (2007). *The New Zealand curriculum*. Learning Media.

Ministry of Education. (2019). *The National Administration Guidelines (NAGS)*. http://www.education.govt.nz/our-work/legislation/nags/

Ministry of Health. (2002). *Building on strengths: A new approach to promoting mental health in New Zealand/Aotearoa*. Ministry of Health.

Ministry of Health. (2016). *Suicide facts: Deaths and intentional self-harm hospitalisations 2013*. http://www.health.govt.nz/system/files/documents/publications/suicide-facts-deaths-intentional-self-harm-hospitalisations-2013-nov16.pdf

Ministry of Health. (2017). *Māori health models—Te Whare Tapa Whā*. http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-whare-tapa-wha

Mitchell, A. (2019). *Mental health: New Zealand's self harm hospitalisations rising*. http://www.newshub.co.nz/home/new-zealand/2019/05/mental-health-new-zealand-s-self-harm-hospitalisations-rising.html

New Zealand Association of Counsellors. (2016). *Code of ethics: A framework for ethical practice*. New Zealand Association of Counsellors.

New Zealand Association of Counsellors. (2019a). *FAQs about counselling*. http://www.nzac.org.nz/counselling-information/faqs-about-counselling/

New Zealand Association of Counsellors. (2019b). *OIA reveals MOH's decision to exclude counsellors as HIPs*. http://www.nzac.org.nz/publications/counselling-aotearoa-news/show/16#Content-341

New Zealand Association of Counsellors. (2019c). *Understanding the culture: Counselling that is practical*. Counselling Aotearoa December 2019. http://

www.nzac.org.nz/publications/counselling-aotearoa-news/show/16#Content-339

New Zealand Association of Counsellors. (2020). *Making the case for more counsellors in secondary schools*. http://www.nzac.org.nz/assets/Uploads/NZAC-Counselling-in-schools-Research-summary.pdf

New Zealand Government. (2019). *The wellbeing budget*. http://www.treasury.govt.nz/publications/wellbeing-budget/wellbeing-budget-2019

New Zealand Post Primary Teachers' Association, & New Zealand Association of Counsellors. (2015). *The school guidance counsellor: Guidelines for principals, boards of trustees, teachers and guidance counsellors*. New Zealand Post Primary Teachers' Association.

New Zealand Principals' Federation. (2020). *President's message*. http://www.nzpf.schoolzineplus.com/news?nid=63

O'Malley, P. (2009). Governmentality and risk. In J. O. Zinn (Ed.), *Social theories of risk and uncertainty: An introduction* (pp. 52–75). Blackwell.

OneNews. (2020). *Mike King's 'near-death experience' is motivation to keep advocating for children's mental health.* http://www.youtube.com/watch?v=Y03UnJNHcXA

Paterson, R., Durie, M., Disley, B., Rangihuna, D., Tiatia-Seath, J., & Tualamali'i, J. (2018). *He ara oranga: Report of the government inquiry into mental health and addiction.* The Government Inquiry into Mental Health Addition. http://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

Petersen, A., & Bunton, R. (Eds.). (1997). *Foucault health and medicine*. Routledge.

Powell, D. (2020). *Schools, corporations, and the war on childhood obesity: How corporate philanthropy shapes public health and education.* Routledge.

Psychology Today. (2019). *What is happiness*. http://www.psychologytoday.com/nz/basics/happiness

Roy, E. (2018). *Crisis in New Zealand health services as depression and anxiety soar*. http://www.theguardian.com/world/2018/dec/04/crisis-in-new-zealand-health-services-as-depression-and-anxiety-soar

Scherer, K. R. (2005). What are emotions? and how can they be measured? *Social Science Information, 44*(4), 695–729. https://doi.org/10.1177/0539018405058216

Sedikides, C., & Wildschut, T. (2018). Finding meaning in nostalgia. *Review of General Psychology, 22*(1), 48–61. https://doi.org/10.1037/gpr0000109

Snowdon, J. (2017). Changes in the age pattern of New Zealand suicide rates. *New Zealand Medical Journal, 130*(1448), 18–26.

Sparklers. (2019a). *About*. https://sparklers.org.nz/about/

Sparklers. (2019b). *Managing emotions*. http://www.sparklers.org.nz/activities/?topic=Managing%20emotions

Sparx. (2018). *About Sparx*. http://www.sparx.org.nz/the-science-behind-sparx

StatsNZ. (2019). *Increase in life-threatening injuries from self-harm*. http://www.stats.govt.nz/news/increase-in-life-threatening-injuries-from-self-harm

Stubbing, J., & Gibson, K. (2019). Young people's explanations for youth suicide in New Zealand: A thematic analysis. *Journal of Youth Studies, 22*(4), 520–532. https://doi.org/10.1080/13676261.2018.1516862

The Zones of Regulation. (2020). *A framework designed to foster self-regulation and emotional control*. http://www.zonesofregulation.com/learn-more-about-the-zones.html

Thompson, M. (2017). *Mental health in NZ: How overcoming the stigma lightens the load*. http://www.newshub.co.nz/home/health/2017/08/mental-health-in-nz-how-overcoming-the-stigma-lightens-the-load.html

Watt Smith, T. (2015). *The book of human emotions*. Profile Books.

Whitaker, R., & Cosgrove, L. (2015). *Psychiatry under the influence: Institutional corruption, social injury, and prescriptions for reform*. Palgrave Macmillan.

World Health Organization. (2020). *Adolescent mental health*. http://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health

Youthline. (2017). *Face to face counselling*. http://www.youthline.co.nz/face-to-face-counselling.html

Vander Schee, C., & Boyles, D. (2010). 'Exergaming', corporate interests and the crisis discourse of childhood obesity. *Sport, Education and Society*, *15*(2), 169-185. https://doi.org/10.1080/13573321003683828

Zwilling, M. (2014). *How to increase productivity by happiness*. http://www.forbes.com/sites/martinzwilling/2014/12/02/how-to-squeeze-productivity-from-employee-happiness/#6cd206ab1efa

4

The ADHD Industry: The Psychiatrisation of the School System in Its Labour Market Context

Charles Marley and David Fryer

Introduction

Our approach to critical knowledge work rejects assumptions of mainstream positivist science that there is one ‘real’ world, about which we can ‘know’ the ‘truth’ by gathering ‘evidence’ which leads to the rejection of null hypotheses. Rather we assume there are indefinitely many accounts of what is the case, each of which would promote the interests of some as opposed to other interest groups. Each account has the status of ‘real’ bestowed upon its ‘objects’ (‘realed’), the status of truth bestowed upon

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its claims ('truthed'), the status of knowledge bestowed upon interlocking sets of its 'truthed' claims ('knowledged'), the status of 'evidence-based' bestowed upon its practices ('evidentialised') within particular regimes of truth. For a fuller explication of this approach please see: Fryer, Marley and Stambe (2020).

Our engagement with: 'what is'; 'what is true'; 'what is known'; and 'what is evidentialised' in this critical frame of reference is quite different from engagement through epistemological and ontological lenses characteristic of Western philosophy. Rather, our approach engages with them as essentially tactical, strategic and political processes. Within our approach where and how objects of knowledge emerge is problematised; as are: which authorities are able to pronounce upon them and upon what basis; which 'problems' are purported to be 'solved'; which aspects of the status quo are reinforced, and so on and so forth (Rose, 1999). Our aim is to understand how particular forms of truth come to be dominant, which interests are served at what times and in which ways, and to reveal their non-necessary and sometimes disreputable origins and unpalatable functions.

For our critical knowledge work on the production of the ADHD child-subject, we engaged with contemporary transdisciplinary research on subjectivity, which positions subjects as "made up", constituted in and by technologies of knowledge and power (Hacking, 1990, p. 3). We consider subjectivity to be multiple, mobile and externally constituted rather than a singular, fixed and internal 'natural essence'. As such, we maintain critical knowledge work must turn its analytical focus on the external 'concrete constellations' in which subjectivity is continually shaped and reshaped (Biehl et al., 2007); i.e. the apparatuses in which human subjects are continually made, un-made, and re-made. The approach we have described has been influenced by the work of Biehl (2005), which considers the human subject as produced within synthetic frameworks that mediate social control and recast concepts of a common humanity (p. 16). For Biehl, and for us, 'subjectivity' is a 'material of politics'—the site upon which governance is enacted—with 'subjective re-assemblage' continually occurring against a changing background of rational-technical politics and regional and local institutional responses.

We sought to make visible the apparatus of interconnections that conditioned the possibility for the rational-technical politics, and the broader social terrain from which they emerged, implicated in the constitution of the ADHD child-subject within a region in Scotland. We drew extensively upon Foucauldian and post-Foucauldian scholarship, particularly writings concerned with governmentality, which we understand as the complex of calculations, programmes, policies, strategies and tactics that shape the conduct of individuals: that which conducts conduct with particular consequences (Foucault, 1991). However, we considered governmentality as more than about controlling actions but as also about constituting ways of thinking, acting and, indeed, being through a wide range of political technologies and government-supported practices and institutions.

By following this approach, our aim was to 'think problematically' (Bacchi, 2012) about contemporary social practices and knowledges that constitute ADHD and to call them into question by connecting their emergence to a plurality of interconnected 'events'. To do this, we followed guidance from Bacchi (2012) to locate 'problematising moments', the times and places where shifts in social reality took place. By locating these moments, we are locating 'crisis moments' (Foucault, 1985), moments in which 'givens' become 'questions', where what was "previously silent" (Foucault, 2001, p. 74) becomes a heard problem, thus providing a point of access in the process of emergence of the 'things' that now appear self-evident. However, as both Bacchi (2012) and Deacon (2000) highlight, these self-evident givens do not become problems due to shifting historical circumstances nor because of new objects that didn't previously exist being created by discourse, but because of the 'totality of discursive and non-discursive elements introducing something into the play of true and false', thus constituting it as a particular object of thought (Deacon, 2000, p. 131). By locating these problematising moments, we are able to see that what is considered self-evident is the result of the interaction of a multiplicity of events at various historical junctures, none of which were necessary nor definitive (Mort & Peters, 2005, p. 19). They are the result of 'politics', the multiplicity of strategic connections involved in the construction of crisis moments at historical junctures (Bacchi, 2012).

The Battle of Truth over ADHD

Our position is that critical knowledge work regarding ADHD (and other 'problems') needs to engage with the 'problem' by avoiding the 'battle over truth' that characterises much of the ADHD debate. Our desire to avoid the 'battle over truth' connects with the first author's experience as a practising clinical psychologist. He was often involved in these battles at the level of the everyday, deploying arguments that highlighted the lack of validity and reliability of the 'evidence' for ADHD but, despite this, there was no impact on the continual requirement for 'assessment of ADHD' within child mental health services.

We see this battle of truth at the level of everyday clinical practice as an enactment of the battle occurring at the level of official institutional knowledges. If one considers the knowledges that construct the 'evidence-base' for ADHD, the battle is fought over the rules and procedures of 'objectivity' and 'methodological rigour', with studies not attending to these procedural requirements deemed 'methodologically flawed'. The outcome of this battle appears to be the 'cancelling out' of each position, most clearly articulated in the standoff between the 'International Consensus Statement on ADHD' (Barkley et al., 2002) and the 'Critique of the International Consensus Statement on ADHD' (Timimi et al., 2004). Despite this, diagnosis and treatment with stimulant medication continued apace: in Scotland, between 2002 and 2011, the increase in prescriptions was 105% (GROS, 2013) with a further increase of 43% between 2012–2016 (Scottish ADHD Coalition, 2018).

By avoiding this battle of truth, we are also avoiding engaging in what we consider a pointless exercise. Despite many critics highlighting that knowledge of ADHD does not conform to the rules and procedures usually required for mainstream scientific credibility, it continues to be dominant; so much so that it has become increasingly difficult to conceptualise young people, considered problematic within certain frames of reference, outside of this explanation. In short, the objects, concepts and procedural requirements of 'objective science' that legitimise ADHD do not make any difference when deployed critically. The master's tools cannot, indeed, be used to dismantle the master's house (Lorde, 2018): the sheer scale and force of the scientific truthing of claims about ADHD by biomedical discourse appear to silence debate within this discursive domain.

For us, this highlights a requirement for a different approach; one that offers a critique of, but outside the frame of reference within which ADHD's legitimacy is usually established. This was our aim with our investigation. We wanted to understand how it was possible to *say* and *do* ADHD, for it to be *enacted*. Our aim was to simultaneously acknowledge the material existence of ADHD but also to reject the reality-version created by the knowledge and discourse that construct it as a 'neurodevelopmental disorder'. For us, there was as little value in engaging in a critique that argues that it is 'not real' as there was in engaging in a battle over truth within its own frame of reference. It is very much 'real', but only in so much as it is constituted through an apparatus that establishes ADHD as a psychiatric disorder.

By considering ADHD in the way described above, we are following Rose (1999). It is commonplace for objects of scientific knowledges to be described as 'socially constructed', especially in 'psy-sciences'. However, as Rose stated, this is not particularly enlightening or useful—"objects of thought are constructed in thought: what else could they be?" (Rose, 1999; p. x). A more useful approach would engage with the ways in which objects are socially constructed; i.e. where they emerge; the authorities that are able to pronounce upon them; the concepts and explanatory regimes that construct them; the problems they solve, etc. The aim here is to understand how they came to be in place—why these objects, knowledges and practices, and not others, structure our reality—and to reveal the origins and functions that have contributed to their emergence (Rose, 1984; cited in Kendall & Wickham, 1999).

But where do you begin such an investigation? ADHD appears 'monolithic'—or, that was certainly our experience—possibly because of its rhetorical scientism, continued exponential rise in application, and the 'global' reach of the knowledge that provides its visibility. These elements combine to provide ADHD with a 'realness' with which it was difficult to argue, making it hard to know where to begin with such an impenetrably and impregnably 'realed' phenomenon?

Extremities of Power and the Knowledge-Work of ADHD

For us, this meant engaging at the micro level: the 'extremities of power'—the ultimate destinations, where it "invests itself in institutions, becomes embodied in techniques, and equips itself with instruments" (Foucault, 1980; p. 96). Within our frame of reference, the 'extremities of power' are found at the level of the everyday, where the application of 'actual' ADHD practice meets with the young person. Rather than continue the debates that characterise the sterile battle of truth of ADHD, our approach attempted to understand how it is possible to say, do and be ADHD, for it to be enacted.

We adopted as our theoretical guide the Foucauldian analytical concept of the apparatus (Foucault, 1980), "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral, and philanthropic propositions [...], the apparatus itself is the system of relations that can be established between these elements" (1980, p. 194). Our intention was to understand what made it possible for the social practice that constructed young people as having ADHD to have emerged within the multiplicity of connecting elements of the apparatus.

Through highlighting the interconnectedness of a multiplicity of events, we highlighted the 'practices' the gave rise to them, the "places where what is said and done, rules imposed and reasons given, the planned and taken for granted meet and interconnect" (Foucault, 1991, p. 75). We thus refer to the specifics of 'what was said', 'what was done', 'who was able to say and do those things' and 'what was the wider background in which this occurred'. More specifically, 'practices' refers to the external relations of intelligibility upon which events rely for legitimacy, the connections that make it possible for specific subjects to say and do specific things and for those things to be *in the true* at that point in time. In this sense, the enactment of the procedures that constitute a specific social activity is contingent upon the wider practices from which they have emerged.

We also found the concept of 'problematisation' important because it captures a two-stage process, which seeks to question how and why certain 'things', such as behaviours, groups, phenomena, become 'problems' but also how these 'things' are shaped as objects of thought (Bacchi, 2012). In applying this concept, we were interested in how young people were discursively positioned as problems and the sites where this occurred (i.e. the school setting, the health setting, policies, guidelines and the social practices). Our aim was to understand the ways in which the young ADHD subject was constituted and the apparatus through which that constitution was 'realed'.

Deploying Critical Theory Through Ethnographic Methods

By employing ethnography as a "way of looking" (Wolcott, 1999; p. 41), as the doing of theory, our approach aimed to reconnect the various elements of the 'apparatus' of ADHD. Our aim was not to investigate ADHD as a 'real' condition, but to investigate the conditions fundamental to its constitution and usage within the social practice of diagnosis and treatment (Meyer & Lunnay, 2013). In this sense, the project can be considered theory-driven (Montgomery et al., 1989), with the account of the apparatus the a priori knowledge that guided the investigation. It was this a priori knowledge that acted as the means of discovering and questioning the 'conditions' (Meyer & Lunnay, 2013), the circumstances without which something cannot exist (Danermark et al., 1997); in this case, the conditions upon which the social practice of ADHD diagnosis and treatment was produced, sustained and modified locally.

More specifically, the project aspired to use a critical theory-driven ethnographic approach to investigate how 'governmental practices', understood expansively as the "heterogeneous strategic relations and practices that shape who we are and how we are to live" (Bacchi & Goodwin, 2016; p. 14), produced 'problems', thus legitimating the means for solving these problems, and how this process was implicated in the production of ADHD locally as a solution. We are following Bacchi and Goodwin (2016) in viewing 'problems' not as a things that exist in a material sense, but as things that have 'come to be', that have been constituted, through the interaction of multiple knowledges, practices and events. The approach, thus, investigated how certain problems 'came to be' problems in order to reveal their ontological politics (Mol, 2002), the various interconnected elements that constructed these 'things' as problems allowing them to become a target for intervention.

By investigating 'problems' and 'solutions', the project adopted an approach influenced by Bacchi and Goodwin (2016) and Rose (2000). For Bacchi and Goodwin, a key analytic task involves "teasing out the conceptual premises underpinning problem representations, tracing their genealogy, reflecting on the practices that sustain them and considering their effects" (p. 17). Similarly, Rose (2000), urges for an analytical focus on 'answers' to 'arguments', arguing that their very status as answers is entirely dependent upon the questioning of something that requires to be answered. The presence of answers and questions indicates problematising activity (Rose, 1992) which, through reconstruction, allows for the interrogation of the networks of connections that provide the answers with their intelligibility (Rose, 2000). Through locating a problem and how it is represented and solved, the aim is to work backwards, or outwards from the problem, and to critically examine the network of connections upon which they are based (Bacchi & Goodwin, 2016): the assumptions, familiar notions and unexamined ways of thinking (Foucault, 1994@@) upon which the problem and solution rest.

This backwards/outwards reading was a key task as this allowed for examination of the history of things assumed to be 'natural', the reasons behind their way of being, the material effects, and what they allowed to follow (Johnson, 1981; cited in Bacchi & Goodwin, 2016). A further key task made possible by a consideration of problems and solutions was the locating of unforeseen effects and their accommodation within the interconnected elements of the apparatus. The incorporation of these unintended effects creates continual displacement, creating changes in the problems represented and solutions proposed, allowing for a critical examination of 'what follows from the effects'; i.e. the historical shifts and changes of the interconnected network of elements that constitute the apparatus.

Mapping Our Analytical Journey

Our investigation was conducted within the National Health Service organisational unit ('trust') that provides healthcare for residents of three large regions in central Scotland. The analytical starting point was observation and audio recording of ADHD clinical appointments and simultaneous analysis of clinical case notes and Child & Adolescent Mental Health Service (CAMHS) management team meeting minutes. The starting point of observation of clinical appointments allowed us to witness first-hand and reflect upon the procedure of ADHD diagnosis and treatment. By considering the procedure that structured the appointment as a solution to problems that have come to be constructed by psychiatric knowledge, we located the subject positions legitimated to inscribe ADHD on the behaviour of young people, the means of judgement that aided the process, and the forms of knowledge and discourse deployed in the process.

As with the observation of the clinical appointments, the case notes provided access to the subject positions able to inscribe ADHD on the behaviour of young people, the means of judgement that aided the process, the forms of knowledge and discourse deployed in the process but also to the wider network of professionals and institutions involved in the problematisation of young people and the various ways in which the problem was constructed. The longest time period covered by the case notes was 12 years and the shortest 8 months, with case notes reflecting the clinical activity between 2002–2015. As such, the case notes are a historical record of the shifts of power/knowledge that allowed for the 'fixing' of ADHD, its embodied inscription, on the young person; they can be considered as a historical record of the extremities of 'power', highlighting the point where power was in direct contact with its object: the young person.

The 'minutes' (notes) of management and clinical team meetings provided summaries of team meetings that had taken place in the service between 2004 and 2015, revealing multiple 'problems' the service had to solve and the impact these had on the day-to-day functioning of the service. These minutes also allowed us to identify and analyse the specific governmental policies that impacted on the service, but also beyond the service relating to the network of connected institutions, allowing for consideration of the role of problems and solutions across the network in shaping thought and action within and across sites.

The policies identified through the document analysis were incorporated into our analytical mapping. We followed Foucault (1991) and Bacchi and Goodwin (2016) in viewing policies as 'practical texts' that offer rules, opinion and advice on how professionals are to 'behave' in relation to the specific problems constructed by the policies, thus acting as a framework of everyday conduct for those that it targets (Foucault, 1986). However, an additional benefit of identifying the specific policies that posed problems and required solutions within CAMHS and the wider institutional network, was that we were able to 'layer' the policies across the discussions that took place in various meetings and then again over individual case notes, allowing for analysis of the ways in which day-to-day thought and action within the service was shaped by and responded to these policies, but also analysis of the emergence of the policies and their constructed problems in relation to wider historical practices, events and relations (Bacchi & Goodwin, 2016).

Our document analysis also guided our movement in the field, directing us towards the sites and professionals involved in the wider network of ADHD within the locality. The conversations that took place with the professionals in the wider network were not set out in advance and did not follow a pre-set structure or order of questions. All of our conversations focussed on the same areas: to identify the subject positions able to speak and act in relation to ADHD, what was *said* and *done* by them and what constituted these spoken and enacted manifestations of discourse and knowledge; i.e. what guided their social activity in relation to ADHD diagnosis and treatment? The aim here, as with the case notes, was to investigate the 'extremities of power', the point where power was in direct contact with the young person within educational sites, and to understand what was being deployed in these interactions and the connections that allowed the forms of knowledges and materialisations of knowledge in action to be in the true and deployable in the present moment, i.e. the heterogeneous elements that conditioned their possibility.

The ‘layering’ of our textual material allowed us to engage synchronically and diachronically which, in a practical sense, was experienced as reading across our various textual materials, but also backwards in time within sets of textual material. Our aim was to locate, track and document the changing discursive background: who was speaking, what was said, what was done, what knowledges and technologies were put to work, how this changed across time and place, who appeared and disappeared, what appeared and disappeared. The aim was to develop a theoretical redescription (Danermark et al., 1997) of the rise of ADHD diagnosis and treatment locally, one that mapped and made visible the multiplicity of heterogeneous elements implicated in the construction of young people as particular types of problems and to provide a genealogical account of the emergence of a local practice of ADHD diagnosis and treatment from within this complex network.

Deindustrialisation, Disadvantage and the Apparatus of Education

Through our critical knowledge work, we challenged the realed-ness of official institutional knowledges that constructed the increasing visibility of ADHD within schools and health services as due to ‘improvements in training’, ‘improved screening tools’, ‘better treatment regimens’ or the ‘accumulation of knowledge of aetiology’ (Atladottir et al., 2015; Safer, 2018). Instead, we situated ADHD within a plurality of interconnected events which, through their interconnection, played a role in conditioning the possibility for the emergence of the local clinical practice of ADHD. We located several ‘wider’ and ‘local’ elements as part of our analysis; however, the elements of deindustrialisation, disadvantage and the role of apparatus of education and solving these ‘problems’ were particularly important and worth elaboration in this chapter.

Our rationale for elaborating the role of these elements was because our analysis revealed the decline of industry in the region and its connection to the enactment of ‘deindustrialisation’ as connected to the current levels of poverty and disadvantage in the region. These elements were prominent throughout the discussions we had with educational professionals. Its visibility took the form of accounts of its impact locally and 'on' the behaviour of children. They also continued to play an important role the problematisation of young people as 'having' ADHD; however, the visibility of the wider historical political and economic events had long since disappeared in the changing discursive background of health and education.

Revealing this aspect of the changing discursive background is particularly important as it has performed a fundamental role in shaping the understanding we have of 'young people', what we expect from them, what we do to achieve this, and what we do when this is not achieved. It is important in other ways too, in that a number of artefacts from this period of social and political upheaval, particularly youth unemployment and reforms to education and health services, played and continue to play, an important role in conditioning our present, but they have disappeared from our accounts of the present, allowing for uncomplicated acceptance of the here and now. We focus on these elements as a means of foregrounding them and allowing examination of their role in the local approach to ADHD.

As mentioned, the first author had previously worked in the region for several years and had only known inequality and disadvantage, with this unquestioning acceptance disrupted by a conversation with an educational professional. The conversation took place in the first meeting with the educational professional. As a starting point in the discussion, the education professional provided a brief social history of the region, highlighting that the building in which the conversating was taking place was once part of a thriving milling community that provided employment to school leavers from the area. According to the educational professional, milling was not the only thriving local industrial area, with agriculture, mining, shipbuilding, glassmaking and malt whisky distilling all present in the area until relatively recently. Historically, the prosperity of the local region was recognised as, in proportion to its size, being one of the wealthiest counties in Scotland (Findlay, 2005). In the present, however, the region has neighbourhoods whose health, income and employment standards sit with the poorest in Scotland (Office of National Statistics, 2011; Scottish Public Health Observatory, 2008).

The ease with which school pupils could leave school and take up employment is borne out by economic data from the time; at the end of the 1960s, the region in which the investigation was conducted had an unemployment rate of approximately 1.5% of the local population throughout the 1950s and 1960s (Stewart, 1991). However, by the mid-to-late 1980s, unemployment had increased to 18.4% (Fraser & Sinfield, 1988), with 37% of jobs in the manufacturing industry lost between 1971–1981 (ibid.). The labour market was particularly problematic for young people, with over a third of males aged 18 to 24 experiencing unemployment within the previous 12 months, double the figure for older males; by 1985, 16% of males and 24% of females who were out of work were under the age of twenty (ibid.). The impact of the changing labour market on youth employment is most clearly documented by considering the destinations of school leavers: around 75% of pupils leaving school in 1978 had gained employment by the following year, with the proportion in Youth Training Schemes (YTS) less than 8% (ibid.). However, by 1985, the percentage of school leavers in employment by the following year had dropped below 30%, with the proportion in in YTS rising to nearly 40% (ibid.).

At the same time as the rising numbers of unemployed young people, removal of welfare entitlements for young people under the age of 18, and restriction of entitlements for young people under the age of 25, resulted in large numbers of young people being marginalised from society. In the midst of the deindustrialisation of the local area, this resulted in the creation of subgroup of young people not in receipt of welfare assistance and not appearing in official unemployment statistics (Levitas, 1996; MacDonald, 1996). As these young people were excluded from official statistics, it is impossible to gauge the numbers of young people materially marginalised by this process; however, if one considers the emergence of the category of NEET as the construction of this particular group of young people as a social problem, as several critics have argued (Bynner & Parsons, 2002; Crisp & Powell, 2017; Furlong, 2006; Melrose, 2012), then an indication of the ‘scale of the problem of NEET’ suggests that, by the early 1990s, approximately 9% (161,000) of 16–17-year-olds per year were being socially excluded from society (Social Exclusion Unit, 1999).

These effects—poverty and disadvantage—play a prominent role in the rational-technical politics that emerge in the aftermath of deindustrialisation, particular the political focus on 'social exclusion' as a problem for schools to play a role in solving and the emergence of 'special education needs' as a category of disability. Both of these elements emerged as an important focus in our investigation as their intersecting genealogical lines created the conditions for an invention of a school-based grid of procedures, knowledges and technologies for 'supporting' young people 'to' learn. Our analysis revealed this grid as emerging as a solution to a proliferation of 'learning problems' conditioned by the emergence of social inclusion as a strategic aim of the apparatus of education and a requirement to meet the learning needs of every pupil positioned as having special education needs by this newly created category of disability. It was the appearance of this grid, conditioned by these intersecting elements, that allowed for an increase in use of psychiatric knowledge within the school.

Social Exclusion and Special Education Needs

Originating in French political discourse in the 1960s and 1970s (Peters & Besley, 2014; Silver, 2010), social exclusion had as its target citizens separated from mainstream society by disability, illness and poverty, with social and economic rather than individual factors constructed as the cause of exclusion (Peters & Besley, 2014). The focus of policy aimed at solving social exclusion that emerged in political discourse in the UK in the aftermath of deindustrialisation (Giddens, 1998, 2000; Peters & Besley, 2014) similarly had citizens as its target, positioning social exclusion as because of 'prospects and networks and life chances' and as 'what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime, poor health and family breakdown' (Blair, 1997; Social Exclusion Unit, 2004).

A difference in the UK construction of social exclusion, however, was that, despite apparent connections to wider demographic and economic factors, solutions targeted particular social groups and *their* problems, rather than on the political and economic background. This is clearly emphasised in the solutions to social exclusion that emerged from the policy focus: it would be tackled through provision of equal opportunity for all and elimination of barriers to these opportunities, which would be achieved through the provision of the individual skills and attributes required to reconnect the *individual* with the labour market (Hills & Stewart, 2005; Levitas, 1998). According to these emerging policies, the 'best defence' against social exclusion 'was to have a job' and the best way to get a job was to 'have a good education' (Social Exclusion Unit, 1999).

In the UK discourse of social exclusion, individuals were individualistically positioned as socially excluded because they lacked education, training and/or skills required for employment. There was also a silencing of the wider political and economic background implicated in social exclusion: the individual barriers that result in social exclusion were constructed as *because of social exclusion*, with education, training and employment constructed as the pathway out of disadvantage and towards social inclusion. This particular shift can be seen as decontextualising and depoliticising the material effects of political and economic approach of 1980s and 1990s allowing for the targeting of the individual as the solution. In this new approach, active individual involvement was encouraged: if citizens are able and willing to engage with state-provided opportunities to self-improve, the result will be social *inclusion* and a pathway out of disadvantage. However, an outcome of this shifting discourse was that the reasons individuals who remained marginalised, was not because of political and economic structures, but because they, as individuals, had not taken advantage of the opportunities made available to them to 'take part in work, in learning, and in society more generally' (Scottish Office Education and Industry Department, 1999).

At the same time of the emergence of social exclusion as a focus of UK political discourse, another important transformation was occurring within the apparatus of education: the replacement of 'handicapped' by 'additional support needs' as the dominant explanation for school-based problems in learning. This is considered an important shift in the apparatus of education as it intersects with social inclusion as a strategic aim of education, allowing for anything that was positioned as acting as a 'barrier to learning' to be constructed as requiring intervention and management.

The gradual appearance of this construction of disability at this historical juncture can be tracked across several governmental policies. The starting point in our investigation was the *Special Education Needs: Report of the Committee of Enquiry into the Education of Handicapped Children and Young People* (Warnock, 1978). The Warnock report is an important element in this changing background as its recommendations were codified as the Education Scotland Act (1981), which in turn conditioned the possibility for the current procedures for managing 'problems' in Scottish schools to be codified as additional support needs. Prior to enactment of the Warnock report, biological and medical discourse provided the procedures for the management of school-based 'problems', visible in the various subcategories that constituted the *Education (Scotland) Act (1945)* classification of 'handicapped'. Each of the 11 subcategories—blind, partially sighted, deaf, partially deaf, delicate, diabetic, educationally subnormal, epileptic, maladjusted, physically handicapped and speech defects—constructed problems as an innate disability, biological in origin and as requiring certification by a 'medical officer' in order to receive either specialist education 'treatment' or as incapable of receiving education.

A shift from 'handicapped' to 'special education needs' emerges from the problematisation of the provision of specialist education according to disability, legitimated by deployment of 'evidence' from newly emergent child and adolescent epidemiological studies (i.e. the Isle of Wight studies: Rutter et al., 1976). The 'problems' constructed by this new form of knowledge were that young people in mainstream school were performing badly, that the relationship between handicap, disability and education was complex, and that other concepts, such as 'social disability', 'incapacity' and 'disadvantage', were equally as problematic disabilities for learning. In this expanded reality of disability, the school environment was positioned as key to whether disabilities would contribute to poor educational outcomes, rather than requiring specialist provision for specific disabilities: if school adjusted to the disability, the young person would not be educationally disadvantaged no matter the nature of their 'disability' (Warnock, 1978, pp. 36–49).

This new conceptual framework of disability expanded the concept from its confinement by biological discourse to one which included social, emotional and behavioural dimensions. Special educational needs were now considered to relate to "all the factors which have a bearing on [his] educational progress" (Warnock, 1978, p. 37), shifting disability from a system of discrete and permanent labels to a dynamic system of educational surveillance and 'treatment', one which was fluid and adjustable to school-based difficulties. This 'thinning of the mesh and widening of the net' (Cohen, 1979) expanded the parameters of who could be targeted by intervention; the net was now wide enough to include any young person considered at risk of poor educational outcomes, with anything impacting on learning now considered legitimate for intervention.

This new understanding of disability legitimated new procedures for the management of what was constructed as special needs. Previously, the categories of 'handicapped' were fixed upon the young person by a medical authority, remaining fixed for the entirety of their time in the educational apparatus and beyond. Specialist education was prescribed as 'treatment', which took the form of segregation from mainstream schools in separate educational facilities specific to the form of disability inscribed on the young person. With the emergence of the new fluid concept of special needs, the mainstream school was reconstituted as the means of management of disability. This new approach would require the mainstream school to adjust educational provision to meet the specific learning problems of young people and would extend to locational, social, functional and academic domains of the school experience (Warnock, 1978).

This new reality of educational disability was codified by the *Education* Act (1981) in England and Wales and the *Education (Scotland)* Act (1981). Both Acts constructed special education needs in line with the Warnock Report, however, the English legislation placed a requirement for the provision to be made in ordinary school (Education Act, 1981, p. 2), whereas the Sottish legislation restricted the requirement to identification of special educational needs, provision of suitable education for meeting these needs and continued surveillance of needs and provision

(Education [Scotland[Act, 1981, pp. 12–15). As such, within the Scottish educational apparatus, school exclusion remained a technology for managing school-based problems; however, the Standards in Scotland's Schools etc. Act (2000) problematised school exclusion as a contributing to the high levels of social exclusion and disadvantage visible in Scottish society. The solution constructed was a 'requirement for mainstreaming education' for *every* pupil, placing responsibility for education of young people positioned as having special educational needs on mainstream schools.

The connection of educational outcomes by the Standards in Scotland's Schools etc. Act (2000) visibly reproduces social exclusion as an individual problem, connects this to poor educational practice, and legitimates the apparatus of education in solving the problem. The act constructed learning problems as underpinned by differing 'personal or social circumstances' which act as obstacles to education and future wellbeing. Removing these obstacles was positioned as a 'duty' of mainstream schools as this would provide 'equity' in education provision and, thus, equity of opportunity for *everyone* regardless of circumstances. Mainstream schools were now required to educate everyone regardless of difference and to encourage them to achieving the highest possibilities available to them based on *individual* abilities and strengths. This new requirement of learning disability—to 'achieve'—was not a requirement of the previous reality of 'handicapped', however, with those constructed as 'handicapped' excluded from mainstream school and the requirement achieve in education. The rationale offered was that 'educated' and 'achieving' young people would provide a "significant contribution to the economic growth of the country, improving wellbeing, family life, lifestyles, communities and the nation as a whole" (Scottish Government, 2017, pp. 16–17). In this new reality, *every* child required an education and to be 'achieving' in order to contribute to the future wellbeing of Scottish society—the young person's wellbeing, specifically, their educational wellbeing, emerges as the link between the young person and their future adult worker citizen self and the economic wellbeing of the nation state.

Creating the Space for Psychiatry: Mainstreaming 'Complex Needs'

The category of 'special education needs' was eventually reconstituted as its current iteration—'additional support needs (ASN)'—by the *Education (Additional Support for Learning) (Scotland) Act (2004)*. Similar to special education needs, ASN aimed to ensure that those with problems of learning would be "given the best possible chance of being a full part of society" (Scottish Parliament Education Committee, 2003; col. 564). This new category, as with the previous, would also allow intervention if, 'for whatever reason', the young person was, 'or was likely to be', unable without support, to benefit from education (*Education (Additional Support for Learning) (Scotland) Act*, 2004, p. 1).

Where additional support needs differed, however, was the inclusion of 'complex needs' within its reach. As outlined, 'special education needs' was legitimated on claims of the existence of problems of learning that were too subtle to be 'picked up' by the previous procedures legitimated by the category of 'handicapped'. The reality created was that there were less noticeable forms of disability that were not being 'treated', that mainstream school was not meeting the needs of this hidden population and was, thus, contributing to poor educational outcomes and social exclusion. The new category of additional support needs, however, now required mainstream schools to meet needs arising from "one or more *complex* factors" or "multiple factors" (ibid., p. 2), with 'factors' vaguely defined as anything "likely to have a significant adverse effect on the school education" (ibid., p. 2).

The inclusion of complexity as a requirement of mainstream school legitimated a shift in the means by which problems of learning would be reduced. Special education needs supported learning through "adjustments in current mainstream provision", with the adjustments—and the problems of learning—considered 'time limited'. ASN, however, expanded what was required of mainstream schools, from provision of time limited adjustments for low-level problems to "significant additional support", which would be required to "continue for more than a year" (ibid., p. 2) for more complex problems. To meet this expanded requirement, mainstream schools would now require involvement of "one or more appropriate agencies", with 'appropriate agencies' defined as local authority and health board departments. Inclusion of the wider network in meeting problems of learning would be authorised by the school—involvement would be defined as appropriate if it could "help in the exercise of any of the education authority's functions", with individual schools required to specify what was required to meet additional support needs (ibid., p.18).

The Everyday Practice of Inclusion: Division, Psychiatrisation and Normalisation

The management of additional support needs at the level of everyday school practice was enacted through a school-based grid of procedures, knowledges and technologies for 'supporting' young people 'to' learn. Our analysis revealed this grid as emerging as a solution to a proliferation of 'learning problems' conditioned by the emergence of social inclusion as a strategic aim of the apparatus of education and a requirement to meet the learning needs of every pupil positioned as having special education needs by this newly created category of disability.

The existence and purpose of the grid were conditioned by the new requirement for mainstream schools to support *every* child and young person to learn irrespective of disability codified by the *Education (Additional Support for Learning) (Scotland) Act (2004)*. The requirement for a 'staged/tiered' approach to management of school-based problems was outlined in official policy, but the specifics of the approach were to be developed by each region (Scottish Government, 2003, p. 91). Both 'official' and professional accounts of the grid enacted locally construct the image of a holistic, supportive and inclusive system that adapts the school environment to meet specific needs, with adaptations based on careful assessment of risk to learning.

The official account of the grid positioned problems of learning not as fixed conditions, but fluid issues that were 'fixable' through application of specific adjustments. The forms of knowledge within the official account, and within the talk of school-based professionals, allowed for structuring of problems as 'caused' by attachment issues, trauma and/or disadvantage, with history and context considered central for understanding the problem. Diagnosis and disorder were not required, support would be based on need, and additional provision would be provided to accommodate needs.

Despite the claims of inclusion of difference and adjustment of environment to meet this, we were able to observe discourses and practices that highlighted the young person as the target, rather than the environment. The practice, rather than being inclusive of need and adjusting to meet these, functioned through division of young people into levels of severity and application of 'interventions' as a means of shaping them to fit school, rather than the other way around. At the lower levels of the staged approach, problems were constructed by attachment or trauma with intervention at the level of the school, with support from educational psychology. However, as the 'problem' was moved up the staged system, it moved into a discursive space where it was reconstituted by psychiatric knowledge and discourse, allowing for targeting by psychiatric intervention.

The reconstituting by psychiatric knowledge appeared to be legitimated by the concept of 'underlying abnormality' being applied to 'problems' that were not resolved through school-based approaches. Persistent problems of learning appeared to cross over into the purview of psychiatry, become assigned to this knowledge for explanation and, thus, for alternative forms of intervention. The reality created appeared to be a reconstituted continuum of need divided into a normal and abnormal binary. On one side are less severe problems, manageable within the apparatus of education, and on the other side are complex and severe problems underpinned by abnormality and requiring specialist psychiatric consideration.

In her examination of the means by which young people were subject to governance through educational policy and practice, Watson (2010) highlights how 'mainstreaming difference' through the discourse of inclusion does not result in the reduction in the use of diagnostic labels; rather the use of the technology increases and its use changes. The critical point illuminated by Watson's analysis was visible across the various conversations with educational professionals conducted for this project: that psychiatric diagnosis become a resource for the production of forms of subjectivity, allowing governance of the subject through associated technologies and expertise. The continued role for psychiatric knowledge was visible in the process of division and normalisation that structured the actual practices of additional support needs at the micro level of their application: without the continued role of the knowledge, the problems considered severe would remain within the mainstream school and would require intervention to reduce the risk to future learning. This continued availability of psychiatric knowledge and associated technologies allows for division and reconstitution of problems as severe and complex and as requiring psychiatric expertise and input, allowing for schools to incorporate new forms of management alongside those within the apparatus of education.

Conclusion

In this chapter, we have reported an empirical examination of the interconnected nexus, apparatus, of discourses, power/knowledges, practices, and procedures and so on through which young people previously likely to be considered 'difficult' non-compliant pupils came to be constituted as psychopathological, psychiatrically diagnosable, psychopharmacologically treatable child-subjects in non-psychiatric community contexts. Our investigation was guided by Foucauldian and post-Foucauldian scholarship and contemporary transdisciplinary ethnographic research relating to subjectivity. In drawing on transdisciplinary ethnographic research, we engaged with subjectivity as both an empirical reality and analytic category (Biehl et al., 2007, p. 5). The position that guided our investigation is that subjects are 'epiphenomena' (Keller, 2007): "made up", constituted in and by technologies of knowledge and power (Hacking, 1990, p. 3). For us, subjectivity is multiple, mobile and externally constituted rather than a singular, fixed and internal 'natural essence'. As such, we engaged with subjectivity by turning our analytical lens on the external 'concrete constellations' in which it is continually shaped and reshaped (Biehl et al., 2007).

By positioning our investigation in the 'concrete constellations' that informed health and education practices, we aimed to understand what made it possible for young people to be made into the ADHD child-subject; to be 'made up' as a young person 'with' ADHD (Foucault, 1982; Hacking, 1999) and, thus, 'treatable' by psychiatric knowledge and medication. We sought to understand this in the present—i.e. against what was ADHD being deployed as a solution?—but also historically—i.e. what made it possible for ADHD to emerge as a deployable solution? Our aim was not to provide a 'sociological description' of forms of governance, but an account of the pluralisation of events that made this way of governing thinkable and actionable in the present (Dean, 2015). Our investigation aimed to make visible the conditions under which different ways of thinking about 'young people' were formed, the means of governance these ways of thinking legitimated, the effects these ways of thinking about and governing young people created, and the ways these effects have contributed to the shifting background upon which new ways of thinking and acting emerged (Dean, 2015).

Our approach allowed us to situate ADHD within a plurality of interconnected events, which included wider 'elements', such as the shifting requirements of the young citizen and the emergence of technologies for achieving them, changing discourses of social exclusion and wellbeing, widening parameters of the category of disability within educational discourse, and neoliberal reforms of health and education. More 'local' elements included the invention of technologies to 'support learning', widening health professional remits, and institutional responses to new requirements within the wider apparatuses of health and education. We did not view these as a singular ontological domain of practice, however, but as a multiplicity of elements, all with their own history, that provided the intelligible background upon which the local social practice of ADHD relied to be acceptable as a solution at the point in time that it was proposed.

Our investigation revealed ADHD as contingent upon two main interconnected apparatuses—health and education—and a multitude of events and problems within these two domains. Within health, 'problems', such as increasing referrals, a requirement to promote 'wellbeing', and a requirement for integrated working with education (and other institutions) created the conditions in which the local approach to ADHD would function as a solution. Within education, social exclusion and the increased parameters of what could be constituted as a learning problem created a ‘space’ within schools in which ‘support’ from external agencies could function. This ‘space’, in which ADHD knowledge was able to function, was conditioned not by the ‘needs’ of young people but by the need of education to solve ‘learning problems’ within a context of increased ‘demand’ created by the requirement of ‘inclusive education’ to meet the needs of every pupil.

Rather than embodying its stated aims of ‘equality for all’, inclusive education was revealed as a means and mode of governmentality of the young person. Education was revealed as a way of educating and shaping young people according to the requirements of a ‘globalised’ free market. The young person was positioned as the future adult worker and, as such, as requiring the necessary skills and abilities for that role. The school, supported by mental health and social services, was the means by which this was enacted, with the technologies of its enactment constructed as ‘inclusive’, as promoting ‘wellbeing’, and as reducing the likelihood of social exclusion and disadvantage through providing the skills to gain employment. Within these interconnected apparatuses, anything considered a ‘risk’ to future educational outcomes became a ‘problem of learning’ and, thus, targetable, first through education and then through mental health services for children and adolescents.

The ‘problems of learning’ constructed as ADHD were multiple, but every single one of them could be placed outside the young person within the structures in which they existed: poorly resourced schools, communities affected by poverty, lingering discourses that construct education as pointless, experience of abuse and trauma—these were all visible during the clinical appointments we observed. In each appointment, however, these were individualised as ‘symptoms’ of ADHD. The outcome, contrary to official knowledges and policy, was not reduced symptoms, improved educational outcomes and increased wellbeing, but the annulling of the voice of the young person through the continued fixing of their experiences as symptoms of ADHD. The continued use of medication and the responsibilisation of the young person to improve their problem were the priority, rather than considering and tackling the context in which they were constructed as a problem.

References

Atladottir, H. O., Gyllenberg, D., Langridge, A., Sandin, S., Hansen, S. N., Leonard, H., & Hultman, C. M. (2015). The increasing prevalence of reported diagnoses of childhood psychiatric disorders: A descriptive multinational comparison. *European Child Adolescent Psychiatry, 24*, 173–183.

Bacchi, C., & Goodwin, S. (2016). *Poststructural policy analysis: A guide to practice*. Macmillan.

Bacchi, C. (2012). Why study problematizations? Making politics visible. *Open Journal of Political Science, 2*(1), 1.

Barkley, R., et al. (2002). International consensus statement on ADHD. *Clinical Child and Family Psychology Review, 5*(2), 89–111.

Biehl, J. (2005). *Vita: Life in a zone of social abandonment*. University of Californian Press.

Biehl, J., Good, B., & Kleinman, A. (2007). *Subjectivity: Ethnographic investigations*. University of Californian Press.

Blair, T. (1997, December 8). *Bringing Britain together*. Speech at Stockwell Park School, South London. Available from http://www.britishpoliticalspeech.org/speech-archive.htm?speech=320. Last accessed 29th September 2020.

Bynner, J., & Parsons, S. (2002). Social exclusion and the transition from school to work: The case of young people not in education, employment, or training (NEET). *Journal of Vocational Behavior, 60*, 289–309.

Cohen, S. (1979). The punitive city: Notes on the dispersal of social control. *Contemporary Crises, 3*, 339–363.

Crisp, R., & Powell, R. (2017). Young people and UK labour market policy: A critique of 'employability' as a tool for understanding youth unemployment. *Urban Studies, 54*(8), 1784–1807.

Danermark, B., Ekström, M., Jakobsen, L., & Karlsson, J. C. (1997). Generalization, scientific inference and models for an explanatory social science. *Explaining Society: Critical Realism in the Social Sciences,* 73–114.

Deacon, R. (2000). Theory as practice: Foucault's concept of problematization. *Telos, 118*, 127–142.

Dean, M. (2015). Neoliberalism, governmentality, ethnography: A response to Michelle Brady. *Foucault Studies, 20*, 356–366.

Education (Additional Support for Learning) (Scotland) Act. http://www.legislation.gov.uk/asp/2004/4/pdfs/asp_20040004_en.pdf. Last accessed 29th September 2020.

Education (Scotland) Act. (1945). Education (Scotland) Act (1945). https://www.legislation.gov.uk/ukpga/Geo6/8-9/37/contents. Last accessed 29th September 2020].

Education Act. (1981). http://www.legislation.gov.uk/ukpga/1981/60/enacted. Last accessed 29th September 2020.

Education (Scotland) Act. (1981). https://www.legislation.gov.uk/ukpga/1981/58. Last accessed 29th September 2020.

Findlay, R. (2005). *Modern Scotland: 1914–2000*. Profile.

Foucault, M. (1980). Power/Knowledge. In C. Gordon (Ed.), *Michel Foucault: Power/ knowledge—Selected interviews and other writings 1972–1977*. Brighton: Harvester Press.

Foucault, M. (1982). Afterword: The subject and power. In H. L. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond Structuralism and Hermeneutics*. Harvester Press.

Foucault, M. (1985). *Discourse and truth: The problematization of parrhesia. Six lectures given by Michel Foucault at Berkley.* Transcribed by J. Pearson. E Northwestern University. Available from https://www.cscd.osaka-u.ac.jp/user/rosaldo/On_Parrehesia_by_Foucault_1983.pdf. Last accessed 29th September 2020.

Foucault, M. (1986). *The use of pleasure. The history of sexuality.* (Vol. 2, R. Hurley, Trans.). Viking Press.

Foucault, M. (1991). Politics and the study of discourse. In G. Burchell, C. Gordon, P. Miller (Eds.), *The Foucault effect: Studies in governmentality*. University of Chicago Press.

Foucault, M. (1994). *Michel Foucault: Power. The essential works of Foucault: 1954–1984*. Penguin Books.

Foucault, M. (2001). *Fearless speech*. Semiotext[e

Fraser, N., & Sinfield, A. (1987). *The Scottish labour force in recession*. Unit for the Study of Government in Scotland, University of Edinburgh. Available from http://www.scottishgovernmentyearbooks.ed.ac.uk/record/22989. Last accessed 29th September 2020.

Fryer, D., Marley, C., & Stambe, R. (2020). The reproduction of compliant labour power through (re)constitution of the child and adult subject: critical knowledge-work. *Awry: Journal of Critical Psychology*, 1(1), 35–49.

Furlong, A. (2006). Not a very NEET solution: Representing problematic labour market transitions among early school-leavers. *Work, Employment and Society, 20*, 553–569.

Giddens, A. (1998). *The third way: The renewal of social democracy*. Polity Press.

Giddens, A. (2000). *The third way and its critics*. Polity Press.

General Register Office for Scotland (GROS). (2013). *Population Estimates, Council and Health Board Areas: Estimated population by age and sex*. Available from http://www.gro-scotland.gov.uk/. Last accessed 29th September 2020.

Hacking, I. (1990). *The taming of chance*. Cambridge University Press.

Hacking, I. (1999). *The social construction of what?* Harvard University Press.

Hills, J., & Stewart, K. (Eds.). (2005). *A more equal society? New Labour, poverty, inequality and exclusion*. Policy Press.

Johnson, B. (1981). Translator's introduction. In J. Derrida (Ed.), *Dissemination*. University of Chicago Press.

Keller, E. F. (2007). Whole bodies, whole persons? Cultural studies, psychoanalysis and, biology. In J. Biehl, B. Good, & A. Kleinman (Eds.), *Subjectivity: Ethnographic investigations*. University of Californian Press.

Kendall, G., & Wickham, G. (1999). *Using Foucault's methods*. Sage.

Levitas, R. (1996). The concept of social exclusion and the new Durkheimian hegemony. *Critical Social Policy, 16*(46), 5–20.

Levitas, R. (1998). *The inclusive society? Social exclusion and New Labour*. Macmillan.

Lorde, A. (2018). *The master's tools will never dismantle the master's house*. Penguin Classics.

MacDonald, R. (1996). Welfare dependency, the enterprise culture and self-employed survival. *Work, Employment and Society, 10*(3), 431–447.

Melrose, M. (2012). Young people, welfare reform and social insecurity. *Youth & Policy, 108*, 1–19.

Meyer, S. B., & Lunnay, B. (2013). The application of abductive and retroductive inference for the design and analysis of theory-driven sociological research. *Sociological Research Online, 18*(1), 1–11.

Mol, A. (2002). *The body multiple: Ontology in medical practice*. Duke University Press.

Montgomery, C. A., Wernerfelt, B., & Balakrishnan, S. (1989). Strategy content and the research process: A critique and commentary. *Strategic Management Journal, 10*(2), 189–197.

Mort, F., & Peters, R. (2005). Foucault recalled: Interview with Michel Foucault (conducted in 1979). *New Formations, 10*, 9–22.

Office for National Statistics (ONS). (2011). *Labour Market Profile: NOMIS Official Labour Market Statistics*. Available from https://www.nomisweb.co.uk/. Last accessed 29th September 2020.

Peters, M. A., & Besley, T. A. (2014). Social exclusion/inclusion: Foucault's analytics of exclusion, the political ecology of social inclusion and the legitimation of inclusive education. *Open Review of Educational Research, 1*(1), 99–115.

Rose, N. (1992). Governing the enterprising self. In P. Heelas & P. Morris (Eds.), *The values of the enterprise culture: The moral debate* (pp. 141–164). Routledge.

Rose, N. (1984). *The formation of the psychology of the individual in England 1870–1939* (Unpublished PhD thesis). University of London.

Rose, N. (1999). *Governing the soul: The shaping of the private self* (2nd ed.). Routledge.

Rose, N. (2000). *Powers of freedom: Reframing political thought* (1st ed.). Cambridge University Press.

Rutter, M., Tizard, J., Yule, W., Graham, P., & Whitmore, K. (1976). Isle of Wight studies, 1964–1974. *Psychological Medicine, 6*(2), 313–332.

Safer, D. J. (2018). Is ADHD really increasing in youth? *Journal of Attention Disorders, 22*, 107–115.

Scottish ADHD Coalition (2018, April). *Attending to parents: Children's ADHD services in Scotland 2018. Results of a parent survey by the Scottish ADHD coalition*. Scottish ADHD Coalition. www.scottishadhdcoalition.org. Available from https://www.scottishadhdcoalition.org/wp-content/uploads/2018/04/SAC-parent-survey-17.4.2018.pdf. Last accessed 29th September 2020.

Scottish Government. (2003). *Moving forward! Additional support for learning*. Scottish Government Publication, Edinburgh. Available from https://www2.gov.scot/Resource/Doc/47021/0023972.pdf. Last accessed 29th September 2020.

Scottish Government. (2017). *Statutory guidance: Standards in Scotland's schools etc. act 2000*. Scottish Government Publication, Edinburgh. Available from http://www.gov.scot/Resource/0051/00515736.pdf. Last accessed 22nd April 2018.

Scottish Office Education and Industry Department (SOEID). (1999). *Social inclusion: Opening the door to a better Scotland*. Scottish Government. Available from https://web.archive.org/web/20060118224240/http://www.scotland.gov.uk:80/library/documents-w7/sima-04.htm. Last accessed 29th September 2020.

Scottish Parliament Education Committee. (2003). *Passage of Education (Additional Support for Learning) (Scotland) Bill 2003*. SPPB 66. Available from http://www.parliament.scot/S2_Bills/Education%20(Additional%20S upport%20for%20Learning)%20(Scotland)%20Bill/BBV66_Vol1.pdf. Last accessed 29th September 2020.

Scottish Public Health Observatory (ScotPHO). (2008). *Health and Well-being Profiles*. Available from http://www.scotpho.org.uk/. Last accessed 29th September 2020.

Silver, H. (2010). Understanding social inclusion and its meaning for Australia. *Australian Journal of Social Issues, 45*(2), 183–211.

Social Exclusion Unit. (1999). *Bridging the gap: New opportunities for 16–18 year olds not in education, employment or training*. Cm 4405, HMSO. Available from https://dera.ioe.ac.uk/15119/. Last accessed 29th September 2020.

Social Exclusion Unit. (2004). *The social exclusion unit*. SEU Publication, Office of the Deputy Prime Minister. Available from http://webarchive.nationalarchives.gov.uk/+/http:/www.cabinetoffice.gov.uk/media/cabinetoffice/social_exclusion_task_force/assets/publications_1997_to_2006/seu_leaflet.pdf. Last accessed 29th September 2020.

Standards in Scotland's Schools etc. Act (2000). https://www.legislation.gov.uk/asp/2000/6/contents. Last accessed 29th September 2020.

Stewart, M. (1991). *Keynes and after* (3rd Edition). Penguin.

Timimi, S., et al. (2004). A critique of the international consensus statement on ADHD. *Clinical Child and Family Psychology Review, 7*(1), 59–63.

Warnock, M. (1978). *Special educational needs: Report of the Committee of Inquiry on the education of handicapped children and young people*. HMSO. Available from http://www.educationengland.org.uk/documents/warnock/warnock1978.pdf. Last accessed 29th September 2020.

Watson, C. (2010). Educational policy in Scotland: inclusion and the control society. *Discourse: Studies in the Cultural Politics of Education, 31*(1), 93–104.

Wolcott, H. (1999). *Ethnography: A way of seeing*. AltaMira.

5

Confronting Neoliberalism's Campus Culture and the Era of "Poor Me"

Stephen L. Muzzatti and Dawn L. Rothe

Introduction

Neoliberalism's impact on our everyday lives, culture, politics and economy is pervasive and all encompassing. Whilst not ignoring the fact that neoliberalism is embedded within the capitalist state, our focus in this chapter is on it as a political ideology whose processes include the deepening "penetration of capitalism into political and social institutions as well as cultural consciousness itself" (Thompson, 2005, p. 23).

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Neoliberalism is the "elevation of capitalism, into an ethic, a set of political imperatives, and a cultural logic" (Thompson, 2005, p. 23). As we will endeavour to illustrate, higher education is not immune from neoliberalism's totalising affect and there is considerable evidence that university administrations piously subscribe to the tenets of neoliberalism. This is especially evident as governments in Canada, the United Kingdom and the United States are aggressively disinvesting in higher education; reducing or removing completely the state's responsibility to ensure that thoughtful, well-educated, robust, critical subjects cross the stage at convocation. Consequentially, universities are reinventing themselves by readily giving way to the demands of the marketplace (Giroux, 2002). Prior to addressing some of the pathologising effects on students, we provide a brief overview of universities' neoliberalism and the way that it has reshaped (and continues to reshape) the work lives of professors, staff and students.

The Spectacle of Neoliberalism's Market Driven University

The corporatisation of the university is an ongoing process that began nearly four decades ago, and today the near complete colonisation of once sacred scholarly spaces is evidenced daily to those of us in the ranks of the professoriate and university front-line staff. From the naming of buildings after the entrepreneur-cum-philanthropist, the corporate "benevolent" donor and the corporate branding of lecture series through advertising blitzes and real-life product placement campaigns on campus, late capitalism's tentacles are everywhere. University presidents are increasingly recruited from the corporate world and universities' governing boards are likewise frequently dominated by private sector representatives. For example, according to recent data from Canada's top fifteen research universities, almost half (49.1%) of their board members are attorneys, finance professionals, insurance executives and other players in the business world (CAUT, 2016). In addition to this strong presence of leaders from the world of private enterprise, we can also count the universities' own top academic administrators, and at least some representatives from the public sector who, regardless of their specific occupation, support and encourage a corporatised ethos. As such, it is little wonder that the voices of frontline university faculty and staff are faint, if not outright muted, in board of governors' decision-making.

One must consider the impact that this corporatisation of university governance has on the vision, values and priorities of the institutions. The evidence from two decades' worth of studies clearly demonstrates that universities are increasingly adopting business or corporate management models and the concomitant values and practices (Brownlee, 2015; Giroux, 2002; Gould, 2003; Hoffstadter, 2000; Slaughter & Rhoades, 2010; Erickson et al., 2020; Tuchman, 2011). Over a decade ago, education professors Sheila Slaughter and Gary Rhoades first wrote of what they term, "academic capitalism". Tracking changes in universities' policies and procedures over a number of years they describe the emergence of an odd blend of entrepreneurialism, top-down managerialism and audit culture coming to dominate the daily existence of faculty and staff. They enumerate several fundamental changes in the priorities and practices of universities in the postindustrial economy from those of their earlier incarnations. Included among them are the privatisation of the public sphere, shifting resources and support from traditional liberal studies disciplines to disciplines more closely linked to corporate markets, and the managerial control of professors and researchers (Slaughter & Rhoades, 2010).

Privatising the Public

Sometimes slickly marketed to faculty, staff and students as a "win–win" public–private partnership (P^3), whilst at other times unapologetically pushed through as a necessary evil in these allegedly tight fiscal times, universities are outsourcing services to corporations, most notably: facilities jobs, student housing, bookstores, printing and campus dining services to name a few. Blumenstyk (2019) refers to this as "embedded for profits". Driven by the neoliberal myth that the private sector is inherently more efficient at delivering good and services than the public sector, much of what is which was undertaken in the name of cost savings ironically ends up being more costly. In most cases, the financial hit is palpable as (formerly) secure, well-paying university jobs are lost and long-term costs increase. As Wekullo (2017) illustrates, because of the profit factors intrinsic within private enterprise, outsourcing becomes expensive for the universities, who then pass these increasing costs onto the next cohort of students in the form of higher tuition and ancillary fees, or at the expense of academic resources for faculty or new hires. Such utilitarian logic is exactly the kind of thinking behind the general pushes and pulls of neoliberalism in which the distinction between public and private institutions has become merged as one, the market-driven ideology supersedes the ethos and values of academia, and where corporate interests are part and parcel of a university (Giroux, 2014; Kotsko, 2018; Mayer, 2017). Yet, the outsourcing to private for-profit corporations is only the tip of the iceberg of the spectacle of neoliberalism's impact on higher education.

Rob from the Poor to Give to the Rich

Like the major private sector conglomerates that they are beginning to resemble, universities are engaging in cost–benefit analyses, not only of their day-to-day operations, such as groundskeeping, facilities maintenance and similar infrastructure work, but of their curricular offerings, research centres and academic programmes. Held up to the profit standard, universities calibrate supply to demand dictating what "forms of knowledge, pedagogy, and research will be rewarded and legitimated" (Giroux, 2002, p. 110). The flipside, of course, is that other forms of knowledge, pedagogy and research, forms that are not as easily co-opted to serve corporate interests, or perhaps openly challenge the hegemony of the global capitalist project, are punished and deligitimised as resources and funds are diverted away from them. Not surprisingly, the costs of what Slaughter and Rhoades (2010) refer to as "Robin Hood in reverse" are disproportionately borne by disciplines in the humanities and social sciences such as English, History, Philosophy and Sociology. Others such as Criminology and Economics, perhaps somewhat more susceptible to neoliberalism's subtle advances, whilst certainly not thriving under this framework, face slightly fewer cuts.

Well established by authorities in the United Kingdom, performance-based funding schemes for universities are now being taken up in earnest by their counterparts in Canada and the United States. This misguided and often poorly developed legislation means that programmes and curricula are being tailored to suit the needs of corporate interests and marketplace demands. Under the auspices of producing employable, job-ready graduates these thinly veiled funding cuts hyper-emphasise credentialism and risk turning universities away from the aspirational ideals of providing a well-rounded critical education into proto-industry training camps. Under this framework, instead of cultivating students' intellectual curiosity, communication and problem-solving skills so that they can actively and meaningfully engage in civic life, the university risks producing little more than malleable cogs in service of neoliberal capitalism—human capital stock.

Managerial Control of Expertise

The control, regulation, and some would suggest, the micromanagement of faculty is yet another example of the corporatisation of the university. It is a process which disenfranchises faculty and, contrary to the official corporatised rhetoric of "serving" students, is actually of little benefit to them and, as will be explored in considerable depth in subsequent sections of this chapter, is potentially quite detrimental. As Giroux (2014) poignantly illustrates, these management models are characterised by administrative bloat, students who are conceived as "customers" and "consumers", and faculty who are defined less through their scholarship than through their grantsmanship. In addition to the increased importance placed on faculty members to underwrite the university's operating costs by securing external funding is the pressure, admittedly more acute in some disciplines than others, to develop and then market their research skills and outputs as consumer goods to government agencies, NGOs and the private sector under the auspices of community engagement. As in the case of student retention, graduation rates and related "success" measures, universities employ sophisticated metrics to assess research productivity.

Adding to the disenfranchisement and precarity of the professoriate is the increased use of part-time and sessional instructors. In addition to being a highly exploitative work environment for part-time faculty members (a heavy work load, poor final remuneration, little if any institutional support or resources, and no job security), these positions serve as an accelerant for the move away from the tenure and tenure track hires. At the neoliberal university the work lives of all faculty and front-line staff become more burdensome and they are expected to do more with less. In addition to dealing with larger classes and having more office contact time and student advising tasks, professors are expected to make themselves available day and night as experts to the news media, consult with outside agencies and industry, promote themselves (and by extension their universities) on social media, and act as recruiters at university fairs and on open days.

A large study of academics in the United Kingdom paints a dire picture for university faculty (and by extension, our students and the wider society) under neoliberalism. The report, based on a survey of almost six thousand professors, was organised under major themes such as: "The dominance and brutality of metrics", "Excessive workload", "Perpetual change", "Vanity projects", "The silenced academic" and "Work and mental health" (Erickson et al., 2020).

It is disturbingly evident that the tightly controlled, yet highly unstable, conditions of the neoliberal university are exemplified by an erosion of the noble ideals of an education including critical thought and self-responsibility, the winnowing away of academic freedom and tenure, a bloated and powerful administration that barely makes an effort to maintain the façade of shared governance, and evermore crass forms of corporate brandalism. In the subsequent sections we will explore some of the consequences of this on the expectations and daily experiences of our students.

Liquid Dreams and Uncertain Futures

Apart from a few very high-profile exceptions, a couple of which we address below, an analysis of the sociocultural subjectivity that accompanies emersion in neoliberalism is noticeably absent from much of the work on the political economy of late capitalism. Whilst in no way diminishing the importance of understanding the operation of global economic forces and the role they played in, for example, the subservience of the state to transnational corporations, the erosion of the middle classes and the disappearance of work in the former industrialised West, in this section we hope to briefly address the sensibilities that are cultivated in what Bourdieu (1977) terms the habitus, as they too are essential in grasping the hopes, dreams and nightmares that our students bring with them to university. To be certain, young people arriving on a university campus for the first time today are no more empty vessels than they are fully formed social beings, and as such we herein seek to illuminate some of the results of their socialisation prior to, and external from, their exposure to the neoliberal university. Though it is arguably intellectually convenient, we have restricted ourselves to introducing the work of a select few critical criminologists and sociologists from the previous generation both because they have contributed greatly to this body of knowledge, but as well because an attempt to produce anything approaching a comprehensive overview would prove to be too lengthy, and well beyond the purview of this chapter.

During the final decades of the twentieth century the complete globalisation of capitalism brought with it doubt and uncertainty in the rapidly deindustrialised West, as instability—economic, political and social—ironically became one of the few remaining constants in life (Muzzatti & Smith, 2018). Examining the impact of these economic and cultural shifts on the everyday/night worlds of ordinary people, sociologist Zygmunt Bauman (2000) coined the term "liquid modernity" to describe the unsettled character of life in the new millennium. According to him, because life shifts so quickly, order and stability are difficult to achieve and virtually impossible to sustain. Likewise, a few years later criminologist Jock Young (2007) wrote of the "vertigo of late modernity"; a malaise of contemporary existence characterised by feelings of uncertainty and insecurity about daily life and what the future holds.

What many political economists missed, but the aforementioned authors and select others (see, for example, the work of Bonnie Berry, Claudio Colaguori, Steve Hall, Simon Winlow and Slavoj Žižek) strive to highlight, is the fact that neoliberalism has not only undermined the economy but is also disorienting and unhinging people. The incongruity which exists between the measurable empirical reality of most people's lives and neoliberalism's carefully scripted cultural realities is tactile.

The decline in living wage jobs, the precariousness of work and growing economic inequality over the past thirty years have reversed many of the economic and social gains made by ordinary working people during the twentieth century. Yet neoliberalism's mass sensibility was forged in a fantasy world of venture capitalism, super wealth and unlimited personal and natural resources. Given the disjuncture between what they know their life to be, and what they are told it should be, the anxieties and ensuing pathologies of hyper-individuation are legion. Perhaps best summed up as narcissism, it includes a swollen sense of self-importance, entitlement and overconfidence, yet also includes vulnerability, insecurity and fragility (see Lasch, 1979; Furedi, 2004, 2017). It is important to note that this phenomenon is not restricted to young people, but that it is evident across the population as the growing ubiquity of the troubled persons industries is testimony. However, it may be more pronounced among the young given one cannot imagine a society they have never known. In other words, being born into and socialised into the habitus of neoliberalism's totalising effect leaves no expectation or revolt against it as that is all that is known. One can think of Plato's allegory of the Cave in this sense. Too, as we explore in the subsequent section, the neoliberal university is conducive and complicit in replicating these attitudes and behaviours.

False Advertising and Dissatisfied Customers

For much of the last century, a university education was understood by individuals as a way by which they could better themselves. In addition to the somewhat intangible benefits of erudition came the measurable vocational and economic benefits of an interesting, well-paying job; the key to a comfortable middle-class existence. The promise of a better life through education both drew upon and fuelled an instrumentalist orientation among parents and students, culminating with swelling university enrolments in the final decades of the twentieth century. Today, a university degree is no longer conceived of as an option, particularly so in the Global North—a chance, perhaps one among several, by which a young person could become economically prosperous—but instead is seen as an absolute necessity for basic economic survival. The irony is brutal: as tuition fees are skyrocketing, more students than ever before are enrolling in university at the same time that employment prospects for graduates are plummeting (CBC, 2013; Coates & Morrison, 2013). Universities know this, yet continue to recruit undergraduates with the same old tired trope of a university degree as a guarantee of employment.

Corporatised education has brought the student debt levels to a crisis, with students burdened by decades of debt (American Federation of Teachers, 2020; Lake, 2019). A problem in Canada, the United Kingdom and elsewhere in Europe, it is most severe in the United States, where it is the second highest consumer liability category (behind only home mortgages) with roughly 45 million people owing $1.6 trillion USD in student loans as of summer 2019 (Fields, 2019; Friedman, 2019).

As Kotsko suggests, student loans "force students to think of their educational choices in financial terms and of themselves as customers" (2018: 123). This indebtedness leads to students performing a market analysis on the costs versus the benefits of their degree. It also fuels students' consumer angst and spurs the creation of more opportunities for the university to infantilise and pathologise them, as financial aid officers refer them to mandatory counselling services to help them deal with the financial stress they incur as a result of their enrolment at university. Of course, the counselling deals with students' subjective assessments of their circumstances, not the objective reality of the financial situation, and is designed to make them feel better about taking on debt. Most universities offer this counselling "free of charge", though students have actually already paid for it, among the exorbitant ancillary fees that were bundled with their tuition. As in Jutel's (2011: 99) analysis of "disease mongering", it is abundantly clear that a number of employees and offices at the neoliberal university stand to benefit directly from the labelling of students as in need of advising and counselling to deal with financial stress. Widening the boundaries of students' manageable problems and treatable woes expands opportunities for those at the university who offer financial advice and psychological counselling whilst the institution itself continues with its lucrative billing structure.

The view of "student as customer" has altered student expectations and subsequently impacted faculty roles. Consider the ongoing drive for assessments and the consequences thereof raised earlier in this chapter. Included among them are students' assessments of professors that are often euphemistically referred to as "Course Surveys" or "Course Evaluations". Whilst not without some merit (and there is considerable variation among universities, contingent upon the instrument's design and use), overall, these instruments fail to measure that which they proport to measure (i.e. the professor's teaching effectiveness, disciplinary knowledge and competency, etc.). Sadly, in addition to revealing a great deal about students' gender biases, ageism, inter alia, what these surveys generally measure are: (1) the student's *opinions* about a professor's teaching capability and knowledge, (2) the student's *satisfaction* with course content and materials assigned and, perhaps most tellingly, (3) the student's *satisfaction* with her/his own predicted overall mark in the course—none of which are accurate measures of professors' teaching competence or expertise (see Hornstein, 2016). The problems associated with the use of these assessment tools by university administrators in retention, tenure and promotion decisions notwithstanding, employing these surveys reinforces the notion of the student as consumer—paying for a service—and then filling out a customer satisfaction survey. The fact that many universities feel they must incentivise students to complete these surveys online in a timely manner by offering prizes ranging from course extra credit and book store credits to cinema passes and gift certificates for nearby restaurants does little to dispel this mindset and serves as yet another form of legitimating neoliberalism's mantra of consumerism and commodification.

The neoliberal campus is disproportionately inhabited by students who think that they are literally accessing a commercial service at university. When combined with the prevalent service sector mantra that "the customer is always right", it should be no surprise that students are often upset and become emotional when told otherwise by a professor (in the form of a poor mark on a test, the denial of a request for a deadline extension or the refusal to provide a recommendation letter). The poor mark, denial or refusal is rarely taken as deserved, reasonable or warranted by the student-customer, but is instead seen as a result of the professor-shop clerk's incompetence, capriciousness or malice. In these circumstances, it's likely that the demand, "Let me speak to the manager!" will follow (Searcy, 2017). Herein the student is not an autonomous individual capable of accepting consequences and learning from her/his mistakes, but a vulnerable, stressed out consumer in need of looking after to ensure their brand loyalty-retention.

Irate Customers at Neoliberal U's Customer Service Desk

As Furedi (2004) notes in his examination of the rise of therapy culture, the beginning of the twenty-first century saw a marked increase in the presence of terms such as "stress", "trauma" and "syndrome" in the popular press and everyday parlance. This, he contends, is predicated on a sense of emotional vulnerability which is then normalised and impacts not only how we understand ourselves, but the people and institutions with whom we interact. The misapplication of these dramatic psychiatric/psychological diagnoses to instances ranging from simple cases of incivility to relatively minor political differences impact the way that people understand and respond to their own discomfort (Berry, 2010). Discomfort is easily transmogrified into trauma where a sense of proportion is sorely lacking—and traumatised people need to be cared for. Equating the impact of commonplace daily stressors, unpleasant exchanges or differences in opinion to those resulting from exposure to life threatening or terrifying events through the liberal application of diagnoses such as Post-Traumatic Stress Disorder (PTSD) by unqualified individuals (ex. Career Counsellors, Teaching and Learning Resource Officers, Equity Awareness and Outreach Consultants, etc.) callously transforms the need for a university to provide an intellectually and politically stimulating environment into the need for it to provide an emotionally comfortable environment.

Many students at the neoliberal university display a volatile blend of narcissistic self-importance and fragility because they have been immersed in institutions that underwrite their sense of subjectivity. This infantilisation predates their enrolment, but is certainly reinforced once they arrive at the neoliberal university, in fact, almost immediately so. For example, the scripts presented to students during orientation activities, both those activities organised by the university itself through its various offices such as Student Services, Student Wellbeing, Harassment Prevention Services, and by student societies and organisations (i.e. student unions and clubs, both academic and social, which themselves require the approval of the university) disproportionately focus on the importance of students feeling safe and comfortable. At some universities, student resources are mandated to be included in every course syllabus, listing university resources from learning communities, tutoring and academic support centres, student success centres, career development, counselling centres and student intervention teams.

In the United States, the Healthy Minds Network for Research on Adolescent and Young Adult Mental Health (HMN) conducted the National Healthy Minds Study. Based on self-reports, this survey of students' mental health found that more than half (54%) of students claimed to be experiencing symptoms of mental health problems (anxiety disorder, depression, etc.). In addition, universities across the United States have "partnered" with Kognito, a for-profit.

company that provides online simulations in the areas of mental health and substance use as well as those on chronic disease, family relations and what it terms "medication adherence" and "patient-provider communication" (Kognito, 2020). Some universities have now instituted mandatory training for faculty and staff members to support students and their mental health issues. The 45-min training provides scenarios wherein participants choose various simulated dialogues in three different scenarios, encouraging "empathy" and student support. The universities subsequently claim that their faculty and staff are competent in leading real-life conversations to improve students' emotional health.

Whilst in no way alleviating the university of its responsibility of providing an environment free of danger or the demonstrable threat thereof, we take issue with the way by which self-proclaimed experts and specialists in said university offices appropriate, indeed, perhaps more correctly, bastardise the language and concepts developed by criminologists, psychologists, medical professionals and others in dealing with victims of violent crime, war, natural disasters and other atrocities and loose them upon university lecture halls. The true cultivation of the vulnerable students occurs when terms such as "abusive" and "harmful" are applied loosely to all manner of things—not simply behaviours—but ideas, words, disciplinary paradigms, theoretical perspectives and course policies. The discourses, promotional materials and, in an increasing number of cases, the impetus for university policies that emerge from these specialist offices actively promote a vulnerable personality which sees learning as a form of abuse and the student as a victim (O'Neill, 2016; Waiton, 2019). Again, as we see in Jutel's (2011) work on disease mongers, there is a real proliferation of information for students in the form of pamphlets, posters, university-wide events and social media campaigns originating with university offices that stand to gain in prestige, staffing and budget allocation from expanding the number of individuals who view themselves as victims, and therefore seek their services. To be clear, this is not to suggest that there are not students who have been victimised, either before or whilst at university, who suffered harm, and who may require the services of these social workers, counsellors and specialists. However, the ever expanding and increasingly subjective and ambiguous definitions of harm negates actual serious harms, devastation and victimisation of individuals. A culture where a broad understanding of harm is cultivated disincentivises a contextual understanding of harm and victimisation. Many university students, by virtue of their youth if nothing else, often lack the life experiences necessary to relatively gauge harm. For example, there is a fundamental, qualitative difference between a professor mocking a student's mental health issues and a professor assigning an excerpt from Szasz's *The Myth of Mental Illness* as one of the required course readings. The former provides real cause to take offence, the latter does not. Unfortunately, the lack of a nuanced, contextual understanding of harm and victimisation means that that difference is easily overlooked at the neoliberal university.

Irate Customers and the Victim is Right Movement

University students today are quick to claim that they have been victimised by a professor's written comment on an assignment, a discussion during office hours, or a course policy not because they are weak, or in the language of some conservative commentators, because they are "snowflakes", but rather because they have been surrounded, at least since high school if not earlier, by a host of self-styled experts that transform the way issues are understood and treated. Genuine forms of historically rooted, structural, social harms such as class bias and racism are being redefined, almost to the point of meaninglessness, when terms such as harm and victimisation are used as tropes or clichés of the neoliberal moment in which we find ourselves. Although he is highly critical of them, O'Neill (2016) goes to some lengths to point out that the fragile university student who sees the dialectic process and learning (i.e. being challenged by a professor or classmate to clarify, elaborate, elucidate, demonstrate internal logic or provide empirical evidence) as a form of abuse is a product of policies and practices that have claimed that ideas are hurtful and that speech must be restricted. Constructed around the more therapeutic understanding of the fragile self this is a unique form of victimhood with little real connection to a collective public basis of meaning and purpose (Waiton, 2019). Contrary to some of the abstract rhetorical flourishes, these claims to victimhood are pre-political in character as they exist in the realm of emotion. They are psychological in that they originate with "offence" rather than in "disagreement", ergo the thesis (or the premise, or findings or the professor, etc.) is not incorrect, but hurtful (Furedi, 2017).

Once confronted with the offence, the student seeks allies, of which there are no shortage at the neoliberal university. This strategy is a significant departure from the not so distant past when the last thing that newly autonomous young adults wanted was to be infantilised and hence were quite reluctant to reveal their vulnerability by seeking redress from the authorities. Whilst we fully acknowledge the varying power dynamics between professor and student, and we realise that some sources of conflict may require mediation, the speed and regularity with which students claim victimisation to elicit sympathy or even to mobilise third parties is the predictable outcome of a cultural milieu where a positive sense of individual capacity is diminished. In their respective works on incivility and antisocial behaviour, Berry (2010) and Waiton (2008) theorise people are reluctant to address matters of offence informally because they have been actively discouraged from doing so by various programmes and authorities that claim it as their purview. This is no less true of matters on the campus of the neoliberal university than it is in the outside world of littering, public urination or noisy neighbourhood parties.

Any number of offices and personnel at the neoliberal university, as well as student unions and, in some instances, department heads, associate deans and other academic middle-managers will validate the concerns of the student-customer-cum-victim. In anxious and uncertain times, claims of victimhood are difficult and, at times, impossible to question (Waiton, 2019). As historian Robert Horwitz (2018) illustrates in his examination of the politics of victimhood in the United States, recognising someone as a victim is an acknowledgement of that person as morally entitled to concern. Confronted with the tale of aggrievement, the agent(s) of the neoliberal university are obliged to act, lest they be regarded as insensitive or uncaring. The deference to victimhood not only signifies the agents' compassion and empathy, but also insulates them from likewise being accused of the original offence compounded by victim-blaming. If followed properly, the policies and procedures that are in place to validate the victim's claims also serve the neoliberal university's will to power. In seeking formal intervention, the vulnerable student-customers-cum-victims further subjugate themselves to the power and authority of the institution. In responding to the claims of victimistation, the neoliberal university extends its regulatory control over its subjects, both the student-customer-victim, and the shop-assistant-professor-victimiser. In this sense, the university takes over the parental or paternalistic role of protector and punisher.

Recognising that the sources of conflict and victimisation at the neoliberal university are myriad, consider momentarily the matter of content in social science courses alone. The omnipresent threat of offending the student-customer-cum-victim has seriously curtailed the opportunity to critically explore controversial social issues, self-ownership and responsibility. Rather than assume that our lecture theatres are filled with eager, intellectually curious critical thinkers thirsty for rigorous inquiry, professors are told that we must be cautious so as to protect neoliberalism's diminished subjects from an ever-growing array of contentious topics and potentially disturbing issues. The diminished subjects are increasing fragile, which is not surprising given the proliferation of emotional pap they received during their secondary schooling. Consider for example the number of widely touted websites that claim to help readers, "feel more prepared, better informed, and safer with their books" (Book Trigger Warnings, n.d.). The idea that students need to be warned that the material they study in a given course may emotionally upset them is further institutionalised in universities in the form of "trigger warnings" (Sanson et al, 2019). The admonitions that we should shy away from discussing this or that topic, let students know of possible "trigger" topics or that, as in the case of some institutions, we are required to provide written warnings in our syllabi is Kafkaesque in its vicious absurdity. Yet, by 2016, already roughly half of professors in the United States use trigger warnings in their syllabi (Kamenetz, 2016). Examples of these "warnings" abound:

> If you find that a particular topic is offensive to you and prevent you from engaging in a certain discussion or watching a certain film or video, please contact me…certain course topics such as violence can be disturbing, if you have experienced a similar form of violence and are triggered by the content, please see me about an alternative assignment.

This growing trend "deflects attention from the intellectual and personal benefits of facing cognitive and emotional challenges in academic contexts… [students] expect to be shielded from the reality that the world is full of terrible things or from the equally disturbing reality of deep disagreement about fundamental matters" (Moshman, 2016). In many cases, triggers have come to mean "not comfortable". For example, consider the tenor of these common student statements.

that recently appeared on one of the author's course discussion boards,

- - Out of the three novels, this novel was my least favorite. This novel was excellent but I found it to be very triggering and disturbing.
- Interesting post. i [sic] totally second you in noting that this novel is leading to my least favorite book [sic] . It [sic] was indeed triggered and disturbed
- This novel was a big trigger for me
- This book is so disturbing. I literally had to stop reading it cause [sic] it was triggering for me.
- So far I really don't like this book because it is very triggering and makes me sick to my stomach.

Worse even than the broken "banking model" that educational theorist Paulo Freire (1970) long ago lamented, faculty are now faced with student-customers cum victims that want to be told only what they need to know for the test, inasmuch as what the professor tells them does not upset them. Such approaches alter the purpose of education from a critical dialectic process whilst simultaneously cultivating students as passive learners, customers and vulnerable subjects in need of the university's neoliberal brand of in loco parentis.

Concluding Thoughts

This chapter was intended as a critique of some of the ways that neoliberalism has impacted life on contemporary university campuses, with particular attention to the reification of the undergraduate as a vulnerable, diminished subject. In this vein, we argue that higher academe, under the pressure of neoliberalism and the need for more and more "customers", is embracing a model of the troubled persons industry. In this sense, universities replicate the broader trend of infantilisation and narcissism whilst simultaneously adding new generations of pathologised adult troubled subjects. In addition, as we see the isomorphic effect of the American model of higher academe on other countries (e.g. Germany, United Kingdom, etc.) one can only expect a global trend of more and more populations readily inducted into the troubled persons industries and its pathological trajectory in the wake of neoliberalism's theology. As Giroux (2003) noted nearly two decades ago, higher education systems are bound by characteristics within countries; however, global forces are changing the nature of higher education across countries wherein academic capitalism is becoming the abnormal "normal".

Admittedly harsh and at times polemical, this analysis and commentary was neither designed as a stern admonition for students to "toughen up", nor as a mocking dismissal of the student support services at universities. Quite the opposite. In fact, we daily marvel at the strength and resiliency of our students, and are grateful for support services, both student-run and those staffed by paid professionals, that help undergraduates navigate and make sense of their lives at university. Our goal in authoring the chapter was to draw attention to and confront the pathologising character of neoliberalism in higher education. Such an endeavour must rightfully include a critique of the culture created for students within neoliberal universities that reinforces the cultural expectations and habitus of their pre-university lives including that of the *troubled person* in the toxic world of hyper-individuation, commodification and consumerism. For us, ignoring how these destructive elements bleed into all aspects of academia is naive.

References

American Federation of Teachers Union. (2020). *The student debt crisis*. Available https://www.aft.org/highered/student-debt-crisis. Accessed 5 March 2021.

Bauman, Z. (2000). *Liquid modernity*. Cambridge, UK: Polity Press

Berry, B. (2010, November 18). *Above reproach: Uncivil behavior, a sense of individual privilege and collective collusion*. Paper presented at the 2010 American Society of Criminology conference. San Francisco.

Blumenstyk, G. (2019, March 16). *College leaders are getting serious about outsourcing*. They Still Have Plenty of Concerns, Too. The Chronicle of Higher Education, . Available https://www.chronicle.com/article/College-Leaders-Are-Getting/245978

Book Trigger Warnings. (n.d.) *Welcome* Available https://booktriggerwarnings.com/index.php?title=Welcome

Bourdieu, P. (1977). *Outline of a theory of practice* (vol. 16). Cambridge: Cambridge University Press.

Brownlee, J. (2015). *Academia Inc: How corporatization is transforming Canadian universities*. Fernwood Publishing.

Canadian Association of University Teachers [CAUT]. (2016). *Do you know who sits on your board?* Available https://www.caut.ca/bulletin/2016/09/do-you-know-who-sits-your-board

Canadian Broadcasting Corporation [CBC]. (2013). *Generation jobless*. Available https://curio.ca/en/video/generation-jobless-2594/

Coates, K., & Morrison, B. (2013) *The graduate's million-dollar promise*. Available https://www.macleans.ca/society/life/the-million-dollar-promise/

Erickson, M., Hanna, P., & Walker, C. (2020). The UK higher education senior management survey: A statactivist response to managerialist governance. *Studies in Higher Education*. https://doi.org/10.1080/03075079.2020.1712693

Fenton, J., & Smith, M. (2019). 'You can't say that!': Critical thinking, identity politics, and the social work academy. *Societies, 9*(4), 71. https://doi.org/10.3390/soc9040071

Fields, S. (2019). *70% of college students graduate with debt. How did we get here?* Marketplace. Available https://www.marketplace.org/2019/09/30/70-of-college-students-graduate-with-debt-how-did-we-get-here/

Freire, P. (1970). *Pedagogy of the oppressed*. Continuum.

Friedman, Z. (2019). *Student Loan Debt Statistics In 2019: A $1.5 Trillion Crisis. Forbes*. Available https://www.forbes.com/sites/zackfriedman/2019/02/25/student-loan-debt-statistics-2019/#9a9fff133fb5

Furedi, F. (2017). *What's happened to the University?* Routledge.

Furedi, F. (2004). *Therapy culture; cultivating vulnerability in an anxious age*. Routledge.

Furedi, F. (1997). *Culture of fear: Risk taking and the morality of low expectations*. Cassell.

Giroux, H. (2002). The corporate war against higher education. *Workplace, 9*, 103–117.

Giroux, H. A. (2003). Selling out higher education. *Policy Futures in Education, 1*(1), 179–200. Available www.wwwords.co.uk/pfie/index.html

Giroux, H. (2014). *Neoliberalism's war on higher education*. Haymarket Books.

Gould, E. (2003). *The university in a corporate culture*. Yale University Press.

Hornstein, H. (2016). Student evaluations of teaching are an inadequate assessment tool for evaluating faculty performance. J*ournal of Cogent Learning, 4*, 1 Available https://www.tandfonline.com/doi/full/;https://doi.org/10.1080/2331186X.2017.1304016

Horwitz, R. B. (2018). Politics as victimhood, victimhood as politics. *Journal of Policy History, 30*(3), 552–574. https://doi.org/10.1017/s0898030618000209

Jutel, A. (2011). *Putting a name to it: Diagnosis in contemporary society*. Johns Hopkins Univ Press.

Kamenetz, A. (2016, September 7). *Half of professors in NPR Ed survey have used 'Trigger Warnings'*. NPR. Available https://www.npr.org/sections/ed/2016/09/07/492979242/half-of-professors-in-npr-ed-survey-have-used-trigger-warnings

Kognito. (2020). About Us. Available https://www.kognito.com/about

Kotsko, A. (2018). *Neoliberalism's Demons: On the political theology of late capital*. Stanford University Press.

Lake, R. (2019). Student loan debt crisis breakdown. *The Balance*. Available https://www.thebalance.com/student-loan-debt-crisis-breakdown-4171739. Accessed 21 October 2020.

Lasch, C. (1979). *The culture of narcissism: American life in an age of diminishing expectations*. New York: W. W. Norton.

Moshman, D. (2016, September 2). A generic trigger warning for college students. *Huffington Post*. Available https://www.huffpost.com/entry/a-generic-trigger-warning_b_8074320

Muzzatti, S., & Smith, E. (2018). "The spirits tell me that you're seeking help": Fortune-telling in late capitalism. In D. Waskul & M. Eaton (Eds.), *The supernatural in society, culture, and history* (pp. 116–135). Temple University Press.

O'Neill, B. (2016). From no platform to safe space: A crisis of enlightenment. In T. Slater (Ed.), *Unsafe space: the crisis of free speech on campus* (pp. 5–21). Palgrave Macmillan.

Plato. BCE 517. *The Allegory of the Cave*. Republic, VII. Available https://web.stanford.edu/class/ihum40/cave.pdf

Sanson, M., Strange, D., & Garry, M. (2019). Trigger warnings are trivially helpful at reducing negative affect, intrusive thoughts, and avoidance. *Clinical Psychological Science, 7*(4), 778–793. Available https://doi.org/10.1177/2167702619827018

Searcy, Y. (2017). *Let Me Speak to the Manager! Inside Higher Ed*. Available https://www.insidehighered.com/views/2017/06/05/higher-ed-should-view-public-not-student-customer-essay

Slaughter, S., & Rhoades, G. (2010). *Academic capitalism and the new economy: Markets, state, and higher education*. Baltimore: The Johns Hopkins University Press.

Thompson, M. (2005). The world according to Harvey. *Democratiya* 3 (Winter), 22–27.

Tuchman, G. (2011). *Wannabe u: Inside the corporate university*. University of Chicago Press.

Waiton, S. (2008). *The politics of antisocial behaviour Amoral Panics*. Routledge.

Waiton, S. (2019). The vulnerable subject. *Societies, 9*(3), 66. https://doi.org/10.3390/soc9030066

Wekullo, C. (2017). Outsourcing in higher education: The known and unknown about the practice. *Journal of Higher Education Policy and Management., 39*(2), 1–16.

Young, J. (2007). *The vertigo of late modernity*. London, UK: Sage.

6

Psychiatric Expansion and the Rise of Workplace Mental Health Initiatives

Bruce M. Z. Cohen

Introduction

In discussing the post-institutional expansion of psychiatric discourse into previously untouched parts of society (such as school, work, and the home), a number of critical mental health scholars have identified the rise of neoliberalism as a key explanatory variable. Neoliberal ideology, it is argued, has successfully reoriented popular conceptions of social problems as the result of individual failings. In such an environment, psychiatry and related psychological disciplines have consequently flourished, offering up individualised solutions which appear to make intelligible the supposed internal source of suffering as well as its alleviation (in the forms of therapy, counselling, drugs, and so on). According to De Vos (2012: 119), the result is that we now inhabit a world of 'psycho-politics,' where the discussion of social and economic issues

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has been 'blurred out' in favour of commodified, psychologised solutions. For Rimke (2016: 5), this 'psychocentrism' is 'inextricable with the emergence and maintenance of neoliberal culture where individuals are taken to be free and autonomous consumers responsible for their own health and illness or distress.' Noting that the power to ultimately define and treat mental illness remains the purview of psychiatrists above all other 'psy-professionals' (such as psychologists, therapists, counsellors, psychiatric nurses, and psychiatric social workers), I have recently argued that we should understand this contemporary moment as promoting a totalising 'psychiatric hegemony' which operates at the behest of capitalist society; one which reflects neoliberal values and norms through the construction and promotion of a powerful psychiatric discourse (including within the language, classifications, and practices of the profession) (Cohen, 2016, 2018).

As a case study of psychiatric expansion in neoliberal society, this chapter discusses how psychiatric discourse has come to dominate understandings of 'mental health' and 'mental illness' in the work environment. As the section below will discuss, there has been a long history of psy-professional interventions in the workplace; something that has always served the needs of capitalism for increased levels of employee productivity. Prior to the 1980s, industrial and occupational psychologists took a lead role, emphasising interventions focused on improving the 'mental happiness' of the workforce (a perspective that promotes the idea that the happier the worker is, the greater the output will be). Precipitated by the concern of business elites for the increasing numbers of 'disengaged' workers in neoliberal society, however, the third section discusses the key drivers that brought about a greater need to identify and correct the behaviour of 'at risk' individuals in the workplace. A solution to which, outlined in the penultimate section, is provided by the psychiatric profession, led by the American Psychiatric Association (APA) and the production of their *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which has increasingly conceptualised 'mental illness' as synonymous with the unhappy, unproductive worker. Through highlighting the available critical research on professionals and workplace mental health issues, it will be concluded that this psychiatric discourse has become so powerful that it has changed the conceptions of mental pathology (and with it, the work practices) of other psy-professional groups, increasing the chances of workers being pathologised as biologically and psychologically suspect individuals.

The Happy Worker

As noted by Davies (2015: 116), the science of work in the nineteenth century is not so different from that of today; since the emergence of industrial society, it has been recognised that worker productivity directly effects economic output. Consequently, there is a need for employers to manage worker fatigue, discipline, and morale so as to increase surplus value. Over time, this has moved from the direct policing of worker production processes by a foreman to the psychological management of employees. Significant here is the introduction of psychologists to the work environment in the early decades of the twentieth century (Illouz, 2007: 12; Pykett, 2015: 146–147); Walsh et al. (2014: 1372) remark that as early as 1901, 'business psychology' was recognised in US publications. 'With empirical methods and instruments,' state the authors, 'scientific psychologists offered the owners of business and industry the promise of harmonious work environments, cost-cutting, increased market share, and better worker-productivity' (Walsh et al. (2014: 1372). Research by prominent industrial psychologists such as Elton Mayo appeared to demonstrate that increasing the morale and contentment of workers had a decisive factor on levels of productivity (though Walsh et al. (2014: 1386) note that such conclusions were drawn at the expense of acknowledging changes in the structural conditions of employment such as regular breaks and pay increases). Thus, a focus on the 'mental happiness' of workers became a key variable for consideration by management as the century progressed (Cabanas & Illouz, 2019: 86–88; Miller & Rose, 2008: 45).

The impact of the psychological sciences on work and employment practices particularly came to prominence when the post-Second World War economic boom created an environment of labour shortages and low retention; under such circumstances, business elites became increasingly interested in the psychology of the content worker. For example, Napoli (cited in Cautin et al., 2013: 43) notes that in the US, '[b]usiness managers … took unprecedented interest in hiring the right worker and keeping him contented on the job.' By the 1950s, the majority of businesses were utilising psychological testing of potential employees. From finding and retaining the 'right worker,' developed the associated idea of the 'happy worker'—an employee who, through positive reinforcements, could increase rates of productivity and, consequently, profits. Through this process, work in capitalist society was reconceptualised as not only a necessity for survival but also a place of improvement, importantly a place to improve oneself. As Rose (1999: 56) has summarised of this so-called humanization of work, 'correctly organized, productive work itself can satisfy the worker; the activity of working itself can provide rewarding personal and social relations for those engaged in it; good work can be a means to self-fulfilment.'

The psychological sciences had a significant role to play in the development of a range of techniques for the selection, management, and improvement of the workforce (Rose, 1999: 82), and the branches of occupational and industrial/organizational psychology ('I/O psychology') expanded accordingly. As Walsh et al. (2014: 1387) have argued of these branches of psychology, they were fundamentally allied to administrators' and managers' assumptions regarding the nature of work within capitalist society. Psychological interventions in the workplace such as counselling and therapy sessions were aimed at making improvements in the individual worker rather than improving the conditions within the workplace. 'Management understood worker complaints as symptoms of individual psychology,' state Walsh et al. (2014: 1386), '[t]hus, solutions focused on the adjustment of workers to management's demands.' Nevertheless, as Illouz (2007: 17) argues, this increased concentration on the emotional life of the worker as central to productivity over the course of the twentieth century had perceived benefits for both employers and employees alike: 'for managers and corporation owners,' she notes,

> the language of psychology was particularly well suited to their interests: psychologists seemed to promise nothing less than to increase profits, fight labor unrest, organize manager-worker relationships in a

> non-confrontational way, and neutralize class struggles by casting them in the benign language of emotions and personality. On the workers' part, the language of psychology was attractive because it had the appearance of being more democratic, for it now made good leadership depend on personality and on the capacity to understand others rather than on innate privilege and social standing.

Thus, during this period, the humanization of work through the imposition of psychologists and related professionals in the workplace was primarily focused on the 'positive mental health' of workers which 'could maximise contentment at the same time as it maximized productivity' (Miller & Rose, 2008: 45). However, as I will argue in the section that follows, this focus on positive mental health at work has significantly shifted in the new millennium to a concentration on the opposite: namely, the identification of employee 'mental illness' as a major threat to productivity.

The Disengaged Worker

While psy-professional activity increasingly infiltrated the work arena in the course of the last century, it is only over the last forty years that psychiatric discourse has come to dominate the field. This change can be considered a move from the focus on the happy worker and emotional improvement through employment, to the surveillance of the unhappy worker and the treatment of under-productivity as pathology. The transformation is predicated on the dominance of a reductionist biomedical psychiatric discourse over psychoanalytic and psychological conceptions of the self in neoliberal society. The power of this discourse has been such that, over time, it has changed the understandings of mental pathology within these associated professions as well. This section briefly discusses the economic issues that facilitated the successful proliferation of the psychiatric discourse into the world of work.

Since the 1990s, economic elites have considered the issue of worker disengagement as perhaps the biggest threat to production and economic output in neoliberal society. While Purser (2019: 135) reports that seven out of ten employees feel 'disengaged' from their work, Davies (2015: 105–106) adds that up to 20 per cent are considered to be 'actively disengaged' (manifested as absenteeism, sickness, and presenteeism; the latter understood as being physically present at work while under- or non-performing). Such lack of employee engagement is estimated to be costing the US economy alone $550 billion a year. With the weakening of the unions and the rarity of collective action in the neoliberal work environment, disengagement, according to Davies, is one of the few remaining ways to resist capital. 'Resistance to work,' he argues, 'no longer manifests itself in organized voice or outright refusal, but in diffuse forms of apathy and chronic health problems'; significantly, these forms of resistance are ones which managers are 'largely unqualified to deal with' (Davies, 2015: 106; see also Purser, 2019: 134–136). Instead, mental health and wellness programmes have been developed to identify, monitor, and 'treat' those workers who show signs of such disengagement as 'at risk,' mentally ill subjects. National and international campaigns which have promoted the importance of mental health in the workplace programmes have been explicit in making direct appeals to businesses' bottom line, suggesting that there may be an 'epidemic' of undiagnosed mentally ill employees within the workforce and that mental health policy needs re-orientating towards this unmet need.

In their recent review of productivity in the workplace, Bubonya et al. (2017: 150) have stated that, 'much of the economic cost of mental illness occurs because workers … are simply less productive when they have mental health issues.' The authors note that in the US, the reduced productivity of workers accounts for half of the total cost of depression in that country. A recent economic analysis of Attention-Deficit/Hyperactivity Disorder (ADHD) in the UK similarly found that, despite the mental illness usually first appearing in childhood, most of the costs are associated with adults and the resulting impact on work (Vibert, 2018: 3). Additionally, a 'return on investment' (RoI) analysis carried out in Australia estimated that mental health conditions cost the country's workplaces A$11 billion a year (broken down as A$4.7 billion due to absenteeism, A$6.1 billion due to presenteeism, and A$146 million due to compensation claims) (PwC, 2014: vi). With the current prevalence of mental illness in the US labour force estimated to be one in four, the Partnership for Workplace Mental Health (2006: 6) suggests that the costs of mental illness to the American employer could be as high as US$ 100 billion per year. The implications of such reporting for policy makers, employers, businesses, and the state are clear: a greater focus on mental illness in the workplace will lead to a healthier and more productive workforce. As the Organisation for Economic Co-operation and Development (OECD) (2012: 208, emphasis added) has stated,

> The high rate of employment among people with mental disorders and the high productivity losses of those workers mean that *the workplace is a key target for mental health policy* aimed at improving and sustaining labour market inclusion of those with mental illness.

To achieve this goal, the OECD (2012: 199) recommends 'a need for policy to shift away from severe to common mental disorders and subthreshold conditions; away from a focus on inactive people to more focus on those employed; and away from reactive to preventive strategies.'

Despite the positive rhetoric of inclusion, Raven (2012) has pointed out that there is a serious ideological bias in such economic analyses which focus entirely on the mental health costs to the employer, while completely ignoring the work environment as a contributor to mental health problems for the employee. Further, she notes that the reporting repeatedly fails to stratify for treatment status, conflating 'treated' and 'untreated' cases so as to grossly exaggerate the size of the 'unmet mental health need' in the workplace (Raven, 2012). Underlining this specific critique of estimates of mental pathology in the workforce is the more general problem for the psychiatric community in accurately defining, measuring, and explaining 'mental illness' (see, e.g., Burstow, 2015; Cohen, 2016: 9–17; Whitaker & Cosgrove, 2015). The science remains as problematic as it was in 1970s, yet this has surprisingly not been a hindrance to expanding successfully into the world of work where, as Wipond and Jakubec (2016: 164) have remarked, workplace mental health programmes have gone 'largely unquestioned.' This has happened due to the psychiatric profession's ability to reflect the changing norms and values of capitalist society within their scientific work and practices (for full discussion, see Cohen, 2016). In other words, forms of social deviance (emotions, behaviours, and attitudes that are seen as breaking social and cultural conventions) are captured in the ideas, research, and the practices of the discipline, and eventually formalised in their classifications of emerging symptoms and new pathologies in medical documents such as the DSM. What this means is that the recent medicalisation of the work environment through such workplace programmes ultimately reflects the demands of neoliberal capital for more engaged and productive subjects in the workforce; the constructed 'social diseases' that now pass for 'mental illnesses' have been so fine-tuned by the profession over the past few decades that previously insignificant aspects of our behaviour and emotions at work including procrastination, losing items, inattention, shyness, poor time keeping, failure to multi-task, aversion to group activities, and low morale are now pathologised as signs of poor mental health. This situation has been predicated on a discourse which utilises the veneer of medical science to conceptualise workers as increasingly susceptible to mental disease for which psychiatric and psychological treatments are legitimate interventions. The following section discusses how psychiatry has adapted their work over the past forty years to progress a discourse of employee disengagement as signs of mental illness.

The Unhappy Worker

The publication in 1980 of the APA's third edition of the DSM (DSM-III) began the formal shift in the mental health system's conception of 'productivity' from a humanistic notion to an occupational concern (Davies, 2017: 197–198). In line with the ideological move within the profession towards biomedicine, previous psychoanalytically influenced understandings of a person's productive capabilities as inhibited by environmental, social, and psychological factors changed to one solely predicated on internal dysfunction or disease (see, e.g., Kirk & Kutchins, 1992). Significant here, the DSM-III introduced the symptom of impaired 'occupational functioning' (it appeared over a hundred times in the manual). In the words of Davies (2017: 199, emphasis added),

> By introducing the assessment of occupational dysfunction as central to the diagnostic process, DSM-III established for the first time a conceptual link between 'mental illness' and 'low labour productivity'*: by operationalising occupational dysfunction a central characteristic of mental illness, in other words, mental illness was theoretically recast as a productive threat.*

The DSM-III specially referred to 'occupational functioning' in relation to 'functioning as a worker, student, or homemaker,' and, in making a diagnosis, required physicians to consider '[t]he amount, complexity, and quality of the work accomplished' (American Psychiatric Association, 1980: 28–29). The symptom appeared in new, 'low level' mental illnesses in the manual including attention deficit disorder, generalised anxiety disorder, and borderline personality disorder. Each subsequent edition of the DSM has further added to the work-related terminology. For example, my own textual analysis has shown that barely mentioned words in the first two DSMs (see American Psychiatric Association, 1952, 1968) such as 'work', 'working,' or 'worker', increased from 72 mentions in the DSM-III to 288 in the DSM-5 (likewise, 'unemployment' and 'unemployed' from six to 46 mentions) (Cohen, 2016: 104).

By the time of the latest edition of the manual (DSM-5, American Psychiatric Association, 2013), psychiatric diagnoses have come to blatantly mirror neoliberal ideology in relating mental illness to underperformance. The diagnostic criteria for the new mental illness of premenstrual dysphoric disorder, for example, states that '[t]he symptoms are associated with clinically significant distress or interference with *work*, school, usual social activities, or relationships with others (e.g. avoidance of social activities; *decreased productivity and efficiency at work*, school, or home).' (American Psychiatric Association, 2013: 172, emphasis added). As Tseris (2018: 171) has commented on the current situation, 'a cursory glance at the [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".' Taking mild forgetfulness—the main component in the new DSM-5 diagnosis of mild neurocognitive disorder—as her example, she argues that this is a significant indication of the need for older workers 'to remain endlessly marketable and productive employees' (Tseris, 2018: 171). Similarly, the DSM-5's introduction of ADHD symptoms that can be directly related to adults and employment issues (commonly understood as the de facto new diagnosis of 'adult ADHD') has been described by critical scholars such as Conrad (2007: 139) as 'the medicalization of underperformance' (see also Moncrieff et al., 2014). The previous conceptualisation of ADHD by the APA as exclusively a disease of childhood has dramatically changed with revisions in the symptomologies for the DSM-5. For example, the second diagnostic criterion for the ADHD symptoms of hyperactivity and impulsivity in the previous DSM-IV-TR (American Psychiatric Association, 2000: 92) was 'often leaves seat in classroom or in other situations in which remaining seated is expected'; in the DSM-5, this has changed to '[o]ften leaves seat in situations when remaining seated is expected (e.g. leaves his or her place in the classroom, *in the office or other workplace*, or in other situations that require remaining in place)' (American Psychiatric Association, 2013: 60, emphasis added). Perhaps unsurprisingly then, the DSM-5 describes Adult ADHD as being 'associated with … *poorer occupational performance, attainment, attendance*, and higher probability of unemployment as well as elevated interpersonal conflict' (American Psychiatric Association, 2013: 63, emphasis added).

This change in psychiatric discourse has caused a seismic shift in the related practices of mental health professionals with regards to the work environment. For example, in a recent German study of psychotherapists' conceptualisations of patients experiencing work-related issues, Flick (2016) outlines a systematic pattern of medicalisation and personalisation of distress which ignores wider social, economic, and political factors involved in the life of the employee (including bullying and harassment, excessive demands made by employers, and the effects of unfulfilling and alienating jobs). Whereas a highly vocal social critique of work in capitalist society used to be a preoccupation of the profession in the country, she notes that the therapists now follow closely the diagnostic criteria of the DSM and the World Health Organization's International Classification of Disease, seeking to normalise labour relations as 'natural' and 'healthy' through reframing the suffering of employees as something due to personality faults and/or family and childhood issues (Flick, 2016:

164–166). In fact, Flick's research demonstrates the professionals' clear disdain for patients' discussion of work-related issues in their sessions; one therapist admits that the topic is 'a drag' and that they would be 'bored' if the session did not return to the subject of family and relationships, another complains that the patient's repetition of their problems with work 'wears me down,' while a third sums up the therapists' disregard for such issues by stating that 'I believe the more ill you are, the more hostile work appears to you' (Flick, 2016: 160–162). The author concludes her study by stating that,

> Paradoxically, treatment aims at restoring the ability to work, without, however, considering work in a sustained manner. The re/interpretation and de-thematization of work-related suffering can be explained by the logic of the profession, the specific therapeutic settings in the clinics, and *perhaps a changed function of psychotherapy in society*. (Flick, 2016: 165, emphasis added)

As psychotherapist Richard Brouillette (2016) has recently reiterated, this heightened concentration on individualised narratives by the profession means that 'therapy could easily become an arm of the state, seeking to "cure" listlessness or a reluctance to work, potentially limiting social and political awareness among those it is intended to serve.' A similar charge has been made by critics of the UK's Improving Access to Psychological Therapies (IAPT) programme, aimed at returning the un(der)employed back to work by means of 'cost effective therapies' (mainly Cognitive Behavioural Therapy) (for an overview, see Layard, 2006). The highly prescriptive nature of these therapies, according to Scanlon (2015), ignores the structural issues which determine national and international economic policy and their consequences, instead blaming the victim through a personalisation of emotional distress. 'In these ways,' he argues, 'dissembling conversations about an "imagined" psychological depression replaces conversations about the very real socio-political and economic "depression" that underlies it—and "psychotherapy" is in danger of becoming the medium through which this dissembling is operationalized' (Scanlon, 2015: 31; for a further review and critique of IAPT, see Moloney 2013).

A similar process of de-politicising the structural issues within the field of employment is also evidenced in workplace mental health programmes themselves. A recent international review of employer guidelines for the identification and management of mental health problems in the workplace by Memish et al. (2017) found that prevention was largely ignored in favour of the detection and treatment of employees with 'mental health issues.' This is despite the authors stating that, 'recent evidence … indicates that favourable workplace conditions have a positive effect on the mental health outcomes of employees, both facilitating the recovery from mental illness as well as enhancing mental well-being' (Memish et al., 2017: 214). Yet, this focus on the individual rather than the organisation is more than just chance. Indeed, national documents that make the 'business case' for promoting mental health programmes in the workplace are often quite explicit on the need to develop more proactive forms of surveillance and detection of 'at risk' employees. For example, in the white paper report *Mental Health in the Labour Force* for the Global Business and Economic Roundtable on Addiction and Mental Health, Watson Wyatt Canada ULC (2007: 9, emphasis added) note the importance of collecting benchmark data on worker disabilities, compensation claims, absenteeism, and rates of productivity to 'reveal *opportunities for identification of high-cost/high-risk employees* and thus for more coordinated health interventions.' PwC's (2014) influential RoI analysis for the Australian government similarly stresses the importance of surveillance of the workforce by suggesting how employees themselves can help organisations in the collection of data on 'at risk' individuals. 'Encouraging employee involvement,' state PwC (2014: 31, emphasis added),

> involves administering a survey to all workers within an organisation. The survey can be used to assess a number of measures, including *job control, health, absence and acceptance*. The results of the survey can then be used to target specific issues which may impact the mental health of the workforce and identify other action programs that may benefit the organisation.

In summarising their own analysis of key North American policy documents on workplace mental health, Wipond and Jakubec (2016:

166–167) propose that, 'the texts seem to mainly serve as encouragements for employers and employees to import dominant standards about productivity, normality, psychological harm, and 'mental health' from the broader society and the "mental health" system deeper into the workplace.' Through interviews with three 'experts' (a trained therapist, a human resources professional, and a 'wellness specialist') responsible for coordinating, promoting, and running workplace mental health programmes within various organisations, the authors highlight three key impacts: first, *coercive* practices which force workers to self-label as mentally disordered. Programmes were often mandated for workers to attend and couched in terms of expectations to be '"mentally well" at all times,' with deviations from this norm formulated as potential signs of mental illness (Wipond & Jakubec, 2016: 171). Second, employees were encouraged to *reframe* workplace conflicts as personal issues. Structural issues within the organisation such as bullying and down-sizing were individualised through mental health initiatives which concentrated on employee 'emotional reactions' and the need for personal adjustment (Wipond & Jakubec, 2016: 173). And thirdly, there was an increased use of diagnostic labels and discriminatory behaviour against those labelled as mentally ill. The authors found that a mental illness diagnosis served the interests of both the employers and the employee, but for quite different reasons. For the employee, it was one of the few legal ways left for dealing with workplace conflict due to the statutory protections offered under disabilities legalisation (of which mental illness is a part), while for the employer, it avoided the focus on power imbalances and structural issues at work, instead medicalising the worker as an 'at risk' biologically or psychologically suspect individual. As one expert cited in Wipond and Jakubec's (2016: 175, emphasis added) study stated,

> Quite often we have found that *the issue is related to conflict in the workplace*—an employee having a conflict with their manager or supervisor. And the way it gets dealt with is unfortunately through the medical system. Which is how the current systems are set up, which is to push people to medicalize issues which should be dealt with on a behavioral level.

Despite the arguments for mental health workplace programmes as positive in leading to necessary accommodations for the worker by the organisation, those employees receiving a mental illness diagnosis in the study were often severanced out. One expert commented that, '[a] lot of these organizations deem it's easier—because they assume that if a person has mental health issues that they will be a quote un-quote re-occurring problem—it's easier to write a cheque' (cited in Wipond & Jakubec, 2016: 177). In contrast, the expert had never witnessed an organisation that had successfully accommodated such employees.

Conclusion

This chapter has surveyed and analysed the changing nature of psy-professional engagement in the world of work. While there has been a long history of psy-interventions which mirror the requirements of capital for greater levels of worker productivity, I have argued here that there has been a significant expansion of such practices due to psychiatry's capture of this field with the rise of neoliberalism. Previous psychological conceptions of the happy, productive worker have been replaced by a negative biomedical discourse which emphasises the dangers to economic output of the disengaged, unhappy employee. While the emergence and rapid expansion of workplace mental health programmes in the new millennium are popularly understood as a positive step forward for businesses and users alike, the critical evidence outlined in this chapter demonstrates that such programmes actually serve to more closely monitor and identify 'at risk' individuals to be either reformed or removed from organisations. Grounded in an individualising psychiatric discourse, structural issues of work are successfully ignored in favour of pathologising un(der)productive, resistant employees as biologically or psychologically suspect. David Harvey has previously stated that, in neoliberal society, illness is 'defined as the inability to work' (cited in Cederström & Spicer, 2015: 4). The successful medicalisation of the work environment by psychiatry means that we could now more precisely say that the inability to work is defined as a 'mental illness.'

References

American Psychiatric Association. (1952). *Diagnostic and statistical manual: mental disorders*. American Psychiatric Association.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). American Psychiatric Association.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (2000) *Diagnostic and statistical manual of mental disorders* (4th edn., rev.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Brouillette, E. (2016). Why therapists should talk politics. *The New York Times*. http://mobile.nytimes.com/blogs/opinionator/2016/03/15/why therapists-should-talk-politics/? Retrieved on 17 March 2016.

Bubonya, M., Cobb-Clark, D. A., & Wooden, M. (2017). Mental health and productivity at work: Does what you do matter? *Labour Economics, 46*, 150–165.

Burstow, B. (2015). *Psychiatry and the business of madness: An ethical and epistemological accounting*. Palgrave Macmillan.

Cabanas, E., & Illouz, E. (2019). *Manufacturing happy citizens: How the science and industry of happiness control our lives*. Polity Press.

Cautin, R. L., Freedheim, D. K., & DeLeon, P. H. (2013). Psychology as a profession. History of PsychologyIn D. K. Freedheim (Ed.), *Handbook of psychology* (Vol. 1, pp. 32–54). Wiley.

Cederström, C., & Spicer, A. (2015). *The wellness syndrome*. Polity Press.

Cohen, B. M. Z. (2016). *Psychiatric hegemony: A Marxist theory of mental illness*. Palgrave Macmillan.

Cohen, B. M. Z. (2018). Marxist Theory. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 46–55). Routledge.

Conrad, P. (2007). *The medicalization of society: On the transformation of human conditions into treatable disorders*. John Hopkins University Press.

Davies, J. (2017). Political pills: psychopharmaceuticals and neoliberalism as mutually supporting. In J. Davies (Ed.), *The sedated society: The causes and harms of our psychiatric drug epidemic* (pp. 189–225). Palgrave Macmillan.

Davies, W. (2015). *The happiness industry: How the government and big business sold us well-being*. Verso.

De Vos, J. (2012). *Psychologisation in times of globalisation*. Routledge.

Flick, S. (2016). Treating social suffering? Work-related suffering and its psychotherapeutic re/interpretation. *Distinktion: Journal of Social Theory, 17*(2), 149–173.

Illouz, E. (2007). *Cold intimacies: The making of emotional capitalism*. Polity Press.

Kirk, S. A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. Aldine De Gruyter.

Layard, R. (2006). *The depression report: A new deal for depression and anxiety disorders*. Centre for Economic Performance, London School of Economics.

Memish, K., Martin, A., Bartlett, L., Dawkins, S., & Sanderson, K. (2017). Workplace mental health: An international review of guidelines. *Preventive Medicine, 101*, 213–222.

Miller, P., & Rose, N. (2008). *Governing the present*. Polity Press.

Moloney, P. (2013). *The therapy industry: The irresistible rise of the talking cure, and why it doesn't work*. Pluto Press.

Moncrieff, J., Rapley, M., & Timimi, S. (2014). The construction of psychiatric diagnoses: The case of adult ADHD. In E. Speed, J. Moncrieff, & M. Rapley (Eds.), *De-medicalizing Misery II* (pp. 76–88). Palgrave Macmillan.

Organisation for Economic Co-operation and Development. (2012). *Sick on the job? Myths and realities about mental health and work*. OECD Publishing.

Partnership for Workplace Mental Health. (2006). *A mentally healthy workforce—It's good for business*. Partnership for Workplace Mental Health.

Purser, R. (2019). *McMindfulness: How mindfulness became the new capitalist spirituality*. Repeater Books.

PwC. (2014). *Creating a mentally healthy workplace: Return on investment analysis*. PricewaterhouseCoopers.

Pykett, J. (2015). *Brain culture: Shaping policy through neuroscience*. Policy Press.

Raven, M. (2012). *Depression and antidepressants in Australia and beyond: A critical public health analysis* (Doctor of Philosophy thesis). University of Wollongong.

Rimke, H. (2016). Introduction-mental and emotional distress as a social justice issue: Beyond psychocentrism. *Studies in Social Justice, 10*(1), 4–17.

Rose, N. (1999). *Governing the soul: The shaping of the private self* (2nd ed.). Free Association Books.

Scanlon, C. (2015). On the perversity of an imagined psychological solution to very real social problems of unemployment (work-lessness) and social exclusion (worth-lessness): A group analytic critique. *Group Analysis, 48*(1), 31–44.

Tseris, E. (2018). Biomedicine, neoliberalism and the pharmaceuticalisation of society. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 169–176). Routledge.

Vibert, S. (2018). *Your attention please: The social and economic impact of ADHD*. Demos.

Walsh, R. T., Teo, T., & Baydala, A. (2014). *A Critical history and philosophy of psychology: Diversity of context, thought, and practice (ebook version).* Cambridge University Press.

Watson Wyatt Canada ULC. (2007) *Mental health in the labour force: Literature review and research gap analysis*. Watson Wyatt Canada ULC.

Whitaker, R., & Cosgrove, L. (2015). *Psychiatry under the influence: Institutional corruption, social injury, and prescriptions for reform.* Palgrave Macmillan.

Wipond, R., & Jakubec, S. (2016). Creating the better workplace in our minds: Workplace "mental health" and the reframing of social problems as psychiatric issues. In B. Burstow (Ed.), *Psychiatry interrogated: An institutional ethnography anthology* (pp. 161–182). Palgrave Macmillan.

7

Orthorexia Nervosa: The Medicalization of Extreme Healthy Eating Practices

Alison Fixsen and Anna Cheshire

Introduction

In this chapter, we examine the construction of the proposed eating disorder orthorexia nervosa (ON), the politics around its potential inclusion in the DSM, the polemic between desirable healthy eating versus pathological or deviant eating and market interests underpinning the identification of new eating disorders. So far orthorexia has been studied largely from an individual ontological perspective (Musolino et al., 2015) neglecting symbolic and normative factors and the role played by psychopolitics in the framing of eating disorders. Our study explores three

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different perspectives on extreme healthy eating; those who self-identify as highly preoccupied with healthy eating, professionals with expertise in eating disorders including ON and posters on an eating disorder social media site. By focusing on and comparing the narratives of individuals who differentially position themselves around debates concerning health and eating, we can begin to understand the tensions around labeling Extreme Healthy Eaters as 'troubled persons' (Gusfield, 1989) and explain how healthy eating gets transformed into a medical/psychiatric condition as constructed/acknowledged first by professionals and subsequently by members of the public. We begin with a constructionist critique of psychiatric diagnosis (Horwitz, 2012; Jutel, 2014) and the expansion of disordered eating categories within its diagnostic armory.

The Medicalization of Eating

The social construction of medicine concerns the processes by which certain behaviors and experiences come to be defined as medical conditions (Conrad & Barker, 2010). From the conventional medical perspective, diagnoses are useful classification tools which allow for shared understanding and aid practitioners in identifying treatment options and predicting treatment outcomes. They can also be useful for patients to help them understand what is happening to them and to gain acknowledgment and support. From a constructionist perspective, a diagnosis represents a 'focal point at which numerous interests, anxieties, values, knowledges, practices and other factors merge and converge' (Jutel & Nettleton, 2011, p. 794). Within our network society, this includes, not just the creation and use of medical diagnoses by experts, but the adoption of labels by those in allied institutions. Delivering a diagnosis is therefore far more than a clinical act; it is a moral indictment which for the individual themselves alters their self-definition and ensures that 'the individual now inhabits an illness' (Klinkenborg, 1994), be this in their own mind or as a life-long part of the individual's medical history.

Of the aspects of medicalization most critiqued by constructionists, those concerned with the construction of mental illness are arguably the most controversial. Historically, the labeling of mental illness was reserved for those whose behavior was extremely bizarre and disruptive, while Freudian psychotherapy paid little attention to diagnosis altogether. Throughout history, what Dell'Osso et al. (2016) describe as the 'psychopathology of eating disorders' has been a moving feast, with the extensive categorization of disordered eating a relatively recent development which needs to be considered as part of the wide move toward the labeling of 'deviant' behaviors according to the language and principles of modern psychiatry. Self-restricted food intake, for example, as recorded in the Middle Ages as *anorexia mirabilis,* was associated with holiness and extraordinary penitential practices (Dell'Osso, 2016), whereas its contemporary version Anorexia Nervosa is regarded as a serious pathological disorder[1] that sits within a spectrum of psychiatric eating and feeding disorders.

The 2013 *Diagnostic and Statistical Manual for Mental Disorders* (*DSM-5)* defines an eating disorder (ED) as 'a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs health or psychosocial functioning' (APA, 2020). Since its inception, the American Psychological Association (APA) has repeatedly altered and extended their classification of eating disorders, with the 2013 version differing from *DSM-IV-TR* on several counts. Three disorders—avoidant/restrictive food intake disorder, rumination disorder and pica—have been moved from 'Feeding and Eating Disorders of Infancy or Early Childhood' to the general section; modifications have been made to anorexia nervosa and bulimia nervosa[2]; and binge eating disorder (BED)[3] has gained the status of a formal diagnosis (APA, 2013). The APA's assertion that these changes, 'better represent the symptoms and behaviors of patients dealing with these conditions across the lifespan' (APA, 2020), has failed to allay the spate of criticisms and allegations that have followed

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[1] A DSM defined disorder characterised by distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat.

[2] A DSM-defined disorder characterized by frequent episodes of binge eating followed by inappropriate behaviors such as self-induced vomiting to avoid weight gain.

[3] A DSM defined as recurring episodes of eating significantly more food in a short period of time than most people would eat under similar circumstances, with episodes marked by feelings of lack of control (APA, 2020).

from the ranks of psychiatrists, psychologists and scholars (Welch et al., 2013). Allegations include secrecy, conflict of interest, lack of empirical substance and medicalization of normality (Horwitz, 2012). Many of these criticisms are detailed in an open letter initiated by the Society for Humanistic Psychology in 2013, which represented over 15,000 individuals who sought major reforms to the DSM (Robbins et al., 2017).

There are a number of pertinent issues to consider concerning the psychiatric labeling of disordered eating practices. Firstly, the over-appropriation of psychiatric labels to unusual eating choices and behaviors can lead to an over-problematizing and stigmatizing of EDs such that the media and others portray them as norm-violating behaviors, with obesity associated with greed, binge eating with lack of self-control etc., resulting in widespread social censure and prejudice (Guthman & DuPuis, 2006). Our second point is posed as a query: should these emerging categories be viewed as psychiatry responding to new clinical information that has emerged from individual 'pathological' cases, or do they represent a deeper dyscrasia founded on a widespread dissatisfaction with and pathologizing of, the contemporary body? A social constructionist perspective would suggest the last option. In order to understand more about these issues, we turn to the empirical literature concerning lay and professional attitudes to dysfunctional eating.

Perspectives on Dysfunctional Eating

A great deal of research has documented the prevalence and negative health implications of stigma attached to having a mental health diagnosis (Corrigan, 2004); less has been written about the stigma associated with particular EDs (Puhl & Suh, 2015). Obesity, for example, would appear to be a highly ubiquitous source of social and self-directed censorship and stigma, with institutions profiting from a 'cult of thinness,' which in turn has spawned multiple industries designed to treat the psycho-pathology of over-eating (Hesse-Biber et al., 2006). Social attitudes to other EDs appear more complex. One study found attitudes toward individuals with EDs to be more stigmatizing than those toward individuals with depression, with the former rated as more fragile, more responsible for their disorder and more likely to use their disorder to gain attention than people with depression (Roehrig & McLean, 2010). However, the study found attitudes to be ambiguous; some participants believed aspects of EDs could be beneficial (e.g., attention to weight loss) but also thought others would be motivated to imitate these behaviors with negative consequences (Roehrig & McLean, 2010). A moral and esthetic hierarchy of EDs also appears to exist among certain groups, with a diagnosis of anorexia viewed as morally superior to being labeled with bulimia nervosa or binge eating disorder, such that a cross-over to the latter could be viewed as shameful or morally weak (Mortimer, 2019).

At the same time, a growing on- and off-line resistance to the stigmatizing and medicalization of EDs has also been documented. This resistance has been aided and supported by feminist literature e.g., Malson's, 2003 paper critiquing the medicalization of anorexia and Saguy's, 2012 paper arguing how fat as an issue relates to gender, social class and race/ethnicity. Both authors call for weight issues to be explored as socially, discursively produced problems (Malson, 2003; Saguy, 2012). On-line *Pro-Ana and Pro-Mia* eating disorder support forums have become increasingly popular, despite strong criticism by those in research and medical communities for promoting serious eating disorders as a lifestyle choice and thereby normalizing them (Borzekowski et al., 2010; Christodoulou, 2012). Some researchers suggest their appeal may be related to the social support they offer, along with mechanisms for coping with a stigmatized illness and self-expression enabled through these sites (Tong et al., 2013; Yeshua-katz, 2015). Others refute the utility of these sites for much more than promoting graphic material to endorse and support eating disorders (Borzekowski et al., 2010).

The views and perceptions of clinicians to the people whom they treat is a generally underexplored area (Currin et al., 2009; Vandereycken, 2011). Some clinicians may refute the need for psychiatric labeling of eating (Vanheule, 2012), however, others may find the use of a label with which to identify aberrant ideas and responses around food and eating in patients/clients helpful for reassurance that their course of action is correct and as a means of convincing the patient/client that they have a medically recognized problem. Existing studies indicate that clinicians find people presenting with EDs particularly challenging (Geller et al., 2001) as patients or clients with EDs such as anorexia frequently exhibit either a strong ambivalence to reducing their symptoms, or a complete lack of interest in change. In one study of clinicians' responses to the adolescent female patients they were treating for an ED, patterns of reactions included a sense of competence and empathy, but also feelings of anger and frustration, feeling worried about clients or angry toward the parents (Satir et al., 2009).

Orthorexia Nervosa—A New Eating Disorder?

One relatively new eating disorder which has yet to be officially unclassified is that of Orthorexia Nervosa (ON), a dependence or fixation on healthy food, where the desire to consume quality food plays the main role in the symptomatology (Varga et al., 2013). This alleged disorder represents one of a range of new maladaptive eating and 'health-promoting' behaviors which have been identified by non-psychiatric clinicians (in this case the then alternative medical practitioner in the 1990's, Dr Steve Bratman) that has gained prominence through a mixture of academic research and media hype. First described in 1997 by Bratman in association with health food junkies (Bratman, 1997), the problem usually begins 'as an innocent habit' used to overcome physical diseases or to improve one's health. To quote Bratman:

> Many of the most unbalanced people I have ever met are those have devoted themselves to healthy eating. In fact, I believe many of them have contracted a novel eating disorder, for which I have coined the name 'orthorexia nervosa.' (Bratman, 1997 quoted 2017)

Despite its unofficial diagnosis, ON has spawned a vast body of statistical studies and the development of multiple orthorexia scales, including the Bratman Orthorexia Test (Bundros et al., 2016) and ORTO-15 (Dunn & Bratman, 2016), all attempting to define and assess risk factors for ON in different population groups. The status of ON as a clinically unique disorder, rather than a variant of other disorders, has become a hot topic of debate among clinicians and health researchers across the globe (Gramaglia et al., 2017). ‘Established’ characteristics of ON now include a growing concern about consuming only healthy food, the presence of high levels of self-discipline and a sense of moral superiority over people who consume junk food (Bratman, Steven, 2000; Varga et al., 2013). Widely regarded as sharing traits with anorexia nervosa and bulimia nervosa (Varga et al., 2013), studies have also linked ON to personality traits including perfectionism and narcissism (Oberle et al., 2017), psychological disorders such as body dysmorphia (Bo et al., 2014) and obsessive compulsive disorder. The vast majority of ON studies are correlational, very few explore the experiences of those with ON traits (Nevin & Vartanian, 2017) or professionals working in areas in which extreme healthy eating practices are observed among clients (Håman et al., 2017).

A growing number of scales used to ‘detect’ ON have emerged in recent years, even so debates still wage around whether or not ON as a disorder really exists (Brytek-Matera, 2012). ‘Orthorexic’ practices can appear to have much in common with ‘pro-health’ eating behaviors, such as vegetarianism, veganism, raw food diets and more recently clean eating, which are increasingly popular with those aiming at physical, mental or spiritual purification. With its links to slimming, sport and exercise, orthorexia has been variously called ‘healthy anorexia’ (Musolino et al., 2015) and a ‘life-style syndrome’ (Haman et al., 2015). In the media, it has been alternatively criticized and glamorized (Haman et al., 2015; Vogue, 2019).

Nicolosi (2006) adopts a wider philosophical perspective of the orthorexia phenomenon to suggest that we now inhabit an ‘orthorexic society’, in which people’s relationship with food is plagued with alimentary fears and obsessions. Three main factors—a weakening of the restraining power of traditional institutions (religion, ethnicity, community) on food intake and dietary practices, the ever-increasing distance between the food producer and consumer and the framing of the body as an individual project (Widdows, 2019)—all underly the orthorexic disposition that characterizes western modernity (Nicolosi, 2006). Twenty-first-century society has witnessed unprecedented attempts to atomize and marketize self-care in the form of body esthetics, as achieved through such things as fitness regimes, low carbohydrate diets and body building (Koven & Wabry, 2015). The result has been a medical and public U-turn in thinking concerning eating practices considered at one time part of marginal subcultures, such as veganism, but also the emergence of more extreme healthy eating norms and behaviors, especially among young females, the population group most heavily targeted for health and beauty products and media messages (McRobbie, 2008). The constant search for accurate information, along with the instability of advice in these messages further contributes to anxieties around food choices (Rangel et al., 2012). A kind of moral panic has ensued over the so-called epidemic of obesity (Guthman & DuPuis, 2006) which, in an individualistic society, has largely been blamed on lack of self-control rather than neoliberal market forces demanding over consumption.

In addition to psychiatry, there are lots of other institutions and social actors who are interested in labeling problems and in the emergence of a 'kind-of-diagnoses.' Media and industries, such as the food, beauty and fitness industries, have outstanding potency in both creating an obsession with healthy eating among the citizens (Koven & Wabry, 2015) and the marketing of products which align with this trend. Numerous other institutions—'Troubled Persons Industries' (Gusfield, 1989)—have subsequently come forward to offer their support to individuals with eating problems. Some such as counseling, clinical psychology and dieticians have existed for decades, others such as online eating forums and various social media sites have emerged more recently with the network society (Manuel Castells, 1996). Following the latter is vast crowd of consumer who, for various reasons such as health status, age and gender, are vulnerable to both the messages conveyed about diet, health and fitness and their treatments, including those concerning extreme eating practices (Fixsen et al., 2020).

In summary, moral debates and vested interests surrounding the labeling of extreme healthy eating as pathological are complex and nuanced (Dell'Osso et al., 2016). While the formal categorizing of psychiatric illnesses remains the privilege of psychiatry and its diagnostic 'experts,' other groups share interests in these labels. It is the adoption and contestation by allied professions and wider society concerning extreme healthy eating practices that form the main topic of our chapter. For this, we now turn to our empirical study of three different cohorts—laypersons and professionals—who have different interests in, and perspectives around, extreme healthy eating.

Methods

We chose triangulation (investigator, method and data triangulation) to gather as many different perspectives on orthorexia nervosa, and the meanings ascribed to extreme 'healthy' eating practices, as possible. Our data set consisted of three sets of on and offline data, gathered over a six-month period by three different researchers working under the direction of the second author. Our final data sets were: nine interviews with people who self-identified as highly preoccupied with healthy eating (cohort A: 'Extreme Healthy Eaters'); 'ortho' threads from an eating disorder social networking site (cohort B: 'Posters'); and seven interviews with clinical psychologists, dieticians and a family therapist who have long term experience of working with eating disorders (cohort C: 'Professionals'). All parts of the study were approved by the University Psychology Ethics Committee.

'Extreme Healthy Eaters' were recruited through poster advertising and social media, and later via snowball sampling. As there is no formal orthorexia diagnosis, the purpose of the study and its inclusion criteria (age 18 years or above and self-reported healthy eating that had taken over their lives) were described in lay terms to prospective participants. Those with a diagnosed psychiatric disorder or who were having inpatient treatment for an eating disorders were excluded from the study. The final cohort (A) consisted of 6 female and 3 male participants. Seven Extreme Healthy Eaters were based in the UK, and two were based in the United States. Recruitment of professionals was purposive and aimed at those with diverse and in-depth expertise in eating disorders, and specifically ON. All professionals identified as female, as attempts to recruit male participants were ultimately unsuccessful. Three professionals were based in the UK, two in USA and one worked in both the UK and USA. (See table one: study participants).

Once initial contact was made, participants were emailed a copy of the participant information sheet and consent form and given an opportunity to ask questions about the study. Interviews were arranged face-to-face or via telephone/skype according to the following participant preferences: Extreme Healthy Eaters face-to-face ($n = 6$), telephone ($n = 3$); Professionals face-to-face ($n = 3$), telephone/skype ($n = 3$). Interviews lasted between 23 and 46 minutes for people with ON and between 37 and 69 minutes for professionals. Interview guides included set topics but were sufficiently flexible to allow participants to raise other topics of importance to them. Participants were assured that the interview was private, and that any data used from the interview would be anonymized and would form part of a larger data set.

Interview Process

Semi-structured interviews with lay people ('Extreme Healthy Eaters') explored the whole context of individuals' eating choices, including healthy eating choices, reasons for eating healthy and impact of the diet including impact on daily activities, physical and psychological well-being and social/educational/work life. Questions also explored the influences on participants' diet. Semi-structured interviews with 'professionals' focused on their perception of and experience of fixations with healthy-eating, what they regarded as the key features of ON, how fixations with healthy-eating manifested in clients, factors influencing their development and professional treatment strategies and their limitations. In addition to analyzing face-to-face and Skype interviews, we analyzed data from threads selected from an 'orthorexia' forum on an eating disorder website collected over a 2-month period between 2017 and 2018. For maximum variability, the data focused on threads that contained multiple responses from a variety of posters. Each thread contained between 10 and 68 comments. This site is accessible within the public domain, and the majority of forums and thread topics can be read without creating an account. All posts on the site are anonymous (the site does not allow users to use their real name as a username).

Data Analysis

In the first stages of analysis, data from different interviews and stakeholder discussions were considered as separate elements. By repeatedly reading transcripts of interviews, the first author familiarized herself with all the data covering the full range of themes. NVivo was then used to extract more codes and analyze different sections of the data in various ways. Finally, maps and diagrams were used to creatively synthesize ideas. As ideas were generated, they were discussed with the research team and with different stakeholders. Data was coded using a modified constant comparison approach (Strauss & Corbin, 2015), inspecting and comparing all data and fragments arising in a given case and moving from a larger to more compact data set (Silverman, 2014). At different stages of data analysis, emerging codes and themes were discussed with the team. As final codes emerged, data was repeatedly rescanned manually to check for any missing or hidden codes or concepts.

Results

Cohort A: Extreme Healthy Eaters

Extreme Healthy Eaters in our study ascribed to a variety of dietary practices for different reasons, however, all emphasized the significant health benefits of eating healthily and avoiding 'junk food.' The idea of food as form of medicine aligned with what they had learned concerning the benefits of eating in a biologically pure way. As Tim explained, refraining from low quality foods could go a long way toward prevent future illness:

> Now that I'm getting older you have to start worrying about things like cancer … Parkinson's, Alzheimer's, all that type of stuff, and a part of why you eat healthy is to try and avoid that in a lot of ways. I think there's a lot of evidence that cancer can be linked to an unhealthy diet and eating high fat fried foods- who knows what that does in terms of the risk of getting cancer? *Tim*

Several of the cohort had chosen to abstain from meat for ethical reasons: 'Not eating meat is not a dietary thing per se, it's animals'; 'I started cooking for myself and meat grossed me out, the blood and bones.' Jane was convinced that 'going' vegan had been the right choice:'"Cowspiracy.".. It's mainly about how the general meat and dairy industry is bad for the environment.' Healthy eating with also part of a chosen lifestyle in which food was used to promote fitness levels and a particular body shape, for recreational or business purposes. Three of the cohort trained in bodybuilding and used dietary manipulation and supplements as a way of achieving their ideal body shape and muscle tone goals:

> It's a good time we're speaking, to be fair, because I'm about to do a competition in the next seven weeks. So… I'm on like a, a strict diet, and right now it'll be more like six meals a day, spread out between maybe two and a half to three hours. And then meals will be just kind of intake a high protein, a low carb, but healthy standard fats. *Jake*

Body builder Liam had 'done a lot of research into nutrition from the bodybuilding, power-lifting side.' Initially, he had been 'heavily influenced' by names 'in the industry' who post on Twitter and YouTube, 'but then you start to develop more of your own understanding' of nutrition.' Now working to establish his own online business, Liam believed that his good physical shape would work in his favor; 'The [online] visuals draw you in…. probably the biggest element is physical appearance.'

Another factor underpinning healthy eating choices was the influence of the family. Stella had a mum who had bulimia, while her grandmother (a 'yo-yo dieter') had been on numerous slimming pills and dieting programs: 'I look at my mum and grandma and I say, "I don't want to be like them."' Despite her attempts to rationalize such behaviors, for Stella, overeating continued to provoke feelings of disgust within herself and toward others:

> I don't know if it's because when, when I quit swimming, I went from 60 kg to 82 fucking kilos, right, I was disgusted in myself. So now I have an even more skewed opinion of fat people, I think it's disgusting. *Stella*

For other Extreme Healthy Eaters, childhood evoked very different food memories. Edi, one of the older members of the cohort, described herself as a little over-weight but 'rather obsessive about healthy eating.' Having grown up in an Italian family, good dietary habits had been instilled into her at an early age; 'there was always a delicious meal on the table, we all sat down at the table together as a family.' Liam also cited his mother as being the biggest influence on his dietary interest and choices; 'All her meals are very, very good in the traditional healthy eating landscape.'

Participants in this study were requested to talk at length about their dietary preferences and eating schedules and most described them in detail. While the planning and monitoring of a 'healthy' diet regime were undoubtedly preoccupying, even sometimes stressful, it provided 'reference points to work from.' Extreme Healthy Eaters experienced feelings of disappointment or guilt after having deviated from their diet; Liam admitted that he felt worse 'mentally' if he didn't eat healthily for some time, 'because I feel like I am not developing toward my goals.' Most Extreme Healthy Eaters could recall social scenarios in which adhering to their usual dietary choices had proved awkward or impossible, nevertheless social isolation (a frequently cited negative consequence of ON) failed to emerge as a major issue for the full cohort. On the contrary, personal contacts with people who followed or advocated similar dietary practices (partners, trainers, therapists, friends), along with information they had gathered from nutritional literature and media could help to reinforce personal beliefs and regimes. In summary, while Extreme Healthy Eaters were aware of the personal and social costs of following a relatively strict diet, all were convinced that of its benefits and most said they felt much better for it. As Clare explained:

> I like the way I eat. I think it's a healthy way to eat, I think, I feel comfortable … and ultimately, I don't see myself changing my diet … And I think health wise I'm doing well. I'm 61 years old, I'm going, almost 62, my last checkup was great, I feel good, I don't have to take a lot of medications and ultimately, proof's in the pudding. *Clare*

Cohort B: Posters

Posters, like Extreme Healthy Eaters, had strict rules around food and eating, but were more self-berating and more concerned about their ability to maintain these rules and the consequences of deviating from them; ‘I have so many rules and fears’; ‘Kept making them [rules] stricter and stricter.’ Following their restrictive regimes did not, however, rid Posters of anxieties around the effects of eating forbidden foods; ‘I can’t let go of my anxiety… I live a sad and pathetic existence.’ Online users adopted their own argot to describe their common experiences; what was known as ‘cycling’ (alternating between orthorexia eating and a former eating disorder) was also commonly discussed on the site. Posters on the site wrote of how orthorexia eating had replaced a past ED, e.g., ‘I suffered from anorexia before it developed into ortho [orthorexia]…I guess now I’d be called a restrictive anorexic.’ For some, this was seen as a sign of recovery; ‘I developed ON [to] counteract all the damage I’ve done.’ The cycle of eating and purging (self-induced vomiting and/or laxative use) was a frequently discussed topic, with which many battled:

> I didn’t realize it but as I started to add more healthy calories into my diet, I added more unhealthy ones too & I began to binge at night. now I have put on 20ish pounds & even though I look healthy, I miss that control of only eating cleanly. And now when I have those binges of unhealthy things, I have resorted to purging.

Breaking one’s resolve was a source of distress, but to keep ‘clean’ and healthy, purging was seen as sometimes necessary; ‘If I don’t eat clean, I will get sick.’ Warnings were issued about the dangers of falling back into old patterns while attempting to clean up or lose weight, and advice offered to those who might feel inclined to purge after ‘messing up,’ e.g., ‘Purging sets a person up to binge and purge. How do I know this? Been there, done that. It’s hell.’ A dilemma for Posters was that, while ‘ortho’ in the sense of ‘healthy eating’ had to be a good thing, being obsessed to the point of complete irrationality was very distressing, e.g., ‘I pretty much just want to die whenever I feel somewhat pressured to eat “normally.”’ Harsh language was used to describe the sense of personal disgust Posters felt when they transgressed from their self-imposed regime (e.g., 'failure'; 'pathetic'; 'fucked up'). Like Extreme Healthy Eaters, some Posters blamed their families for their extreme attitudes to food, e.g., 'Mother and sister would guilt me for like eating a bag of chips or something ridiculous'; 'eating decisions are governed by a single rule, ruthlessly drilled into my head by my retired gymnast parents.' In contrast, the website was portrayed as a safe place to express one's fears and emotions. Sharing their transgressions and concerns was, for some Posters, a huge relief, 'Realizing that I'm not alone. That it isn't just a failure on my part but a biological response.' Messages of support and reassurance were offered to others who had broken rules; e.g., 'The holidays is *so* rough to eat through with disordered food stuffs, I commend you for doing it.' There was also a celebratory tone in some threads concerning a shared adherence to food purity; 'I must be really demented because I don't see how this is sad. I mean, it's fabulous. Our binges are all about healthy foods. That's a win.'

Cohort C: Professionals

Professionals in our study voiced strident opinions concerning attitudes to food, health and appearance in society and their effects on young females in particular. Sue, who had worked with eating disorders for over three decades, spoke of 'witnessing the emergence of idiosyncratic, irrational ideas about the power of food to affect health and wellbeing.' Our environment had, Anna considered, 'provided us with lots of rules about how to get it right, and certainly for a woman body image, food and eating, is the kind of big, dominant story.' There were feminist issues here; when Nina moved to Los Angeles (LA) she was struck by how objectified women there were, 'so much was about body size, and also a sense of inferiority.' Until recently, it was her higher income clients that leaned toward orthorexia, however, she had noted a restricted, elitist type of eating emerging within the US Latino community, as part of an ethos of 'finding a better life.' Wendy spoke of a growing panic over the health crisis in the States, with major food companies competing with each other over this; 'Let's make sugar look bad, let's make dairy look bad.'

These messages were prominent everywhere in LA, 'There's billboards with, "oh let's freeze off your fat," or "try this juice cleanse."' While LA might be seen as the 'home of orthorexia,' Pippa, who had worked with sports people from around the world, believed the high prevalence of orthorexia in her male clients had a lot to do with the pressures of that particular work environment, but also the influence of social media on attitudes toward food and body image:

> [ON] almost seems more of an acceptable illness for a male to have- whereas there's a lot of stigmas, I think, with anorexia in males generally, so people don't always admit it. And I think a lot of that [pressure] comes from the bodybuilding community … and Instagram … food blogs. *Pippa*

Trying to get a client to move out of their 'orthorexic pattern' was described as 'absolute murder,' because it was 'a safety behaviour' of a similar kind to people with OCD washing their hands compulsively. Speaking from her experiences in California, Anna described a 'very interesting trend' in which the entire family could hold these core beliefs about food and health, although most of the professionals regarded the mother's role as central, 'Majority wise it's the women or the mother, the matriarch figure, running the ideology and running the thought process of the orthorexic tendencies.' Sue blamed the parents for setting these eating trends and sending out unhelpful messages to their children; 'Parents think it's smart and cool, "oh I'm not eating carbs, oh I'm not eating meat, our family is becoming vegetarian," they're not wise.' Family therapist Harriet felt this went right to the root of parenting in modern society:

> Homelife, it's something about not being nurtured … you know, mums and dads aren't available, either they're working long hours. … there's some very strict families, and that's the only thing they've [the young person has] got in control of themselves- how much they put inside their bodies. *Harriet*

Professionals as a body considered ON to be associated with other EDs, primarily anorexia and bulimia nervosa. Many of their clients shared the obsessive, perfectionist traits of anorexics; ‘Neat and tidy. Conscientious. High achievers in sports. They’ve got healthy eating and they go to the local grammar school, that’s another flag.’ (Harriet). Unlike anorexia nervosa and bulimia, however, ‘healthy eating’/restrictive eating was problematic because it is ‘so validated… rewarded in our society.’ In addition, many clients whom dietician Wendy would consider as ‘orthorexic’ had started out with digestive problems or food intolerances, then progressed to a deeper pathology.

Although most freely used the term orthorexia, professionals were divided in their opinions about the usefulness for treatment purposes. Pippa was part of an ON working group who were keen to get it included in the DSM. Nina, on the other hand, was concerned that, were it to become an official diagnosis, it could be used in schools to single out picky eaters such as her child with Asperger’s syndrome. Sue saw no virtue in pathologizing healthy eating unless it was causing gross nutritional deficiencies or creating excessive paranoia about food. Having recovered from a short-lived eating disorder herself, Sue considered the expanding the DSM to include clinically non-significant symptoms and behaviors to be a dangerous trend. Where treatment had improved could be seen in ‘how we understand such patterns, and how we think of them in terms of a person’s ability to function.’

Discussion

Our findings focused on extreme healthy eating from three perspectives; participants who self-identified as ‘extreme’ healthy eaters, posters on an eating disorder (‘*pro-ana*’) Internet forum and non-psychiatric professionals with experience in treating eating disorders. For Extreme Healthy Eaters, adherence to healthy eating was seen as part of a lifestyle choice, the alternative being framed as moral compromise or impending ill health. Aware of the personal and social costs of following a more or less strict diet, members of this cohort critiqued ‘junk food’ eating, framing their healthy eating practices as an act of self-care with positive moral, social and ecological consequences. Posters on the *pro-ana* site expressed similar sentiments concerning the benefits of adherence to healthy eating practices and the hazards of poor quality foods, however, they were more troubled over the extent to which preoccupations with weight and eating dominated their lives. They wrote of their various psychological and physical struggles, including alternating between healthy ‘ortho’ eating and binging and purging (‘b/p’), otherwise known as ‘cycling’. As described in other studies of on-line eating forums, the anonymous nature of posts may have allowed for more frank discussion of stigmatized topic areas (Tong et al., 2013; Yeshua-katz, 2015), while sense of community was furthered through expressions of mutual support and the use of an in-group argot (Fixsen & Ridge, 2017).

Professionals, while intrinsically supporting healthy balanced diets, saw their role as challenging extreme eating beliefs and behaviors which might become pathological. They regarded orthorexia nervosa as multifactorial, citing exposure during childhood and adolescence to extreme attitudes and behaviors related to exercise and diet as part of the problem. In general, professionals’ criticism was leveled at ‘colluding’ agents such as media, communities and parents, rather than sufferers themselves, who were largely viewed as victims of a wider social dyscrasia. By and large, members of cohorts shared a common feature: while castigating modern society for its poor food choices, they sought for explanations and conclusions concerning their own and others’ eating practices within a framework of self-optimization and popular psychology.

The Consequences of Labeling

Most of the vast body of clinical literature on EDs has failed to consider the symbolic and normative factors concerned with the labeling of disordered eating or the agents and industries making and staking their various claims in this field. The social constructionist approach on the other hand takes a broad perspective of a dynamic society, regarding both the labels and meanings that individuals and institutions use for all phenomena including ‘deviant’ eating practices as subject to constant reconstitution (Gergen, 1985). As our study illustrates, those who self-identify as Extreme Healthy Eaters may take a different perspective to those tasked with diagnosing or treating their problems. Thus, while those with ON may be viewed as vulnerable persons seeking to cope with the constant barrage of health and fitness advice circulating through a society obsessed with the pursuit of a perfect body, our study suggests a diverse set of rationales to exist among health food advocates, who may choose food as their remedy for personal health reasons, ethical issues or other psychosocial ills plaguing modern society. In this sense, our Extreme Health Eaters reflect a growing viewpoint concerning the importance of self-care within the political and medical community, even while some take some of these messages to an extreme.

As a social problem (such as 'disordered' eating) becomes a recognized social fact it demands solutions and interventions from individuals and institutions in society, including those representing new professions that have emerged in a symbiotic relationship with that problem. Our study serves as an illustration of how extreme healthy eating has spawned a whole set of 'psy-professional' actors (Cohen, 2015)—dieticians, clinical psychologists, sports therapists and others—who stake claims in this field and repurpose psychiatric labels in the course of their work. The multiplication of 'troubled persons' (Gusfield, 1989) agencies (such as 'pro-ana' forums) on the Internet is a further indication of the need to reconsider both the institutions influencing psychiatric diagnoses and the processes leading to the medicalization of 'issues' in the first instance. Yet, the power to definitively validate mental illness, including that relating to eating and feeding, remains the prerogative of psychiatry (APA, 2013). Hence, while psy-professionals may disagree among each other about particular categorizations, practitioners and their clients have found themselves under increasing pressure to adopt the language and labels of psychiatry for financial, credibility and insurance reasons (Jutel, 2014).

The construction of new EDs has other implications, such as in the monitoring of new forms of human behavior, the re-categorization of existing behaviors previously defined as 'eccentric' and an acceptance by society that 'Troubled Persons Professions' (Gusfield, 1989) are necessary to intercede on behalf of lay persons and to correct these psychosocial problems. Eating is also a highly lucrative industry, and one that thrives on the creation of new opportunities to problematize fundamentals of human life. Once in the public domain, labels such as orthorexia become ever more fashionable and profitable, with markets potentially 'feeding' the eating problems they purport to address. What is labeled as ON is therefore the creation of a society in which hyper-reflexivity around food choices, conflicting information concerning correctness of diet, preoccupation with bodily shape and appearance and emphasis on individual rather than societal responsibility—each propelled by market forces—combine with individual susceptibilities and ecological/moral concerns, to predispose individuals toward extreme 'healthy' eating beliefs and behaviors. The construct that is orthorexia nervosa is thus an excellent example of the way in which a phenomenon (healthy eating) gets gradually transformed into a psychiatric illness that over time is acted upon and capitalized by more and more sectors of society and notably 'Troubled Persons Industries.'

Study Strengths and Limitations

Our consideration of extreme healthy eating from three sets of perspectives outside of psychiatry and our highlighting of the normative and practical complexities around the framing of extreme healthy eating as orthorexia nervosa or otherwise are, we suggest, highly novel. In addition, our findings illustrate how the construction of a new psychiatric category such as ON is highly complex, and how neoteric meanings and labels can come to be attached to phenomena which are not in themselves entirely new (such as extreme forms of eating). For logistical reasons, however, our sample was small, and thus our conclusions tentative. We therefore welcome further studies in this area.

References

APA. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5 diagnostic and statistical manual of mental disorders : DSM-5* (5th ed.). American Psychiatric Association Publishing.

APA. (2020). Eating disorders- American Psychiatric Association. Retrieved February 16, 2020, from https://www.psychiatry.org/psychiatrists/practice/dsm/updates-to-dsm-5

Bo, S., Zoccali, R., Ponzo, V., Soldati, L., De Carli, L., Benso, A., Fea, E., Rainoldi, A., Durazzo, M., Fassino, S., & Abbate-Daga, G. (2014). University courses, eating problems and muscle dysmorphia: Are there any associations? *Journal of Translational Medicine, 12*, 221.

Borzekowski, D. L. G., Schenk, S., Wilson, J. L., & Peebles, R. (2010). E-Ana and e-Mia: A content analysis of pro-eating disorder web sites. *American Journal of Public Health, 100*(8), 1526–1534.

Bratman, S. D. K. (2000). *Health food Junkies: Orthorexia Nervosa: Overcoming the obsession with healthful eating*. Random House.

Bratman, S. (1997). Health food junkie. *Yoga Journal* (September–October). Retrieved from https://www.beyondveg.com/bratman-s/hfj/hf-junkie-1a.shtml

Bratman, S. (2017). Orthorexia vs. theories of healthy eating. *Eating and Weight Disorders*, *22*(3), 381–385

Brytek-Matera, A. (2012). Orthorexia nervosa - An eating disorder, obsessive-compulsive disorder or disturbed eating habit? *Archives of Psychiatry and Psychotherapy., 1*, 55–60.

Bundros, J., Clifford, D., Silliman, K., & Neyman Morris, M. (2016). Prevalence of Orthorexia nervosa among college students based on Bratman's test and associated tendencies. *Appetite, 101*, 86–94.

Castells, M. (1996). *The rise of the network society: The information age: Economy, society, and culture*. Blackwell, Cambridge.

Christodoulou, M. (2012). Pro-anorexia websites pose public health challenge. *The Lancet, 379*(9811), 110.

Cohen, B. M. Z. (2015). *Mental health user narratives. New perspectives on illness and recovery*. Palgrave Macmillan.

Conrad, P., & Barker, K. K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behavior, 51*(S1), S69–S79.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614–635.

Currin, L., Waller, G., & Schmidt, U. (2009). Primary care physicians' knowledge of and attitudes toward the eating disorders: Do they affect clinical actions? *International Journal of Eating Disorders, 42*(5), 453–458.

Dell'Osso, L., Abelli, M., Carpita, B., Pini, S., Castellini, G., Carmassi, C., & Ricca, V. (2016). Historical evolution of the concept of anorexia nervosa and relationships with orthorexia nervosa, autism, and obsessive-compulsive spectrum. *Neuropsychiatric Disease and Treatment, 12*, 1651–1660.

Dunn, T. M., & Bratman, S. (2016). On orthorexia nervosa: A review of the literature and proposed diagnostic criteria. *Eating Behaviors, 21*, 11–17.

Fixsen, A. M., & Ridge, D. (2017). Stories of hell and healing: Internet users' construction of benzodiazepine distress and withdrawal. *Qualitative Health Research, 27*(13), 2030–2041.

Fixsen, A., Cheshire, A., & Berry, M. (2020). The social construction of a concept- orthorexia nervosa: Morality narratives and psycho-politics. *Qualitative Health Research, 30*(7), 1101–1113.

Geller, J., Williams, K. D., & Srikameswaran, S. (2001). Clinician stance in the treatment of chronic eating disorders. *European Eating Disorders Review*. https://doi.org/10.1002/erv.443

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266–275.

Gramaglia, C., Brytek-Matera, A., Rogoza, R., & Zeppegno, P. (2017). Orthorexia and anorexia nervosa: Two distinct phenomena? A cross-cultural comparison of orthorexic behaviours in clinical and non-clinical samples. *BMC Psychiatry, 17*(1), 75.

Gusfield, J. R. (1989). Constructing the ownership of social problems: Fun and profit in the welfare state. *Social Problems, 36*(5), 431–441.

Guthman, J., & DuPuis, M. (2006). Embodying neoliberalism: Economy, culture, and the politics of fat. *Environment and Planning d: Society and Space, 24*, 427–448.

Haman, L., Barker-Ruchti, N., Patriksson, G., & Lindgren, E. C. (2015). Orthorexia nervosa: An integrative literature review of a lifestyle syndrome. *International Journal of Qualitative Studies on Health and Well-Being, 10*(1), 26799.

Håman, L., Lindgren, E. C., & Prell, H. (2017). "If it's not Iron it's Iron f*cking biggest Ironman": Personal trainers's views on health norms, orthorexia and deviant behaviours. *International Journal of Qualitative Studies on Health and Well-Being, 12*(2). https://doi.org/10.1080/17482631.2017.1364602

Hesse-Biber, S., Leavy, P., Quinn, C. E., & Zoino, J. (2006). The mass marketing of disordered eating and eating disorders: The social psychology of women, thinness and culture. *Women's Studies International Forum, 29*(2), 208–224.

Horwitz, A. (2012). Social constructions of mental illness. In *Oxford handbook of philosophy of the social sciences* (pp. 1–23). Oxford University Press.

Jutel, A., & Nettleton, S. (2011). Towards a sociology of diagnosis: Reflections and opportunities. *Social Science and Medicine, 73*(6), 80–793.

Jutel, A. G. (2014). *Putting a name to it: Diagnosis in contemporary society*. John Hopkins University Press.

Klinkenborg, V. (1994). Dangerous diagnoses. *New Yorker*, pp. 78–80.

Koven, N. S., & Wabry, A. (2015). The clinical basis of orthorexia nervosa: Emerging perspectives. *Neuropsychiatric Disease and Treatment, 18*(11), 385–394.

Malson, H. (2003). *The thin woman: Feminism, Post-structuralism and the social psychology of anorexia nervosa*. Routledge.

McRobbie, A. (2008). Young women and consumer culture. *Cultural Studies, 22*(5), 531–550.

Mortimer, R. (2019). Pride before a fall: Shame, diagnostic crossover, and eating disorders. *Journal of Bioethical Inquiry, 16*(3), 365–374.

Musolino, C., Warin, M., Wade, T., & Gilchrist, P. (2015). "Healthy anorexia": The complexity of care in disordered eating. *Social Science and Medicine, 131*, 18–25.

Nevin, S. M., & Vartanian, L. R. (2017). The stigma of clean dieting and orthorexia nervosa. *Journal of Eating Disorders*, *5*(37).

Nicolosi, G. (2006). Biotechnologies, alimentary fears and the orthorexic society. *Tailoring Biotechnologies, 2*(3), 37–56.

Oberle, C. D., Samaghabadi, R. O., & Hughes, E. M. (2017). Orthorexia nervosa: Assessment and correlates with gender, BMI, and personality. *Appetite, 108*(2017), 303–310.

Puhl, R., & Suh, Y. (2015). Stigma and eating and weight disorders. *Current Psychiatry Reports, 17*(3), 552.

Rangel, C., Dukeshire, S., & MacDonald, L. (2012). Diet and anxiety. An exploration into the Orthorexic Society. *Appetite*, 58(1), 124–132.

Robbins, B. D., Kamens, S. R., & Elkins, D. N. (2017). DSM-5 reform efforts by the society for humanistic psychology. *Journal of Humanistic Psychology, 57*(6), 602–624.

Roehrig, J. P., & McLean, C. P. (2010). A comparison of stigma toward eating disorders versus depression. *International Journal of Eating Disorders, 43*(7), 671–674.

Saguy, A. (2012). Why fat is a feminist issue. *Sex Roles*, *66*(9–10), 600–607.

Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. A. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to clinician and patient factors. *International Journal of Eating Disorders, 42*(6), 511–521.

Silverman, D. (2014). *Interpreting qualitative data* (5th ed.). Sage.

Strauss, A., & Corbin, J. (2015). *Basics of qualitative research: Grounded theory procedures and techniques* (4th ed.). Sage.

Tong, S. T., Heinemann-LaFave, D., Jeon, J., Kolodziej-Smith, R., & Warshay, N. (2013). The use of pro-ana blogs for online social support. *Eating Disorders, 21*(5), 408–422.

Vandereycken, W. (2011). Media hype, diagnostic fad or genuine disorder? Professionals' opinions about night eating syndrome, orthorexia, muscle Dysmorphia, and emetophobia. *Eating Disorders, 19*(2), 145–155.

Vanheule, S. (2012). Diagnosis in the field of psychotherapy: A plea for an alternative to the DSM-5.x. *Psychology and Psychotherapy: Theory, Research and Practice*, *85*(2), 128–142.

Varga, M., Dukay-Szabó, S., Túry, F., & Van Furth Eric, F. (2013). Evidence and gaps in the literature on orthorexia nervosa. *Eating and Weight Disorders, 18*(2), 103–111.

Vogue Magazine. (2019). Is orthorexia nervosa the eating disorder for the digital age? Retrieved from https://twitter.com/voguemagazine/status/1082682849109688320

Welch, S., Kalssen, C., Borsova, O., & Clotheir, H. (2013). The DSM-5 controversies: How should psychologists respond? *Canadian Psychology, 54*(3), 166–175.

Widdows, H. (2019). *Perfect me: Beauty as an ethical ideal*. Princeton University Press.

Yeshua-katz, D. (2015). Online stigma resistance in the pro-ana community. *Qualitative Health Research*, *25*(10), 1347–1358.

8

The Psychiatric Surveillance of Pregnancy and Early Parenting

Emma Tseris

In many healthcare contexts across the globe, it has become commonplace for pregnant women and women who have recently given birth to be asked to complete questionnaires aimed at detecting mental disorders arising during pregnancy or in the early months of parenting.[1] In the months before and after childbirth (hereafter referred to as the perinatal period), healthcare workers are strongly encouraged to conduct assessments of mental health in addition to physical health check-ups, through the use of screening tools, and referral pathways for women who reach a threshold of mental health 'risk' to specialist mental health providers

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[1] Pregnancy and childbirth are experiences that people of all genders experience. However, aside from the discussion on male PND, the screening tools for perinatal mental health that are analysed in this chapter have been constructed to assess perinatal mental health outcomes in women, as they are underpinned by cissexist assumptions about gender.

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(Venkatesh et al., 2016). The widespread use of mental health screening tools in perinatal healthcare settings, regardless of whether women have articulated any mental health concerns or have been identified as having a history of mental health difficulties, reflects a now widespread understanding that pregnancy is a 'high risk' time for the emergence of mental health problems, even for women who have had no prior engagement with mental health services. Universal screening practices are justified on the basis of early detection and treatment of perinatal depression (PND)—a psychiatric diagnosis that is used to describe experiences including sadness, loss of interest, appetite disturbance, fatigue, insomnia and irritability during the perinatal period (Fancourt & Perkins, 2018). PND, which is thought to affect as many as one in four new mothers, has been strongly connected to a wide range of adverse outcomes, not only for women, but also for their young children and families (Dadi et al., 2020).

This chapter examines the implications of perinatal mental health screening practices on how women's distress during pregnancy and early motherhood comes to be understood and 'managed' through psychiatric expertise, in ways that have significantly expanded the role and scope of perinatal health services into the mental health domain. Although a holistic approach to healthcare is often beneficial, critical analysis of the discourse of PND makes visible an array of problematic assumptions, including oppressive notions about women's role as carers, 'good mother' and intensive parenting tropes, and hetero-patriarchal power relations. Additionally, in more recent times, the psy-surveillance of the perinatal period has expanded further, with rising numbers of fathers and co-parents being diagnosed with PND. This shift demonstrates an ever-increasing array of experiences and reactions to parenting that are coming to be understood as 'mental illness'.

In developing this argument and critique of PND and psy-surveillance, this chapter does not seek to call into question the severity of distress that some people experience in the perinatal period, and the need for effective responses and supports. Although challenging the simplistic ways in which PND has been linked to a broad array of adverse outcomes, it is also not the aim of this chapter to ignore the potential consequences of severe distress on parents or their children. The analysis that is offered does, however, seek to explore what is rendered visible, and therefore what is left invisible, in the increasing trend towards constructing distress arising during the experience of early parenting as evidence of a ‘mental disorder’.

Connections Between Perinatal Psychiatric Surveillance and Psy-Institutions

The introduction of mental health screening practices for all women during the perinatal period increases the likelihood that women will come to the attention of mental health services during the course of accessing routine healthcare appointments. Discourses surrounding PND focus attention on pharmaceutical, therapeutic and self-care management strategies as solutions to mental distress (Fitelson et al., 2011). In this way, the PND diagnosis creates expanding markets for the growth of psy-expertise, with psy-institutions and psy-professionals benefiting from the notion that new parents require professional medical and psychological interventions at increasing rates. This focus on distress as arising from ‘dysfunctions’ within individual women, leading to an individual ‘treatment’ response, deters new parents from building their own support network or accessing their own communities for resources and guidance to manage the early days of parenting (Lee, 2006). Rather, taken-for-granted assumptions about the prevalence of ‘disorder’ and psychological ‘vulnerability’ during the perinatal period support the expansion of professional services to provide assistance to new mothers who are seen to be failing to ‘adjust’ to the demands of new parenting.

The contemporary turn towards formal, therapeutic services during the perinatal period elevates the influence of psy-institutions and psy-professionals within contemporary societies, who privilege—financially and in the form of social status—from public perceptions of the increasing relevance of psy-expertise beyond the bounds of conventional ‘mental illness’ categories, into more ‘everyday’ experiences, such as parenting. Moreover, assumptions relating to a rising ‘perinatal mental health crisis’ justify calls for the allocation of spending and community attention to psy-institutions and psy-professionals, to provide commentary on and solutions for the distress experienced by women in the perinatal period (Osborne et al., 2021).

Notwithstanding the experiences of some people who find psychological responses to distress comforting and helpful (Tseris, 2018), the resources that are directed towards psy-institutions to address the very real distress experienced by some new parents comes at the expense of alternative, socio-political understandings and responses. Although it is often claimed that the PND diagnosis increases women and children's wellbeing by mitigating the 'risk factors' that are associated with perinatal distress, PND renders invisible a broad array of social contexts and gendered power relations and their impacts on new mothers during the perinatal period. Further, by rendering unhappiness as a highly undesirable trait in pregnant women and new mothers, perinatal mental health screening reduces women's capacity to identify and protest against an array of inequitable social arrangements that commonly arise or worsen when women become mothers (O'Brien Hallstein, 2011). Moreover, universal assessment practices aimed at identifying mental disorders among pregnant women and new mothers extend the already extensive surveillance of women's lives and objectification of women's emotional experiences by psychiatry, whereby women are more likely than men to be diagnosed as mentally ill and to receive psychiatric treatment, with femininity often being conflated with mental instability and 'madness' (Ussher, 2018). Thus, it is important that critical mental health scholars interrogate the ways in which perinatal mental health screening supports oppressive structures including patriarchy and neoliberalism, by problematising women if their experiences of mothering do not fit within narrow social ideals, deflecting attention away from social conditions and onto 'risky' women, promoting compliance with normative gender roles, and positioning individual women as disproportionately responsible for the health outcomes of themselves, their babies and their families. In summary, the paradigm of postnatal *depression* obscures the experience of perinatal *oppression*, by concealing the social drivers of perinatal distress, and providing only a narrow set of psycho-pharmacological solutions.

Gendered Medicalisation and Psychiatric Expansion

Feminist scholars have identified that women have been disproportionately affected by the medicalisation of an increasing range of experiences that were historically not thought of as requiring or benefiting from medical expertise (Prosen & Tavčar Krajnc, 2013). Pregnancy is a good example of such medicalisation, as it is a bodily process that is easily distinguishable from an illness, and yet in contemporary times has come to be understood as an inherently 'risky' state, requiring intensive medical supervision.

While dominant societal discourses situate women's perinatal 'mental health'—women's capacity to perform emotional stability and happiness, and to experience new mothering as an inherently rewarding and fulfilling experience—without the aid of medical interventions, as the most ideal and 'natural' response to pregnancy and mothering, such representations are frequently unattainable and removed from the realities of early parenthood:

> I didn't at all honestly struggle in it. Like, he wakes up every three hours. 'That's okay. I'll feed you.' I felt like I just loved it so much. That I was like, 'This is awesome!'…It just kind of worked for us, I felt like. It wasn't as much of a transition as I thought it would be. (first-person account of mothering, cited in Cronin-Fisher & Parcell, 2019)

In contrast to idealised accounts of the inherent 'joys' of mothering, the diagnosis of PND acts as a signal that a woman has not met societal expectations regarding stereotypical representations of motherhood—she is distressed when she should be blissful, and this may impact on her ability to perform the relentless physical, mental and emotional family work that motherhood demands of her (or, worse still, she may be *unwilling* to take on such a role). In this way, the PND diagnosis serves as a marker of a woman's failure to live up to the patriarchal 'good mother' myth, whereby ideal mothering is understood to be a realisation of 'real' womanhood—a 'natural', instinctive and fully satisfying experience (Sinai-Glazer, 2016). Although PND is constructed as a common experience that affects many women, PND is understood to be cause for serious concern, which requires medical attention and correction. An immediate medical response is justified on the basis that women who are ‘inappropriately’ or ‘dysfunctionally’ distressed in the perinatal period have not only failed to elicit a socially acceptable emotional response, but that their distressed emotional state is likely to have adverse impacts on their baby, for example, low birth weight, psychological issues, increased risk of diarrhoea and suboptimal feeding patterns (Ogbo et al., 2018). Other studies have linked PND to adverse developmental outcomes, behavioural concerns and academic performance (Netsi et al., 2018). Further, PND is said to cause ruptures in infant-mother attachment:

> The symptoms of depression and anxiety can make it difficult to engage in *joyful* parenting and impact upon the interactions between mother and baby. (The Parent-Infant Research Institute, 2020, italics mine)

Importantly, such characterisations of perinatal mental illness as signified by a ‘lack of joy’ significantly broaden the construct of perinatal depression, far beyond notions of sadness or distress. A requirement that mothers experience and express ‘joy’, in order to foster wellbeing in their children, demonstrates the high expectations that exist for mothers. This may prove to be an unreachable goal for many women, especially those who are experiencing significant stressors or intersecting social inequalities. It reveals ever-increasing parameters for the kinds of behaviours and experiences that are able to be labelled as mental illness in the perinatal period, therefore increasing the likelihood that women will come to the attention of psy-professionals in the perinatal period for ‘treatment’ and ‘risk management’.

Perinatal Mental Health Screening Practices

Developed in 1987, the ten-item Edinburgh Depression Scale remains one of the most well-known and widely used perinatal mental health screening tools. It is comprised of 10 statements, and women are asked to rate the frequency of their experiences, from ‘yes, most of the time’ to ‘no, never’. Statements include: I have been able to laugh and see the funny side of things; things have been getting on top of me; I have been so unhappy that I have been crying; the thought of harming myself has occurred to me. The statements are therefore broad and open to differing interpretations; nevertheless, the scale has been translated into over 60 languages and continues to be widely used in both clinical and research settings (Cox, 2017).

The introduction of routine perinatal mental health screening for PND is an example of an expansion of the psychiatric gaze outside of specialist mental health services, into the everyday lives of a substantial proportion of women who become mothers. It is a pertinent example of psychiatric surveillance as a key characteristic of contemporary, neoliberal societies (Cohen, 2016). Perinatal screening practices are carried out by staff including nurses, midwives and obstetricians, leading to their roles expanding beyond the purview of physical health towards an assessment of emotional lability and mental health risk. Assertions that PND is a ‘hidden’ and ‘under-diagnosed’ problem underpin calls for an increased rollout of screening practices, which not surprisingly, is related to increased rates of detection of PND (Mitchell & Coyne, 2009). Other authors have argued for PND interventions to occur prior to conception to ‘strengthen a woman’s resilience and reduce her likelihood of developing perinatal depression’ (Avni-Barron et al., 2010). Although such calls are nearly always underpinned by good intentions regarding efforts to reduce women’s distress, combined with concerns for child wellbeing, the effects of psy-expansion in the perinatal period should not be thought of in simple benign terms: psy-discourses lead to understandings of women’s experiences that have de-politicising effects, by invisibilizing the social contexts of women’s lives, and diluting the potential for a social analysis of women’s experiences of distress (de Vos, 2012). In addition, mental health campaigns, which aim to reduce the stigma of mental health diagnoses, to encourage people to understand their distress using psy-language, and to access mainstream mental health services, expand the purview of psy-techniques, while concealing the oppressive nature of mental health system responses and the existence of alternative ways of understanding and responding to distress (Gorman & LeFrancois, 2017).

Once labelled with PND, psy-interventions are rendered the most legitimate response to distress, with dominant constructions of the PND describing the need for immediate and unquestioning compliance with 'expert' medical knowledges (Venkatesh et al., 2016). In this way, the PND discourse reflects and extends upon the notion of pregnancy as a 'risky' time, with medical expertise being situated as relevant and beneficial knowledge for understanding pregnant women's bodies and minds and managing risks. Such a perspective reflects and perpetuates neoliberal ideologies, which attempt to locate and manage risk within individuals, while rendering social, cultural, political and economic conditions invisible (Ayo, 2012).

Perinatal Depression and Mothering Myths

As many critical mental health scholars have noted, within highly psychiatrised and neoliberal contexts, people can experience some solace and societal validation in understanding their distress as evidence of mental illness rather than a character flaw or evidence of insufficient individual effort (Tseris, 2019). As the 'good mother' discourse is so dominant in contemporary Western contexts, it is often the only narrative of mothering that is available, and the contrast for many women between the myth and their own lived experiences can be stark. Within such contexts, psychiatric understandings of perinatal distress can act as a compensatory discourse through which women who do not experience parenting as an unambiguously joyful or fulfilling time can navigate their experiences of a 'spoiled' motherhood identity (Jaworska, 2018). In doing so, however, women must 'admit' to their inferior mothering status:

> Have finally admitted i have pnd. I've had depression before so i know i have a slow road to recovery ahead. I would so appreciate anyone else's stories of how they overcame pnd. (research participant, in Jaworska, 2018)

A further cost of the PND diagnosis is that it leaves the 'good mother' stereotype intact and unproblematised, with PND discourses providing no room for an analysis of how realistic or useful this construction of mothering is, or a socio-contextual understanding of how stressors experienced by women in the perinatal period might preclude a woman from feeling euphoric. Indeed, social stressors, including lack of social support, experiences of gendered violence, racism and low socioeconomic status are already well-known correlates of a PND diagnosis. High socioeconomic status has been found to reduce the likelihood of a PND diagnosis (Ogbo et al., 2019). Nevertheless, such knowledge is rarely used to question what is being measured in PND screening practices and thus the legitimacy of the PND diagnosis; rather, it is simply used to identify those mothers most 'at risk' of developing PND (for example, see Ogbo et al., 2018). Although some mental health organisations describe risk factors for PND that are inherently social—stressful life events, lack of social supports, a history of abuse, a difficult birth, or a restless baby—such risk factors are usually viewed as simply co-existing with or exacerbating the effects of biological causes. PND discourses therefore demonstrate a strong reluctance to question the practice of labelling perinatal distress as a mental disorder, leading to a regrettable missed opportunity to engage with the social determinants of emotional distress in the perinatal period, which are present for nearly all women due to patriarchy, but are even more marked for women experiencing intersecting social inequalities, in particular, for women of colour who frequently experience heightened racial prejudice in the reproductive period (Lobel & Ibrahim, 2018).

Critical scholarship on mothering discourses has further demonstrated the classed, raced and gendered assumptions that underpin notions of 'good' and 'bad' motherhood, for example, the conflation of material resources with 'good' motherhood, and the ways in which Eurocentric and middle-class parenting practices—in particular, the contemporary, Western ideal of 'intensive mothering', wherein women are expected to discard their pre-mother lives, and to dedicate their time and energy fully to supporting their child, while being knowledgeable and receptive to expert parenting guidance—act as a template against which all mothers are assessed (Cronin-Fisher & Parcell, 2019). Meanwhile, dominant narratives of the 'mentally ill' mother—who is constructed as emotionally unstable, inconsistent, distracted, irrational, and unreliable—stand in sharp contrast to the mother engaged in 'intensive parenting' practices, meaning that mental illness in mothers is often deemed to be synonymous with neglectful and 'risky' parenting (Halsa, 2018). Consequently, mental health assessments conducted in the perinatal period may lead to child protection concerns due to deficit-laden assumptions about the parenting capacities of women experiencing mental distress—a potentially devastating outcome for already marginalised women, which fails to adequately examine the social contexts in which women might be experiencing distress as new mothers, or indeed, the shaky and often discriminatory basis upon which assessments of 'good' mothering are made. Through drawing a simplistic causal link between women's mental distress and the wellbeing of children, the PND diagnosis deflects attention from structural inequalities such as poverty and racism, which may underpin both women's misery and reduced wellbeing in children, leading to neat but false certainties about the benefits of PND screening and early intervention efforts aimed at reducing women's symptomatology, which offer very little or no attention to socio-political contexts or resources.

In response to the narrowness of psy-discourses in understanding women's experiences in the perinatal period, attempts have been made to develop more comprehensive screening tools to account for women's broader social contexts. For example, the Antenatal Risk Questionnaire (ANRQ) aims to explore psychosocial factors in the development of pregnant women's mental distress and includes more contextual questions: Is your relationship with your partner an emotionally supportive one? Were you emotionally abused when you were growing up? Have you ever been sexually or physically abused? (Austin et al., 2005). While obviously offering a much improved analysis of women's distress through its more socio-contextual line of questioning, the purpose of the questions continues to be related to predicting PND, thus continuing to be focused upon individual women as the site of pathology and 'risk', albeit as a result of social circumstances rather than simply biological or psychological causes. Consequently, the ANRQ still reflects a narrow view of child wellbeing, whereby social problems continue to be diluted to an analysis of individuals (Joy & Beddoe, 2019). Moreover, the ANRQ uses epidemiological data, which can be useful for understanding probabilities relating to adverse outcomes at a population level, to determine risk for individuals. This approach is problematic, as it is not possible to use epidemiological data to determine *which* individuals in a group of people who have experienced adverse events will go on to experience negative outcomes (Kelly-Irving & Delpierre, 2019). Thus, whole cohorts of women who have experienced 'trauma' are stigmatised within such tools, as assumptions are made that they are likely to experience PND and demonstrate poor parenting. A stronger re-conceptualisation of mothering myths and structural inequality is therefore needed, including a more radical critique of oppressive assumptions about mothering that position women as responsible for any and all problems that arise in their children, that privilege white-centric structures of family, and that fail to rigorously consider the broader impacts of poverty, racism and other oppressions on the wellbeing of children and families (Halsa, 2018; Joy & Beddoe, 2019).

Psychological or Socio-Political Vulnerability?

Perinatal mental health screening practices, and the associated discourses that link perinatal mental illness to adverse developmental outcomes in children, have led to the perinatal period being viewed as a time when women are inherently psychologically vulnerable. Although some groups of women are viewed as more vulnerable to 'mental illness' than others, all women are viewed as potential candidates for a PND diagnosis (World Health Organisation, 2020). Mental health campaigns urge friends and family to monitor women with newborn babies for possible signs and symptoms of PND, encouraging them to 'talk about it and get professional help' (Tresillian, 2020). Such advice, worryingly, risks co-opting women's most important support networks and shifting their role from one of support to a newfound focus on diagnosis and risk assessment. As already noted, simplistic ideas about PND as an individual dysfunction or mental disorder conceal an array of personal and social challenges that are faced by so many women when navigating new motherhood, including lack of family-friendly venues, pressure to be an ideal mother, lack of support from employers, loss of some friendships and sleep deprivation (Worrall, 2018). It is telling, then, that this individualising approach to understanding distress occurs at a time when gendered inequalities often become most stark; indeed for some women, gendered inequalities and notions of fixed gender roles within their heterosexual partnerships emerge for the first time in the perinatal period (O'Brien Hallstein, 2011), with the minority of men who take on the role of primary carer being constructed as 'less masculine' for taking on 'women's work' (Faircloth, 2020). Emerging research on the invisible 'mental labour' of parenting—tasks including planning, monitoring, instructing, and remembering—demonstrates that it is overwhelmingly performed by women, regardless of their partners' level of other parenting involvement (Robertson et al., 2019). In addition, the perinatal period is a time of heightened risk of domestic violence (Lieberman et al., 2009). Therefore, it is necessary for critical scholarship to work towards the disentanglement of the perinatal period from notions of *psychological* vulnerability, with the notion of *psychosocial* vulnerability offering a more accurate depiction of the myriad ways in which pregnancy and new motherhood often expose women to a range of oppressive practices and discourses, which can be summarised as the devastating effects of 'patriarchal institutionalised motherhood' (Green, 2015).

'Treatments' for Perinatal Depression

In addition to understanding women's distress—or the amorphous and broad concept of a 'lack of joy' in the perinatal period—in ways that pathologise women by drawing upon notions of psychological 'dysfunction', psy-discourses justify the expansion of a range of psychopharmaceutical and therapeutic markets to resolve PND, with strong focus in PND literature on treating women through pharmacological solutions, even though antidepressant medications may pose safety concerns to infants, as they are secreted in breast milk (Lobel & Ibrahim, 2018). Strongly held perceptions about the biological and hormonal basis of maternal distress add weight to campaigns advocating for the universal assessment of perinatal mental illness, despite the evidence for the biomedical causation of depression in women being highly contested (Schultz & Hunter, 2016).

In addition to pharmacological responses, cognitive behavioural therapy (CBT) is a common therapeutic strategy offered to women diagnosed with PND, which aims to challenge and reconstruct 'dysfunctional' belief systems in order to reduce emotional distress. CBT has been heavily critiqued for positioning distress as arising from disordered and 'incorrect' thinking, rather than from oppressive social circumstances (Proctor, 2008). Nevertheless, some forms of CBT in relation to PND do attempt to create space for women to explore 'good mother' myths, and to construct more realistic notions of mothering—for example, 'being a 'good enough' mother is ok' (O'Mahen et al., 2012). Here, however, women are still positioned as responsible for their distress, due to their acceptance of problematic mothering myths, even though such myths are so dominant and highly valued within contemporary, Western contexts. In this way, women are paradoxically both measured against 'good mother' myths within their everyday lives, while simultaneously at risk of being labelled as mentally ill for experiencing despair in response to such tropes.

Beyond the therapy room, women in the perinatal period are constantly surrounded by psy-discourses and are encouraged to engage in taxing self-monitoring processes aimed at recognising and managing the 'signs' of mental illness. As maternal distress is understood to be linked to a range of adverse developmental effects for children, there is a strong moralising component to self-care imperatives aimed at cultivating positivity and happiness in pregnancy and new motherhood, reflecting and perpetuating a neoliberal turn in healthcare that emphasises individual prudence, hard work and responsibility as the primary determinants of health and wellbeing (Ayo, 2012). Popular baby books reinforce the importance of rigorous self-monitoring during pregnancy and early parenting, with ominous statements such as 'everything you do, feel, and think affects your growing baby in some way' (Stoppard, cited in Hogan, 2017). Claims about early childhood as the most pivotal life stage have been critiqued as being reductionist and based upon shaky evidence, and yet have enjoyed broad support within both academic and lay conceptualisations of child development (Macvarish et al., 2014). They justify the intrusion of the 'troubled persons industry' into pregnancy and early parenting experiences, and produce broad societal acceptance of the professional and personal surveillance of perinatal distress.

In summary, women are positioned as responsible for micro-managing their emotional states and 'working on' their happiness, for the wellbeing of themselves, their babies and their families, regardless of their interpersonal and socio-political circumstances. Such perspectives, focused upon the individual actions of women, render invisible the difference that social resources and social transformation would make to improving experiences during the perinatal period, including free healthcare, free childcare, paid parental leave, dismantled gender roles, or indeed, understandings of childrearing that challenge Western norms and distribute care responsibilities beyond the nuclear family.

Engagement with psychiatric discourses to 'treat' experiences of distress can therefore be viewed as a strategic appropriation of women's subjectivity by psy-discourses, which transform what is potentially a political stance being expressed by women as they articulate their distress, into evidence of a psychiatric dysfunction (de Vos, 2012). This stands in contrast to a critical feminist analysis of women's distress as providing evidence of resistance to and a rejection of gender oppression (Burstow, 1992)—with PND being able to be viewed as a response to unrealistic and oppressive gender tropes that emerge across diverse work, family life and social contexts. As asked by de Vos (2012, p. 57), 'can we escape this endless psychologising and come to a truly political assessment?'.

The New Terrain of Male PND

In recent years, mental health awareness campaigns relating to PND have turned their attention to PND as a diagnosis that should be given to people of all genders. The expansion of the PND discourse to describe fathering and co-parenting experiences demonstrates that men, who throughout the twentieth century have often experienced much less intrusion of psychological expertise and medicalisation than women, are now becoming increasingly likely to be scrutinised by psy-discourses in their everyday lives (Lee, 2010). Here, we can see psy-expertise capitalising on changing roles within families wherein men are starting to take on a larger (though usually not equal) role in caregiving, essentially doubling the therapeutic market. Indeed, in a similar way to claims made about the under-diagnosis of female PND and the need for more screening, male PND is also thought to be under-diagnosed, which underpins calls for more widespread screening and intervention (Philpott, 2016).

In contrast to female PND discourses, psychoeducation messages regarding male PND often do not incorporate the strong moralising tone found within female PND psychoeducation, regarding the links between parental happiness and child wellbeing that women are so sternly warned about. In accounts of male PND, concerns about the father-baby relationship and the impacts on child development are often absent. Instead, the psy-messages that are directed towards men are often strongly reassuring and focus on goals beyond the baby's wellbeing, for example, goals relating to reigniting sex and intimacy following childbirth, or managing the stressors involved in their role as 'breadwinner'. As a result, male PND discourses may function to strengthen rather than dismantle normative gender roles, by failing to problematise unequal care arrangements and promoting the idea that men will ideally take on an 'active' and yet unequal parenting role, for example:

> The best way to build your confidence as a dad is to get stuck in and give it a go. This will also help you work as a team and *take some of the load off* your partner. (Beyond Blue, 2020, italics mine)

By using the psychological notion of a 'lack of confidence' to explain the substantial inequalities that so commonly exist in heterosexual partnerships regarding the distribution of childrearing tasks, such statements conceal the socially constructed nature of parenting, representing a missed opportunity to identify, challenge and transform normative arrangements. As a result, while discourses of male PND draw upon emerging ideas of men as 'active parents', they may function to largely reinforce dominant notions of fixed gender roles and expectations, by drawing upon normative ideas about men's roles at work, in heterosexual partnerships, and in childrearing, thus leaving little space for more equitable understandings of parenting. As such conceptualisations are able to sit comfortably alongside notions of female PND and 'risky' mothering, they do little to avert the psychiatric gaze from women or to allow for a more rigorous account of the socio-political and gendered aspects of care arrangements, and hetero-patriarchal family life. These depoliticising effects of male PND are reflective of Jordan's (2019) analysis of how 'new' forms of masculinity and fathering, which appear to subvert traditional assumptions by invoking notions of care and nurturing, often subtly reinforce traditional gender norms and ideals.

Concluding Reflections

Popular images of new motherhood are imbued with notions of unbridled bliss, ignoring the often relentless and repetitive labour involved in caring for newborn babies which, combined with unrealistic and highly gendered expectations of 'intensive mothering', can lead to women feeling exhausted, isolated and undervalued. For some women, such pressures are exacerbated by additional oppressions including domestic violence, racism and poverty. That many women in such contexts experience despair and deserve support is not in question. Given these social stressors, asking women how they are experiencing the perinatal period is, in and of itself, a good idea, and could provide a potential pathway of acknowledging the oppressions of heteropatriarchy. However, perinatal mental health screening, and the PND diagnosis, do not serve this purpose. Rather, the now widespread use of mental health screening tools to assess women during the perinatal period serves to reinforce highly gendered expectations regarding childrearing, whereby women are rendered responsible not only for taking on the majority of the parenting tasks within a heterosexual family unit, but for doing so while expressing distress in according to normative psychological scripts—that is, they are expected to acknowledge difficulties in coping, talk about feelings, accept offers of help and access professional support (Royal College of Psychiatrists, 2011). Thus, women who do not express distress risk being constructed as not engaging sufficiently with their emotions (with an important aspect of the troubled persons industries being emotional expression), while 'too much' distress denotes an 'illness'. Women who do not find ways to express and regulate their emotions in expected ways face the outcome of being labelled as 'disordered', with their parenting capacity immediately being brought into question, and psychopharmaceutical and therapeutic strategies being imposed. This discourse of 'illness' is perilous for feminist activism as it normalises fixed gender roles, the unfair distribution of care work, and the personal costs of 'intensive mothering' discourses. Constructions of male PND demonstrate a further expansion of psy-expertise on perinatal experiences into the lives of men, however notions of male PND may do little to address fixed ideas about gender roles and inequitable caring responsibilities, and sometimes resulting in a reinforcement of gender stereotypes. The PND diagnosis thus negates the role of social policies and structural changes in improving the lives of mothers, for example, the benefits that would be achieved by reconfiguring gender roles, working towards a more equitable distribution of care, challenging gender binarism, implementing universal and free childcare, and addressing the intersections of gender inequality, poverty and racism. Further, PND places the professional gaze squarely on individual 'dysfunctional' women and outdated mothering tropes, increasing the already disproportionate surveillance of women's lives by psychiatric discourses and practices, without changing any material realities or questioning the Eurocentric assumptions that underpin assessments of perinatal mental illness and associated notions of parenting capacity. For this reason, assessments of women's wellbeing in the perinatal period that are constructed within the constraints of psychiatric discourse are at best limited and are often extremely disempowering and discriminative. While re-naming PND as 'perinatal distress' could go some way towards replacing ideas about women's dysfunction with a more socially aware and less pathologising view of women's emotional experiences, it would still position women in the perinatal period as an legitimate focus of psychiatric assessment and naturalise the categorisation of women's distress into 'normal' and 'abnormal' categories. An alternative notion of perinatal *oppression*, on the other hand, has the potential to produce a broader, structural analysis of women's lives, beyond the purview of psy-expertise. In addition to making visible the social drivers of distress, it is also vital to explore the ways in which notions of women's 'mental health' in the perinatal period reflect patriarchal ideas about ideal womanhood (which intersect with racism and classism for women of colour and women of low socioeconomic status), and to unpack the socio-political interests that are served through discourses that assume simplistic causal links between women's 'mental health', 'good' mothering and child wellbeing.

References

Austin, M. P., Hadzi-Pavlovic, D., Saint, K., & Parker, G. (2005). Antenatal screening for the prediction of postnatal depression: Validation of a psychosocial Pregnancy Risk Questionnaire. *Acta Psychiatrica Scandinavica, 112*(4), 310–317.

Avni-Barron, O., Hoagland, K., Ford, C., & Miller, L. J. (2010). Preconception planning to reduce the risk of perinatal depression and anxiety disorders. *Expert Review of Obstetrics & Gynecology, 5*(4), 421–435.

Ayo, N. (2012). Understanding health promotion in a neoliberal climate and the making of health conscious citizens. *Critical Public Health, 22*(1), 99–105.

Beyond Blue. (2020). *Dadvice for new and expectant dads*. Retrieved from https://healthyfamilies.beyondblue.org.au/pregnancy-and-new-parents/dadvice-for-new-dads

Burstow, B. (1992). *Radical feminist therapy: Working in the context of violence*. Sage.

Cohen, B. (2016). *Psychiatric hegemony: A Marxist theory of mental illness*. Palgrave Macmillan.

Cox, J. (2017). Use and misuse of the Edinburgh Postnatal Depression Scale (EPDS): A ten point 'survival analysis.' *Archives of Women's Mental Health, 20*, 789–790.

Cronin-Fisher, V., & Parcell, E. S. (2019). Making sense of dissatisfaction during the transition to motherhood through relational dialectics theory. *Journal of Family Communication, 19*(2), 157–170.

Dadi, A. F., Miller, E. R., & Mwanri, L. (2020). Postnatal depression and its association with adverse infant health outcomes in low-and middle-income countries: A systematic review and meta-analysis. *BMC Pregnancy and Childbirth, 20*(1), 1–15.

de Vos, J. (2012). *Psychologisation in times of globalisation*. Routledge.

Faircloth, C. (2020). When equal partners become unequal parents: couple relationships and intensive parenting culture. *Families, Relationships and Societies, 10*(2), 231–248.

Fancourt, D., & Perkins, R. (2018). Effect of singing interventions on symptoms of postnatal depression: Three-arm randomised controlled trial. *The British Journal of Psychiatry, 212*(2), 119–121.

Fitelson, E., Kim, S., Baker, A. S., & Leight, K. (2011). Treatment of postpartum depression: Clinical, psychological and pharmacological options. *International Journal of Women's Health, 3*, 1–14.

Gorman, R., & LeFrancois, B. A. (2017). Mad Studies. In B. M. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 107–114). Routledge.

Green, F. J. (2015). Re-conceptualising motherhood: Reaching back to move forward. *Journal of Family Studies, 21*(3), 196–207.

Halsa, A. (2018). Trapped between madness and motherhood: Mothering alone. *Social Work in Mental Health, 16*(1), 46–61.

Hogan, S. (2017). The tyranny of expectations of post-natal delight: Gendered happiness. *Journal of Gender Studies, 26*(1), 45–55.

Jaworska, S. (2018). 'Bad' mums tell the 'untellable': Narrative practices and agency in online stories about postnatal depression on Mumsnet. *Discourse, Context & Media, 25*, 25–33.

Jordan, A. (2019). *The new politics of fatherhood: Men's movements and masculinities*. Palgrave Macmillan.

Joy, E., & Beddoe, L. (2019). ACEs, cultural considerations and 'common sense' in Aotearoa New Zealand. *Social Policy and Society, 18*(3), 491–497.

Kelly-Irving, M., & Delpierre, C. (2019). A critique of the adverse childhood experiences framework in epidemiology and public health: Uses and misuses. *Social Policy and Society, 18*(3), 445–456.

Lee, E. (2006). Medicalizing motherhood. *Society, 43*(6), 47–50.

Lee, E. (2010). Pathologising fatherhood: The case of male post natal depression in Britain. In B. Gough & S. Robertson (Eds.), *Men, masculinities and health: Critical perspectives* (pp. 161–177). Palgrave Macmillan

Lieberman, A. F., Diaz, M. A., & Van Horn, P. (2009). Safer Beginnings: Perinatal child-parent psychotherapy for newborns and mothers exposed to domestic violence. *Zero to Three Journal, 29*(5), 17–22.

Lobel, M., & Ibrahim, S. M. (2018). Emotions and mental health during pregnancy and postpartum. *Women's Reproductive Health, 5*(1), 13–19.

Macvarish, J., Lee, E., & Lowe, P. (2014). The 'First Three Years' Movement and the Infant Brain: A review of critiques. *Sociology Compass, 8*(6), 792–804.

Mitchell, A. J., & Coyne, J. (2009). Screening for postnatal depression: Barriers to success. *BJOG: An International Journal of Obstetrics & Gynaecology, 116*(1), 11–14.

Netsi, E., Pearson, R. M., Murray, L., Cooper, P., Craske, M. G., & Stein, A. (2018). Association of persistent and severe postnatal depression with child outcomes. *JAMA Psychiatry, 75*(3), 247–253.

O'Brien Hallstein, D. L. (2011). She gives birth, she's wearing a bikini: Mobilizing the postpregnant celebrity mom body to manage the post–second wave crisis in femininity. *Women's Studies in Communication, 34*(2), 111–138.

O'Mahen, H., Fedock, G., Henshaw, E., Himle, J. A., Forman, J., & Flynn, H. A. (2012). Modifying CBT for perinatal depression: What do women want?: A qualitative study. *Cognitive and Behavioral Practice, 19*(2), 359–371.

Ogbo, F. A., Eastwood, J., Hendry, A., Jalaludin, B., Agho, K. E., Barnett, B., & Page, A. (2018). Determinants of antenatal depression and postnatal depression in Australia. *BMC Psychiatry, 18*(1), 49.

Ogbo, F. A., Kingsley Ezeh, O., Dhami, M. V., Naz, S., Khanlari, S., McKenzie, A., Agho, K., Page, A., Ussher, J., Perz, J., & Eastwood, J. (2019). Perinatal distress and depression in culturally and linguistically diverse (CALD) Australian women: The role of psychosocial and obstetric factors. *International Journal of Environmental Research and Public Health, 16*(16), 2945.

Osborne, L. M., Kimmel, M. C., & Surkan, P. J. (2021). The crisis of perinatal mental health in the age of Covid-19. *Maternal and Child Health Journal, 25*(3), 1–4.

Philpott, L. F. (2016). Paternal postnatal depression: An overview for primary healthcare professionals. *Primary Health Care, 26*(6), 23–27.

Proctor, G. (2008). CBT: The obscuring of power in the name of science. *European Journal of Psychotherapy and Counselling, 10*(3), 231–245.

Prosen, M., & Tavčar Krajnc, M. (2013). Sociological conceptualization of the medicalization of pregnancy and childbirth: The implications in Slovenia. *Revija Za Sociologiju, 43*, 251–272.

Robertson, L. G., Anderson, T. L., Hall, M. E. L., & Kim, C. L. (2019). Mothers and mental labor: A phenomenological focus group study of family-related thinking work. *Psychology of Women Quarterly, 43*(2), 184–200.

Royal College of Psychiatrists. (2011). Post natal depression: Help is at hand. Retrieved from https://www.sth.nhs.uk/clientfiles/File/PostNatalDepression%5B1%5D.pdf

Schultz, W., & Hunter, N. (2016). Depression, chemical imbalances, and feminism. *Journal of Feminist Family Therapy, 28*(4), 159–173.

Sinai-Glazer, H. (2016). Who else is in the room? The Good mother myth in the social worker-mother client encounter. *Social Policy and Society, 15*(3), 351–367.

The Parent-Infant Research Institute. (2020). Understanding emotional health and postnatal depression. Retrieved from https://www.piri.org.au/for-parents/understanding-emotional-health-postnatal-depression/?hilite=postnatal+depression

Tresillian. (2020). *Stress: Postnatal depression*. Retrieved from https://www.tresillian.org.au/advice-tips/stress/postnatal-depression

Tseris, E. (2018). A feminist critique of trauma therapy. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 251–257). Routledge.

Tseris, E. (2019). *Trauma, women's mental health, and social justice*. Routledge.

Ussher, J. (2018). A critical feminist analysis of madness: Pathologising femininity through psychiatric discourse. In B. M. Z. Cohen (Ed.), *Routledge international handbook of critical mental health* (pp. 72–78). Routledge.

Venkatesh, K. K., Nadel, H., Blewett, D., Freeman, M. P., Kaimal, A. J., & Riley, L. E. (2016). Implementation of universal screening for depression during pregnancy: Feasibility and impact on obstetric care. *American Journal of Obstetrics and Gynecology, 215*(4), 517-e511.

World Health Organisation. (2020). Maternal mental health. Retrieved from https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/

Worrall, A. (2018). Bringing our gaze to perinatal depression. *International Journal of Narrative Therapy and Community Work, 2*, 1–11.

9

Unpacking the Labelling Process: Framing Responsibility in Sex Addiction

Emmanuelle Larocque, Baptiste Brossard,
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Unpacking the Labelling Process: Framing Responsibility in Sex Addiction

A remarkable characteristic of troubled persons industry today is its abundant production of labels: multiple categories are created and recycled to describe an increasing variety of emotional states and behavioural patterns. What do these labels do to the shaping of mental health in contemporary societies? The labelling theory, adapted by Scheff (1966) to the area of mental health, takes on a new significance in this context,

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and still sets the scene for productive research explorations (Dixon, 2015; Perry, 2011; Thompson, 2014; Turowetz & Maynard, 2019; Wright et al., 2011). It remains a major concern for sociologists of mental health to understand the social implications of labelling processes.

In this chapter, we wish to contribute to this perspective with the case of sex addiction, which presents an interesting socio-historical trajectory. Sporadically emerging in the 1960s, sex addiction started being envisioned as a potential psychiatric diagnosis in the 1970s and 1980s academic literature. It was included in the DSM-III-R's (1987), as a sub-division of "sexual dysfunction not otherwise specified" before being excluded in the DSM-IV (1994), which instead selected "hypersexual disorder". Both the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) and the *International Classification for Diseases* (ICD) now favour the notions of compulsivity and impulsivity to frame excessive sexuality (Reid & Kafka, 2014). No pharmaceutical drug was specifically created to "treat" sex addiction. Nevertheless, sex addiction became a popular notion, abundantly employed by psy-professional groups, the media, in fiction, journalism, the church, the criminal justice system, the self-help industry, and so forth (authors, forthcoming; Irvine, 1995; Reay et al., 2015). How are various actors dealing with this category, especially considering that, unlike many categories studied in the literature, it is not legitimized by the mainstream medical and psychiatric classifications anymore? Sex addiction constitutes a heuristic case study to better understand the contemporary micro-politics of labelling in mental health beyond psychiatry.

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Specifically, this chapter is concerned with how therapists and "sex addicts"[1] use this category, what the labelling process signifies to them and how it contributes to producing the social existence of this trouble. This led us to the notion of responsibility. Indeed, in studying how our participants reflected upon what it meant to them to call someone or designate oneself as a sex addict, they all raised that such labelling changed something to the way in which they perceive agency in regard to sexual conduct; for instance in "de-responsibilizing" the individual or enacting possibilities for self-transformation.

Theoretical Background

The present reflection is part of a broader project that aims to understand the social history and experiences of behavioural addictions, especially to sport, sex and work, through Hacking's (1998) theory of ecological niches. This theory examines how, in a given society at a given moment of its history, some "transient mental illnesses" emerge and disappear. The rising popularity of "behavioural addictions" since the 1980s make them a suitable case study for this perspective. Hacking theorizes that four "vectors" must meet for a transient mental illness to exist, and in this text, we will focus on two of these.

First, "medical taxonomy", as rephrased by Brossard (2019, p. 6), means that for a mental illness to exist, there needs to be an "identification of a social configuration in which some people are led to get involved in the diffusion of a studied category, and others to endorse this category for their self-description". This aspect of Hacking's theory follows the long and productive tradition of studying how labelling processes associate certain people with certain "mental illnesses". Especially, the labelling theory (Scheff, 1966) asserts that certain forms of social transgressions, characterized as "residual" because they do not match any clearly written or formalized sets of norms, can be re-framed into mental illnesses by health professionals, which patients might endorse as their

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[1] In this paper, we use the term "sex addict" to refer to a person who either self-designates as a sex addict or has been diagnosed as such by a third party.

only option. Another vector of Hacking's (1998) theory of ecological niche is "release". A transient mental illness emerges when it provides the concerned people with a way—often the only way—to escape their social strains, such as constraining norms, economic difficulties or various cultural expectations. Whilst some subjectively benign types of residual transgressions will go unnoticed and may even be normalized (e.g. "you know men watching porn is not a big deal. It's kind of almost to be expected" says Karla, a therapist from Montreal), other residual transgressions are deemed too disruptive to be normalized (e.g. when masturbation, or watching pornography, prevents someone from working or fulfilling some family expectation). From this perspective—according to both Scheff's and Hacking's theories—labelling processes do not only consist of putting a name on symptoms: they are productive social forces involved in the emergence of mental disorders. They have *real effects on real people*.

However, it remains to understand the micro-politics of labelling, that is, the various ways in which people can be labelled in mundane settings, and this attends to questions regarding the micro-processes at the basis of medicalization (Halfmann, 2011). In this paper, we show, firstly how people use labels with different "intensity", in the sense that labelling can express various meanings, from asserting the reality of an illness to being only a tool for communication.

Going further, we show, secondly, the detailed intricacies between the meanings of labelling and responsibility, referring to Brickman et al.'s (1982) models of helping and coping that distinguish between attribution of responsibility for problems and for solutions. Applying this typology of responsibility as to shed light on the micro-dynamics of labelling processes of sex addiction shows how social actors implicated in the process of "helping and coping" view problems and perceive solutions according to underlying sets of assumptions embodied in four models of responsibility—the moral, the compensatory, the enlightenment and the medical model. As developed further, under the moral model of responsibility, the problem is perceived as a weakness of character where individuals, no matter what the social context, are viewed as highly responsible for their own fate and are expected to take action to change the trajectory of their illness, a message deeply engrained in the self-help tradition. The compensatory model carries that people are not responsible for their trouble but for their transformation and healing. Therapists embody the compensatory model when they expect people to participate in solving a problem they did not create. The enlightenment model promotes the idea that troubled individuals are considered as responsible for the cause of their trouble but not for its solution. This perspective places emphasis on "enlightening participants as to the true nature of their problem (which they may not regard as something for which they should take responsibility)" (Brickman et al., 1982, p. 373) and their inability to "exert the control necessary to effect change on an individual basis" (Zevon et al., 1982, p. 406). Finally, under the medical model, the person is neither responsible for his trouble nor to find the solution and where resolution of the trouble rests in the hands of the clinician—as in Parsons' notion of the "sick role" (1951), whose fulfillment implies the decreasing responsibility attributed to the ill person and the usual social expectations in the eyes of others. Through interview analysis, we will show how these models of responsibility intertwine with various practices of labelling.

Drawing from this framework, the chapter is organized as follows. After briefly presenting our methodology, we develop the analysis in two parts. First, we describe how therapists and sex addicts in Canada and Australia make use of the label sex addiction. We begin by looking at therapists to investigate the variety of their positions regarding the use of "sex addiction" as a clinical category. We then raise the same question about sex addicts, portraying their different relations to the label "sex addiction". In the second part, we examine how the standpoints of therapists and of sex addicts relate to representations regarding responsibility towards sexuality and addiction. As we will illustrate, framing responsibility appears to be a critical dimension of labelling processes, especially for a category such as sex addiction where moral roots run deep. This perspective will contribute to understand an important aspect of the troubled persons industry, that is, how labels with contested professional legitimacy still make sense for some actors and establish meanings relevant to mental health. Indeed, despite inconsistencies and lack of official support from the psychiatric field, labels come to life and build currency in the social world through an active process of interactions and negotiations between groups of actors where varying interests, social positions, knowledge and grievances are at play.

Methodology

The qualitative findings presented here are based on audio recorded interviews conducted face-to-face or via Skype with eighteen professionals (social workers, therapists, sexologists, psychologists, counsellors, psychotherapists)[2] from eastern Canada and southeastern Australia who either advertise themselves as experts in the field of sex addiction or who regularly provide therapeutic services to individuals who identify as sex addicts. Data is also drawn from thirteen face-to-face interviews with self-designated sex addicts or individuals who have been diagnosed as such by a third party, aged 18 and over. Participants were recruited mainly by sending posters to professionals who work out of private practice and community health centres and by advertising on university grounds. For biographical interviews, we also contacted various Twelve Steps groups via email and invited group leaders to promote our study with their members. Responses from the sex addiction groups were extremely favourable. As a result, our sample consists mainly of Twelve Steps program members (9 for Sex Addicts Anonymous and 3 for Sexaholics Anonymous), aged between their mid-twenties and early seventies. They also had a range of educational qualifications, employments, religious beliefs and affiliations and relationship statuses. Recruiting female participants proved to be a difficult task, as only two biographical interviews were conducted with participants who identified as female. Our semi-structured interviews, that lasted one to two hours in duration, were designed to gather information about the lived experience of sex addiction and, more specifically, to elicit narratives regarding the emergence and diffusion of the category. The data was transcribed verbatim and imported into NVivo, a software designed for qualitative data

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[2] To simplify, we will use the generic term “therapists” in this text when referring to these categories of psy-professionals.

management and analysis. Coding was performed first by using categories drawn from Hacking's theory of ecological niches, which serves as the foundational theory that guides this broader research. The authors, along with other members of the research team, discussed the interviews and reflected on compelling segments during team meetings to identify general themes. This reflective and iterative process made it possible for us to then transform findings into refined categories of analysis by using an inductive thematic analysis framework (Boyatzis, 1998; Creswell, 1998), appropriate for investigating a range of experiences.

A Situated Data Sample

A few particularities of our data sample must be mentioned. First, most participants from the sex addiction programs expressed a willingness to partake in this research for a number of reasons, ranging from the desire to help push the field of sex addiction research forward, the need to remedy against the negative impacts of their addictions (a way to put their sexual addiction problems to good use) and the potential positive effects of participation on their well-being. Also worth noting is that more than half of the experts interviewed promoted a multi-disciplinary approach and advocated for the use of Twelve Steps programs as a complementary treatment to individual therapy. Most of these experts had also obtained their Certified Sex Addiction Therapist (CSAT) training through the International Institute for Trauma and Addiction Professionals (IITAP), founded by Patrick Carnes, who pioneered the field of sexual addiction. This is informative in regards to the discourses that may link some of the therapists and the sex addicts on the basis of the philosophical foundations of self-help groups (which vary from offering strict rules of "sobriety", namely through the faith-based Sexaholics Anonymous, to being more lenient around the definition of sex addiction, such as the Sex Addicts Anonymous groups) (Irvine, 1995). Given our limited sample of sex addicts uninvolved with a fellowship, the narrative trajectories of most participants are highly tainted by the addiction terminology promoted by Twelve Steps programs, which, as noted by Pienaar and Dilkes-Frayne (2017, p. 146), “reference the norm and conceptual logic of ‘addiction-as-disease’”.

What’s in a Label? On the Micro-Politics of Sex Addiction

Our first findings relate to the micro-politics of labelling or the ways by which people can be labelled and medicalized in mundane settings (Halfmann, 2011). As we will see, the label of sex addiction expresses various meanings, from asserting the “reality” of an illness to being, only, a tool for communication. This is an important point from a labelling perspective as well as for the study of troubled persons industry: once a label is used in the social world, it does not only designate various interpretations of a trouble, but also a variable degree of realness attributed to the related disorder.

Negotiating the Labelling Process: The Therapists’ View

The narratives of therapists first show that the category sex addiction is employed with great variability. As a Canadian psychologist explains: “It’s a contested label where some people accept it and fight for it. And other people say, ‘this is ludicrous’ and fight against it. It’s quite divisive”. Not bound by the strict diagnostic criteria of the DSM, sex addiction is free to take on many forms, moulding itself to the moral and ethical values of the therapist and individuals who adopt the term, leading to widely disparate ways of dealing with the alleged illness (Brown, 1995). Whilst there are stark differences between professions (e.g. a social worker’s scope of practice may not be the same as a psychologist’s and may differ from one country to another) the lens through which mental health professionals evaluate, challenge and define “sex addiction” provides rich insights into the meaning given to the label. The therapists’ postures towards the category can be understood through three dynamics: bearing witness (to the "realness" of the trouble); unpacking (what the label "actually" tells, somewhat deceptively, about troubles); and meaning-making (understanding how their clients use the category to make sense of their trouble).

Bearing Witness

Some therapists maintained that sex addiction exists because the suffering it causes cannot be denied. For instance, one Australian psychologist spoke of the controversial nature of the label but in view of the pain she witnesses in her office, she says: "There is usually, often deep underlying pain. So … yeah. I'm a believer". Another psychologist from Montreal explains that bearing witness to this suffering confirms the existence of the trouble: "I can't deny that it exists. I mean, in my office, it exists […]. They come here because it has destroyed their lives". Some therapists extend this observation to a social level where suffering surpasses the typical male profile. As one sex addiction specialist notes, more women and adolescents are coming forward and expressing distress regarding excessive sexual behaviours, and as these populations are largely excluded from the sex addiction scientific literature, he hopes to "contribute to expanding knowledge in that area", to acknowledge the suffering of these particular groups. In all these cases, *bearing witness to a label refers to a dimension of the labelling process by which some professionals acknowledge and use a label in order to recognize the suffering of the people who experience it.*

However, *bearing witness* also includes cases in which the labelling professional accepts the label in clinical encounters, without thinking it as the best one to describe the state of their client. Some therapists report that they welcome the language of addiction as means of honouring the lived experience of their clients—without necessarily endorsing the underlying conception of addiction. As a therapist in Sydney notes, "I will use compulsion with my clients. Sometimes they might come to me and use the word addiction, and if they want to use the word addiction, if they're comfortable with that, then we will use it". Therefore, for certain professionals, the label is only a name, as this therapist from Melbourne highlights: "I don't really get hung up on the language. … if you want to call it hypersexuality or you say its problematic relationship with pornography addiction, I sort of like pathological relationship to sex. *But the name of it doesn't really matter*".

Unpacking

A number of therapists show themselves more reluctant to use "sex addiction" as a label. One social worker from Canada affirms that "sex addiction… it's just too narrow of a thing. And it's problematic and it can also mean that lots of sex is bad, and… it resonates with me as being a little bit sex negative in that sense". A counsellor from Australia has similar reservations since "sex addiction" conveys a quantitative approach to normativity, "attacking human creativity because we are all different—thank god for that one—and we can't say you do sex 3 times a week that is normal and if you do it 4 times a week you aren't normal because the terms normal, abnormal don't even exist". As a Montreal psychologist adds, there is no "good amount" of sex in itself and therefore the problem is more the "mismatch" of libido between sexual partners than an individual's sexual drive itself. Another psychologist in Australia specifies, it is not always that people are addicted but rather, that "they have definitely overstepped the bounds of consent with their partners". These therapists tend to refrain from using sex addiction uncritically, on the basis that it pathologizes a person, medicalizes sociosexual issues, limits sexual expression and also raises ethical and consensual concerns.

Due to these reservations, many therapists consider that the label is only a starting point that needs to be *unpacked*, to gain access to the "actual" problems of the clients:

> If somebody came to me and said "I'm a sex addict", I would try to understand what they mean by that and try to unpack and try to make sense of what they mean. *Some people need that label in order to make sense of their lives and that's totally fine.* So if somebody needed to be like "I'm a sex addict, help me", I'd say okay, I'll help you, but let's look at other

> kinds of behaviors that are going around. *I would never say you're not a sex addict*. (Social worker, Canada)

Unpacking refers to a dimension of labelling that, without necessarily denying the existence of what is labelled, consists of deconstructing what the label actually means for people. A tool mobilized in narrative practices (Brown & Augusta-Scott, 2007), unpacking aims to socially locate the trouble and generate alternative descriptions by encouraging clients to "gain a reflective perspective on their life and to challenge the 'truths' that define, objectify or subjugate them as they explore new options" (Besley, 2002, p. 134). Within this process, one can estimate the risks and benefits as well as the broader social implications of adhering to such a label. For this reason, many therapists (favourable or not to sex addiction) seem to endorse a skeptical, cautious attitude towards this category with their clients.

Meaning-Making

> When people call me on the phone and they say "Do you treat sexual behavior… Do you treat sex addiction?" I'll ask them right then when they are on the phone "Exactly what do you mean by that"? And they usually say something like "My spouse discovered that I'm having an affair", or "My spouse discovered that I've done this or that". And I'll say "And so who exactly considers that an addiction?". (Psychologist, Canada)

Another range of postures associated with the label "sex addiction" concern whether therapists consider that the label is itself included in the meaning-making operations that people—the addict and their spouse—resort to in order to structure and give meaning to their difficulties. Thus, in describing a client who "had a very high sex drive", an Australian therapist comments:

> He was dealing with the issues around having multiple affairs and the impact of that on his marriage. But even within his marriage, he and his wife had a very high level of sexual activity. So he would call it an

> addiction, I think his wife would call it an addiction, because that helps them make sense of it.

A Montreal-based therapist also explains that spouses are often the ones that insist on using the term sex addiction to explain extra-marital affairs: "it's more understandable if it's an addiction and something they can't control". The question then becomes: who calls whom a sex addict and for which motives? Either way, labelling is far from a neutral process (White, 1994), where people come to organizing their lives around a normalizing and regulating storyline shaped by cultural discourse, as provided by the self-ascribed or given label. *Meaning-making refers to a dimension of labelling that consists of analyzing the way by which the concerned people use a label to make sense of their difficulties.*

Whereas in traditional therapeutic encounters, professionals tend to take on the role of a gatekeeper, controlling access to diagnostic labels, the labelling process seems to be taken loosely in the case of sex addiction—and maybe others: several postures towards labelling, that can be combined, shape not only the interpretation given to problems, but also the degree of "realness" attributed to them.

Experiencing the Label: The Sex Addict's View

We now turn our attention to self-designated sex addicts to comprehend how they experience and contribute to the labelling process. This process is constructed through two key micro-dynamics: identification (how they find the label and then endorse it as part of their identity) and disclosure (under what condition they share the label or hold it secret).

Identification

Self-designated addicts can feel the repercussions of uncertainty in the medical and psychological worlds. When they realize that different specialists have different approaches, they might take some time to "find" the label. Their endorsement of sex addiction to designate their problem often comes from diverse groups of helpers, especially therapists and fellow addicts met in mutual-help groups. For instance, in his 40 year-long career as a "struggling sex addict", Paul[3] has met with a dozen psychologists and psychiatrists but none of which he felt truly understood him. Having been through the psychiatric revolving door a few too many times, he mostly relied on accounts of lived experience to navigate the emotional landscape of sex addiction: "some of the most eureka light-bulb moments have been from fellow addicts". His Twelve Steps program collective was the social setting in which he could feel that his difficulties were understood and properly labelled. Yet, the "exposure" to the label does not come without ambivalence; as Audrey puts it, "I had a hard time accepting that term: addiction". She describes it as a "progressive type of definition": "I first came to terms with addiction a couple of years ago and it was my therapist that pointed out that this was becoming an addictive behaviour. So it wasn't personally initiated… it was more her that defined it". Coming to terms with the label seems to be part of a process that is often prompted by others, whether it is therapists or fellow sex addicts. Carlos further explains:

> I can identify right away when someone is totally in denial. So when did I realize that I had a problem? Well, I finally came to terms with this… our labelling says an addiction, I don't like labels and never have liked labels. But it was when I decided to go and see a therapist.

For many—but this might be due to the fact that our sample mostly consists of Twelve Steps programs members—whilst therapy provides a platform to learn about sex addiction, the sentiment of "fitting in" and of "being included and understood" comes mainly from identifying with such groups. It is indeed the shared experience of sex addiction that allows people to look beyond the "deviant" and "outsider" label. Daniel highlights the empathetic dimension: "Most of the people that I interact with a lot are sex addicts. Marvelous people really. There's all kinds of people, doctors, professionals, drunks, you got them all". In sum, seeing people as "nice, ordinary guys" enables to overcome the

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[3] Names have been changed to protect anonymity and confidentiality of the research participants.

negative stereotypes associated with addiction and, in line with stigma literature (Link & Phelan, 2001), the deep experience of shame. Thus, identification is a dimension of the labelling process that can be experienced positively: the labelled person gets the feeling to have found the "right" name to put on their issues.

Disclosure

But once the label is appropriated by someone, what about sharing it with others? This is the issue of disclosure. The labelling can provoke some relief. As Josh words it, "it opened the door for me to get professional help". However, at the same time, the distance expressed towards the label takes the form of a constant hesitation. Should they tell their spouses, their family or their friends? As one female sex addict reports: "that's one thing I'm fearful of when I do get into a committed relationship, is how do I share this with someone without scaring them away". Disclosure is socially and culturally framed, especially as in some Twelve Steps groups and in certain therapeutic contexts, full disclosure is considered a condition of recovery: the recovering person has to "come out" as a sex addict in front of their partner and tell them about their potential mischiefs.

The expectation to "hold no secrets" exerts a certain pressure, balanced with considerations for the recipient: disclosure can backfire. Carlos, reflecting on this issue, tells us that he realizes "how much pain" he has caused to his wife, "not only because of my infidelities or the things that I have done as a sex addict, but as well in the full disclosure to her. She… She didn't need to know many of the details that I've told her". In this context, certain sex addicts choose not to disclose everything in order to protect others. The risks outweigh the benefits: "The risk is immense. We are encouraged to be as open and transparent as possible, I'm okay with that principle, but it depends with who" (Alexis). Another explains: "There's a part of me that wants to come totally clean, but then there's the same part of me that doesn't want to hurt people or tell the whole story". The risks not only concern reaction of other but the desire to protect oneself: "I will not generally share specifically what sex addiction is. I have my own ways around that… it's a way of… of protecting myself and making sure that I can be safe… I'm very selective in how I use it because there could always be consequences".

On the "positive" side of disclosing, Mathew described the feeling of freedom that it can generate. Considering the stigma attached to sex addiction, he narrates his first steps in a Twelve Steps group, in 2012: "I was sitting in a room where everyone else, *everyone else*, was in my position and completely understood me. So I can't even describe how liberating that is". Fear of anticipated stigmatization leads some to see these groups as settings where they can display their "true selves". Paul expresses this relief: "In many cases for the first time in our lives, we have a place where we can be totally open and honest about our 'secret life'", insisting on the reaction of his fellows to disclosure; instead of disgust, he received encouragements, such as "I can relate", "I hear you", "Thanks for sharing".

In other words, most addicts are torn between the social expectations that accompany "fully embracing the label", which, as stated by one participant, involves disclosing "everything", and the risks for themselves and others to do so. This translates for many as the impression to be leading a double life. Paul, as many participants, employs the reference to Dr *Jekyll and Hyde* to describe the "double life" he had as an addict, "covering his track". In "hiding behind the mask of public compliance" (Scott, 1985, p. 34), some seek ways to blend in and, as Paul describes, "live the societal norm", such is the social control function of the troubled-persons professions grounded in illness ideology—to ensure that troubled people are brought "into the stream of 'adjusted citizens'" (Gusfield, 1989, p. 433). Paul adds:

> not only does society view us as damaged goods, if our story is told in "polite and rational society", but we (the struggling addict) view ourselves as sick deviants. We carry the misguided belief, but it has an element of truth, that if people knew who we really are, or knew what we do or think, then we would lose their acceptance/love/understanding.

In this section, we have examined how therapists and sex addicts experience and partake in the labelling process: bearing witness, unpacking and meaning-making for therapists, identification and disclosure for self-designated addicts. However, the underlying issue of these processes is common. From the moment a label emerges and gains some social existence, the various actors involved with the troubled persons industry will have the possibility to use it, redefine it and integrate it to their everyday practices. In doing so, they can use it as a tool to assert the "realness" of what is designated by the label, taken as a word which refers to real problems, real suffering or real identities.

Framing Responsibility

Psy-professionals have classically been considered as "moral entrepreneurs" (Becker, 1963, pp. 150–152), enforcing "conformity to existing normative standards" (Levine & Troiden, 1988, p. 348), sometimes pathologizing, sometimes normalizing the problem of their clients or patients (Scheff, 2010). But how does such normativity operate? In the area of mental health, labelling someone expresses something about their agency, or their ability to make decisions. It is, clearly, a moral issue, and therefore labelling processes carry with them strong moral standards. Typically, sex addiction is a powerful normative category, saturated with assumptions about what a normal or expected sexual conduct is. In view of our data, we argue that this especially regards conceptions of responsibility. Indeed, labelling oneself or someone as "sex addict" entails the representation of a certain form of (problematical) responsibility related to sexual conducts, and this issue characterizes some important meanings that different protagonists, including therapists and self-designated addicts, but also intermediaries like Twelve Steps programs that shape criteria for membership, associate with the labelling process. Framing responsibility thus appears to be a critical determinant of labelling processes in real-world settings: the ways in which responsibility is conceived in relation to labelling strongly orients how people engage with the studied category.

A Continuum-Model of Responsibility

Although models of responsibility are presented as separate from each other in Brickman et al.'s classical typology, the discourses of both therapists and self-designated sex addicts invite us to view responsibility as operating on a continuum between the Moral-Enlightened-Compensatory frames. Indeed, within the elastic boundaries of labels such as sex addiction (Briggs et al., 2017) and even porn addiction (Taylor, 2019a, 2019b), both therapists and sex addicts tend to navigate between these frames as a way to determine and adjust the consequences of the label. Hence, responsibility acts at a micro-level as a normative social force that shapes the labelling process. This re-configuration process can be described as the intertwining of three driving forces: (1) attributing causality to increase responsibility, (2) weighing the effects of the label on agency and (3) considering the social location of responsibility.

Between Causality and Responsibility

Some therapists consider that labelling augments responsibility: once labelled, people would better know what problem they struggle with and thus be more accountable for what they do. One therapist, trained by Patrick Carnes, uses a biomedical etiology to assess the question:

> Although there are neurological effects derived from the addictive behavior, the person still has the ability to make different choices. […] The person who is labelled (as a sex addict) is still viewed has having the responsibility and the capacity to make different choices. The therapy process will help in determining what alternative options exist and how the person can get the addictive behaviour under control … there's a possibility for the person to do things differently. (Sex addiction specialist, Canada)

Emphasis on neurological or genetic conceptions of mental illness typically promote a decrease in responsibility by channelling "fatalism and passivity" (Maturo, 2012, p. 130), mimicking the effects of Parsons's "sick role" (1951). Hence, therapists such as the latter engage in a counter-balancing act by fostering responsibility through collaborative therapeutic agendas where clients are expected to learn an employ the skills needed to resolve the problematized behaviour. This "emancipatory" perception of labelling resonates with Brickman et al.'s (1982) "compensatory model". To contextualize, this perspective legitimizes the individualistic and neoliberalist viewpoint in which political and social institutions have increasingly less responsibility for citizen's well-being (Maturo, 2012). Josh, a young father who has been struggling with "sex addiction" for over 12 years, adds nuance to this perspective by explaining that, whilst finding the label shifted the way he framed the problematized sexual behaviour "because it paved the way for me to say I need some really strong medicine, I need some real help, I'm not like the guy who just had a bad habit", in the end, "powerlessness still remained".

Powerless but Responsible: The Addiction Contradiction

Typically, the Twelve Steps programs that most of our participants attended, endorse a model of responsibility where self-described sex addicts are required to admit that it is beyond their reach to control their behaviours without the help of a higher power and a community of fellow addicts (Irvine, 1999). If self-designated addicts all note, at some point, that they have agency towards their therapeutic achievements—partly through disclosure and the construction of a certain relation to the label—they also feel that their struggle is against something for which they have limited agency, either defining their addiction as characterized by an inner "lack of control" or viewing it as a disease, external to them, that "corrupts":

> you very quickly realize who actually is like you and who is not, and people who are like you are, yeah your personalities are remarkably similar, even though, I mean, they're remarkably similar in so much as they partake in the disease, because I think *it corrupts people in a similar way*, towards a similar point, um, I think there's always still that affinity. (Jackson, sex addict)

The idea of an addiction as lack of control was vocalized by many therapists and is directly mentioned by Josh: "I have all the characteristics of an addict, I can't stop when I start, I don't have the power of choice, I don't want do the things that I'm doing". Audrey's statement exemplifies the process by which "lack of control" solidifies as a criteria for sex addiction:

> Yeah, I think it's kind of… daily kind of acceptance and the Twelve steps group helped me to kind of come to terms with the fact that I am not in full control of this. And that's it's… it's a disease essentially, and it's okay to admit that I don't have full power over my compulsive behaviors. And so in that sense I think the program has been helpful for me to kind of accept that. In this case, like yes it is addiction and it's okay that it's an addiction.

Similarly, losing power over one's own conduct can be described through the idea of volition:

> But the key thing is that I can't control it despite my best efforts. It's always there in the back of my mind and it's… I cannot… Yeah, I do not have the ability to stop of my own volition. You know, and I can… there's been many times over the years where I think it's very… it's very clear that I am unable to stop with that. (Brodie, sex addict)

Therefore, sex addicts conceive their difficulty through the "enlightenment model" of responsibility (Brickman et al.'s, 1982), which, when taken to an extreme, consists of asserting one's "powerlessness" in the face of addiction and of submitting oneself to an authority figure who might provide the answers.

The use of the addiction lexicon expresses the absence of choice for what the addicts do and become. From this standpoint, the notion of responsibility in addiction narratives, like in the case of drug addiction, takes the form of a "contradictory reflex", as explained by Pienaar and Dilkes-Frayne (2017, p. 147): "although addiction is understood to be a disease of the will, marked by loss of control, affected individuals are expected to exercise their will in order to overcome it". Contradictions of such nature have also been reported by Keane (2001). Distress around this contradiction is reflected in the discourses of participants who normalize lack of control as a key feature of the addiction whilst regarding personal responsibility as the solution:

> The solution really from what I can tell is, in short form, people taking responsibility for their own shortcomings, and acknowledging that they don't have to be perfect, but that they have to actually acknowledge where they went wrong, because so long as the sex addict feels like they're a victim they'll never stop being a sex addict. (Jackson, sex addict)

If Jackson's narrative is in line with the "mainstream" framework proposed by Twelve Steps programs, many individual versions exist even within these groups. For example, one participant explains how disclosure intertwined with the moral responsibility he felt throughout therapy:

> I wasn't ready to disclose. So… I started going to one therapist. I went there for a year. And it was all leading up to redisclosure… No sooner did I disclosed everything to my wife that I acted out again. And then… So I had a re-re-disclose like a month later. Because I had… There are no secrets, there's no recovery with secrets, *I have to be honorable*. (Carlos, sex addict)

Others actively resist the label because the term sex addiction:

> reinforces that I have no control over this, I have no responsibility, I'm not "Poor me, the disease got the better of me. I have to go and see the sex worker. No, poor me". That's what this constantly reinforces. The notion of lack of control is, in this context, contradictory because "You feel like you're out of control but you aren't. You really do have control" (Daniel, sex addict)

Some therapists share this hesitancy to use the label for the reason that it would diminish the responsibility of their clients, in line with the "moral model" of responsibility.

> I don't like to say that it's an illness in which you have no control over, it takes over you. It does take over you in certain ways but does that take away responsibility? I don't like to take responsibility away from people. I want them to be responsible for their actions and the choices they make. (psychologist, Montreal)

The eagerness for the freedom of choice is illustrated by one sex addict who, despite his membership to a fellowship, critiques the label on the basis that he refuses to feel powerless:

> You know the second meeting, we came to realize we were powerless over this addiction, that our lives had become unmanageable. That's step one. That never sat well with me. *I always realized I had a choice.* Even when I felt like I didn't, I always made the decision to go to the park or the bathhouse, or a sex worker or whatever. I was trying it for a while, trying that add on to see if it fits, to see if I was powerless. But no, from the very beginning I never really believed that. It just felt it wasn't right. Yes I'm powerless… I felt powerless, *it doesn't mean I am.* (Luke, sex addict)

This perspective was sustained by another sexologist in Canada who mentioned that one of the effects of labelling attends to its potentiality to reduce agency, especially when the label looks as if it provided an excuse without addressing the root of the problem. A therapist from Australia sees it the same way: "See, if you can say 'it's not my fault, I'm an addict', it's letting go responsibility".

To its extreme, this reasoning leads some to suspect that "sex addiction" might only mask their misbehaviours:

> And that's the question I get asked in treatment all the time, especially by wives, is 'I need to know if my husband's an asshole or an addict'. And my job, my specialty, is to be able to answer that question because that is… that's a categorical sort of question we can find criteria for. And if that criteria is not met then that person's just abusing that behavior for some other reasons. (Sex therapist, Australia)

More generally, between lacking control and wanting to assume total responsibility, most of the sex addicts encountered during this study have a variable definition of responsibility in relation to the degree of control they feel they can exercise over their own conducts, which also influences their relation to the label “sex addiction”. This is reflected by the common use of the metaphor of the three circles, promoted in Twelve Steps programs. The “inner circle” encompasses the addictive behaviours in itself (such as watching pornography or being unfaithful). The “middle circle” represents behaviours that are not morally reprehensible but may trigger the addictive behaviour (such as watching television or drinking alcohol). The “outer circle” is the safe zone of admitted behaviour (such as spending time with family or gardening). In terms of responsibility, if addicts cannot control themselves once they act in the “inner circle”, they can still manage to avoid “middle circle behaviours”. This constitutes a “solution” to the contradictory reflex mentioned earlier, and also a way of clearly visualizing the implications of the enlightenment model: responsibility is limited, so one has to be aware of its “dangerous” areas.

But, it also implies that *all behaviours* can be situated, through of and enacted in relation to the addiction. This is what Jackson explains: addiction is “everywhere”—a total experience.

> In terms of things I do for hobbies, that has changed dramatically in the last year as a result of trying to address this addiction, but at present, very little actually. My life is primarily consisting of recovery work, chores, school work, and whenever possible, some religious activities. […]. Fundamentally I think that I now read my entire life through the lens of ‘where does this take me relative to my addiction’? Everything in my life is about the addiction, there is nothing that is not about the addiction.

Others tend to frame responsibility not so much in the act itself but in their relation to how they feel when acting out a certain way: “it’s not so much the act, it’s my relationship to the act. That’s where the distinction lies” (Carl, sex addict). Looking into the types of relationships to the sexual acts being fostered at home, in self-help groups or in the clinic might reveal some of the taken-for-granted normative discourses that prevail and allow to frame responsibility (or lack thereof) as an individual problem.

The Social Location of Responsibility

Interestingly, some therapists challenge this depoliticized and ahistorical standpoint and consider responsibility not at an individual level, but rather as a social problem whose "boundaries change in accordance with the development of new technologies and changing morality around sex" (Sex addiction specialist, Canada). One Australian therapist calls sex addiction a pandemic, largely due to the omnipresent porn industry—a common argument to contextualize the perceived difficulty many have to regulate their sexual behaviour. As a way to highlight the macro-level processes at hand, the same therapist also compares the porn industry to the tobacco industry in that it would use tactics to "hook" people and deny the associate harm, in the same way that it has been done for cigarettes. Moreover, some professionals mentioned the business of sex addiction, wary of the proliferation of treatments and services as it generates more "sex addicts": "so all of a sudden it is a big business and it is a household now, there are these bad sides of it and there is the good side that it gets socially accepted", says a sex therapist in Australia. Note that these general considerations on what is called the "sexualization of society" (Attwood, 2009) do not exclude that some responsibility can be given to individuals, as per Brickman et al.'s (1982) "compensatory model" of responsibility. Whereas therapists take on the role of gatekeeper-educator in the latter model (by labelling the trouble but also by educating, empowering and helping the person build better coping mechanisms) (Zevon et al., 1982), several professionals supplement therapy with Twelve Steps programs, thus providing a more authoritative moral force to the recovery journey. This indicates a movement between the compensatory, moral and enlightenment frames—a co-occurrence of the underlying assumptions that each frame carries.

To summarize, labelling processes come with certain enacted representations of responsibility. On one end, therapists tend to frame responsibility within the boundaries of the moral model (people are fully responsible for their actions), the enlightenment model (their self-destructive impulses require enlightenment that can only be provided by others, and especially disciplining figures, who understand their suffering) and the compensatory model (they are not responsible of their pathogenic contexts but of their reaction to it). On the other end, sex addicts, yet having complex and varied notions of what sex addiction implies in terms of responsibility, are inclined to the enlightenment model. These attributional stances exert a direct and pervasive effect on the process and meanings of labelling in therapeutic encounters as they partially determine what labelling implies for the construction of moral subjects, at least during clinical encounters. More fundamentally, we have shown that, in the case of sex addiction but probably in other cases, labelling processes intertwine with models of responsibility, which converge to produce a type of normative agency in the therapeutic process.

Conclusion

In this chapter, our objective was first to better understand how psy-professionals and self-described sex addicts use, quite reflexively, the label "sex addiction"—how labelling happens in context (Thompson, 2014). Second, we showed that representations of responsibility constitute a core component in this process: the ways in which responsibility is conceived in relation to labelling strongly orients how people engage with a category. We highlighted the multiple intertwinings that can exist between the meanings associated to labelling and responsibility. For therapists, various levels of endorsement and resistance relate to whether sex addiction "really exists" according to them, and whether labelling diminishes or increases the responsibilities of clients. For self-designated sex addicts, what matters is the difficulties of identifying with the category and disclosing it selectively in various settings, maintaining the idea that they had to take responsibility on something that is partly (or completely) out of their control.

In detailing how these meanings were articulated, privileging a micro-social level of analysis that underlies the circulation of a label in societies more generally, we aimed at contributing to the sociological perspectives of the troubled persons industry, taken quite pragmatically as the set of configurations through which certain categories label emotional states and behavioural patterns deemed abnormal (including psychiatry and psychology, but not only). Our scale of analysis makes possible to understand why certain categories, such as sex addiction, become widely used despite their contested status: they make sense for both professionals and labelled people, as much as the labelling processes can be variably appropriated by them, re-defined, resisted to, and resonate with moral perceptions, such as those surrounding responsibility; in other words, a category does not mechanically circulate but needs to be negotiated in multiple settings for it to exist socially. More broadly, we propose that paying close attention to the micro-politics of a label highlights the productive power of the "troubled-persons industry" in relation to the macro-level processes in which everyday meaning-making practices are embedded. This, we hypothesize, makes some grassroots social conditions for psychiatric-like categories such as sex addiction to exist in the troubled persons industry, beyond psychiatry.

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References

Attwood, F. (Ed.). (2009). *Mainstreaming sex: The sexualization of western culture*. I.B. Tauris.

Becker, H. S. (1963). *Outsiders: Studies in the sociology of deviance.* Free Press Glencoe.

Besley, A. C. (Tina). (2002). Foucault and the turn to narrative therapy. *British Journal of Guidance and Counselling, 30*(2), 125–143.

Boyatzis, R. (1998). *Transforming qualitative information: Thematic analysis and codedevelopment*. Sage.

Brickman, P., Rabinowitz, V. C., Karuza, J., Coates, D., Cohn, E., & Kidder, L. (1982). Modelsof helping and coping. *American Psychologist, 37*(4), 368–384.

Briggs, J., & Gough, d. N., & Nair, R. (2017). Losing control in sex addiction: 'Addict' and 'non-addict' accounts. *Sexual and Relationship Therapy, 32*(2), 195–209.

Brossard, B. (2019). Why mental disorders flourish and wither: Extending the theory of ecological Niches. *Social Science and Medicine, 237*, 1–8.

Brown, C., & Augusta-Scott, T. (2007). *Situating knowledge and power in therapeutic alliance*. Sage.

Brown, P. (1995). Naming and framing: The social construction of diagnosis and illness. *Journal of Health and Social Behavior (Extra Issue),* 34–52.

Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five approaches*. Sage.

Dixon, J. (2015). Treatment, deterrence or labelling: Mentally disordered offenders' perspectives on social control. *Sociology of Health & Illness, 37*(8), 1299–1313.

Gusfield, J. R. (1989). Constructing the ownership of social problems: Fun and profit in the welfare state. *Social Problems, 36*(5), 431–441.

Hacking, I. (1998). *Mad travelers*. University Press of Virginia.

Halfmann, D. T. (2011). Recognizing medicalization and demedicalization: Discourses, Practices, and identities. *Health, 16*(2), 186–207.

Irvine, J. M. (1995). Reinventing perversion: Sex addiction and cultural anxieties. *Journal of the History of Sexuality, 5*, 429–450.

Irvine, L. (1999). *Codependant Forevermore: The invention of self in a twelve step group*. The University of Chicago Press.

Keane, H. (2001). Public and private practices: Addiction autobiography and its contradictions. *Contemporary Drug Problem, 28*, 567–595.

Levine, M. P., & Troiden, R. R. (1988). The myth of sexual compulsivity. *Journal of SexResearch, 25*(3), 347–363.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. *Annual Review of Sociology, 27*, 363–385.

Maturo, A. (2012). Medicalization: Current concepts and future directions in a bionic society. *Mens Sana Monographs, 10*(1), 122–133.

Parsons, T. (1951). *The social system.* Routledge & Kegan Paul.

Perry, B. L. (2011). The labeling paradox: Stigma, the Sick role, and social networks in mental illness. *Journal of Health and Social Behavior, 52*, 460–477.

Pienaar, K., & Dilkes-Frayne, E. (2017). Telling different stories, making new realities: The ontological politics of 'addiction' biographies. *International Journal of Drug Policy, 44*, 145–154.

Reay, B., Attwood, N., & Gooder, C. (2015). *Sex addiction: A critical history.* Bristol: Polity

Reid, R., & Kafka, M. (2014). Controversies about hypersexual disorder and the DSM5. *Current Sexual Health Reports, 6*, 259–264.

Scheff, T. J. (1966). *Being mentally III. A sociological theory*. Aldine de Gruyter.

Scheff, T. J. (2010). Updating labelling theory: Normalizing but not enabling. *Nordic Journal of Social Research, 1*(1), 1–7.

Scott, J. C. (1985). *Weapons of the Weak: Everyday forms of peasant resistance*. Yale University Press.

Taylor, K. (2019a). Pornography addiction: The fabrication of a transient sexual disease. *History of the Human Sciences, 32*(5), 56–83.

Taylor, K. (2019b). Nosology and metaphor: How pornography viewers make sense of pornography addiction. *Sexualities, 23*(4), 609–629.

Thompson, G. (2014). Labelling in interactional practice: Applying labeling theory to interactions and interactional analysis. *Symbolic Interaction*, 1–25.

Turowetz, J., & Maynard, D. W. (2019). Documenting diagnosis: Testing, labelling, and the production of medical records in an autism clinic. *Sociology of Health and Illness, 41*(6), 1023–1039.

White, M. (1994). The politics of therapy: Putting to rest the illusion of neutrality. *Dulwich Centre Newsletter, 1*, 1–4.

Wright, A., Jorm, A. F., & Mackinnon, A. J. (2011). Labeling of mental disorders and stigma in young people. *Social Science and Medicine, 73*(4), 498–506.

Zevon, M. A., Jurgis, K. Jr., & Brickman, P. (1982). Responsibility and the elderly: Applications to psychotherapy. *Psychotherapy: Theory Research and Practice, 19*(4), 405–411.

10

Carceral Psychiatry

Ruari-Santiago McBride

Introduction

Psychiatry, as a discipline, consists of individual practitioners, professional bodies, published texts, nosological categories, diagnostic instruments, therapeutic technologies, and specifically designed spaces oriented towards the therapeutic regulation of troubled persons. Since its emergence at the beginning of the nineteenth century, psychiatry has been closely aligned to biopolitical objectives and governmental attempts to manage (sub-) populations through processes of classification, discipline, and punishment (Foucault 1975 [1991]). State-sponsorship has enhanced psychiatry's cultural legitimacy and institutional authority, affording the discipline with significant administrative as well as political power. Psychiatry's ability to produce medico-scientific knowledge about the human mind as well as develop therapeutic technologies capable

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of making individuals more sceptical to self-regulation, meanwhile, has offered governments an ethical basis and practical means to manage its most troubling citizens (Miller & Rose, 1994). The close symbiosis between psychiatric activity-knowledge-power and State attempts to manage troubled persons manifests acutely within the genealogy of carcerality.[1]

Prior to the nineteenth century, 'mad' people in Europe were mostly treated similarly to 'criminals'—they were chained in dungeons and left to rot (Foucault 1965 [1988]). Towards the end of the eighteenth century, 'madness' and 'criminality' began to be conceptually separated by the emerging disciplines of psychiatry and criminology. As the 'mad' became categorically distinguished from the 'bad', specially-designed institutions of containment and isolation emerged to manage these distinct sub-populations—the asylum and the prison (Cooter, 1976). Asylums and the mad were the dominion of psychiatry, while prisons and the bad were criminology's territory. During the nineteenth century, the network of asylums and prisons greatly expanded through state-sponsorship. In England and Wales, for example, there were approximately 5,000 people housed across 21 asylums in 1847, but by 1914 there were over 100,000 contained within 102 public asylums, a figure that rose to over 125,000 people by 1930 (Rutherford, 2003). This rapid escalation in the confinement of 'mad' people meant that many asylums were overcrowded, with conditions denigrating and severe malpractice proliferating (Wright, 1997). The mistreatment of the 'mad' became a source of controversy by the mid-twentieth century, one that snowballed during the 1960s and 1970s into a forceful deinstitutionalisation movement that called for a closure of asylums and a move towards care in the community. The treatment of imprisoned people, however, was not the subject of such moral outrage and the status of prisons as an essential social institution went largely unchallenged for a discussion on prion abolition discourse see McBride [2018]).

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[1] In this chapter I use 'carceral' to refer to the totality of the prison system, including prison policies, physical prison infrastructure, prison rules and protocols, and the actions-knowledge-power of prison staff. 'Carcerality' is used to refer to how this complex system operates to control and discipline prisoners.

Large-scale closure of asylums across the UK began in the 1980s as a radical shift in practice occurred—one that emphasised the human rights of people experiencing mental ill-health and demanded care and support within community-based settings. As deinstitutionalisation took place, the number of people imprisoned rose rapidly (for an in-depth discussion on the relationship between deinstitutionalisation and prison population figures see Ben-Moshe [2017]). Between 1900 and 2017 the prison population in England and Wales quadrupled, with around half of this increase taking place since 1990 (Sturge, 2020). As the prison population was growing, so too did concerns about the number of people in prison experiencing mental disorder and illness. This is reflected in the raft of policy documents published since the 1990s dedicated to the classifying and enumerating 'mentally disordered offenders' within the prison system as well as the development of technical solutions to manage this 'dangerous' (sub) population (Home Office, 1999, 2002, 2005a, 2005b). In the face of a swelling prison population, many of whom were said to have complex mental health needs, the British government drew heavily on psychiatric knowledge and technologies to advance the therapeutic reform of prison and enhance the rehabilitative capacity of prisons (McBride, 2017a). Such therapeutic reforms were ethically legitimised through claims of scientificity and morally justified as attempts to improve prison conditions and reduce danger to prisoners and staff (McBride, 2020).

The effect of therapeutic prisons reforms have been shown to be wide-ranging. Prison staff are trained to be more 'psychologically aware' and attuned to discourses of recovery and risk; while an increasing number of mental health experts—occupational therapists, mental health nurses, social workers, psychologists, psychiatrists—are employed in prisons to assess and treat prisoners (McBride, 2017a). Prison establishments have been refurbished, and new ones designed, to be therapeutic resources capable of assisting imprisoned people to recover from mental ill-health (McBride, 2020). As a result, psychiatric diagnoses and therapies have become increasingly fundamental in matters of criminal sentencing, sentence conditions, parole, and prison recall (Pilgrim, 2001; Reddy, 2002). Ultimately, this enmeshing of psychiatric knowledge and activities within carcerality has emboldened the micro-power of psychiatrists, and other mental health professionals, working within prisons and afforded them considerable authority over the lives of imprisoned people. Yet, despite governmental optimism in psychiatry's capacity to effectively reimagine prisons, therapeutic reforms have been shown to be riddled with ontological and epistemological contradictions as well as technical limitations that render such gains implausible (McBride, 2020). Rather than reform prisons into spaces of care and support for troubled prisoners, therapeutic reforms have deeply implicated psychiatry in the punitive and disciplinary logic of carcerality (McBride, 2017a). Yet, to date, there remains little critical analysis of the role of psychiatry within contemporary carcerality. Furthermore, little attention has been paid to how psychiatry shapes the lives of imprisoned people.

In this chapter, I attend to these identified gaps. First, I offer a critical analysis of contemporary psychiatric discourse on 'prison psychiatry.' In so doing, I outline how the irreconcilability of prison psychiatry and the acculturation of psychiatrists to the carceral logic affects the lives of imprisoned people. I then go on to describe these effects in greater detail through the narratives of formerly imprisoned men. By recounting carceral clinical encounters, I show how psychiatry is explicitly experienced by imprisoned people as a coercive agency of power. To conclude, I argue that a semantic shift away from 'prison psychiatry' to 'carceral psychiatry' is required in recognition of the complex entangling of psychiatric activity-knowledge-power within contemporary carcerality.

A Methodological Note

In this chapter I have adopted a bricolage approach, premised on the analysis of a multitude of 'texts' from a range of sources (Yardely, 2008). The primary texts analysed here include contemporary psychiatric discourse on 'prison psychiatry' (published after 2000) and the transcripts of interviews with five former prisoners. The interview transcripts were generated as part of an ethnographic study I undertook of prison mental health policy and practice (2011–2014), which involved me attending a mental health unit in a high security prison and working closely with a peer-support organisation led by former prisoners. I conducted approximately 30 interviews with the former prisoners, mental health service users, psychologists, psychiatrists, prison officers, governors, and policy makers I met along the way (for more on this methodology see Browne and McBride [2015] and McBride [2017b]).

The analysis presented is critical. My reading of 'prison psychiatry' is heavily influenced by the works of Foucault (1975 [1991]), Miller and Rose (1994), and Rose (1998), which direct us to consider how the discipline of psychiatry as a branch of knowledge and social practice is orientated towards untroubling troubled people through techniques of control and self-regulation. My reading of 'prison psychiatry' is further influenced by scholars such as Davis (2003), Wacquant (2009), and Scott (2013) who draw attention to the ways in which contemporary prison systems operate to manage (sub-) populations classified as troubling within capitalist societies (i.e. the poor, people of colour, migrants) in ways that are harmful for the individual as well as devastating for the communities they come from/return to. Finally, this analysis builds on the work of Brown (2008) and McBride (2017b) who highlight the importance of listening to prisoners' accounts of their experiences and undertaking scholarship with the implicit aim of challenging the dehumanisation of imprisoned people. As such, the critical analysis presented here is attuned to the complex permeations of carceral power that riddle through 'prison psychiatry' and how such permeations intersect across the lives of imprisoned people.

'Prison Psychiatry'

Irreconcilability, Acculturation and Harmful Effects

In the mid-twentieth century, Powelson and Bendix (1951) published a study on '*Psychiatry in Prison*.' An in-depth discussion of their article here offers a valuable watermark to critically reflect upon contemporary discourse on 'prison psychiatry.' Writing within the context of the USA, Powelson (a psychiatrist) and Bendix (a sociologist) saw the treatment of prisoners as one of the 'major social problems of our time' (1951:

73). The authors delineated what they considered to be the distinctiveness of the liberal rehabilitative approach of medical staff and the disciplinary approach of custodial staff, describing how these contrasting occupational orientations produce constant tension in everyday practice. Powelson and Bendix highlight how these competing orientations generate differing perceptions of prisoners. On the one hand, the norms of psychiatry, they suggest, places emphasis on the mental health of the person, creates recognition that actions are determined by a person's emotional history, and requires the suspense of moral judgement of a person's actions for the sake of therapeutic success. On the other hand, the norms of custody frames prisoners as cunning malingerers (particularly in relation to mental health issues) whose actions reflect their depravity and, as such, necessitates punishment for any violation of prison rules. The authors also stress that custody staff outnumber mental health staff and have the final say in prison decision-making, which gives custody ultimate 'power over' prisoners. Consequently, Powelson and Bendix argue that there is an inherent *irreconcilability of psychiatric practice within carceral space* since all therapeutic work in prison is inflected by securitised operational paradigms and the punitive staff culture, which subordinates prisoner 'health' in favour of order and discipline.

Powelson and Bendix go on to argue that irreconcilability of psychiatry in prison means that psychiatrists who hope to promote rehabilitation and health "cannot, in fact, pursue this goal" since the physical conditions and the mental climate surrounding medical and psychiatric aid within prisons "make ordinary standards of medical and psychiatric practice completely inapplicable" (1951: 81). Reinforcing this claim the authors suggest the prevailing occupational culture of custody frames compassion as a weakness and hardness as a strength, meaning the characteristics of good psychiatric practice are devalued in prisons. Powelson and Bendix polemically outline how this leaves prison psychiatrists with four options: (1) become an officer, and stop pretence of practicing medicine; (2) adopt custody's punitive attitude towards the prisoner; (3) practice psychiatry without appreciation of the futility of this work; or, (4) become aware of the irreconcilability of practicing psychiatry in prison and leave the prison to practice elsewhere. The authors feel many psychiatrists will come to tolerate the gulf between aims and actual practice of psychiatry in prison and, over time, begin to adopt the prevailing attitudes of custody staff (i.e., that prisoners are morally weak malingerers who are criminals by choice or due to personal failure). The *acculturation of psychiatrists to the norms of carcerality* means that in many respects psychiatrists practicing in prisons come to act in the best interests of institutional order and discipline as opposed to the health needs of prisoners.

Powelson and Bendix argue that the irreconcilability of prison psychiatry and the acculturation of prison psychiatrists affects prisoners in numerous ways. First, due to the prevailing attitudes among custody staff, any application to psychiatry may be held against prisoners as further evidence of their malingering tendencies. Second, the dispensation of pharmaceutical drugs is limited and clinical encounters curtailed due to security protocols, which severely erode the quality of care provided. Third, the enmeshing of prison psychiatry within the carceral logic means that prisons are offered 'therapies' that typically have punitive or disciplinary implications (at the time Powelson and Bendix indicate this included: electric shock, insulin shock, fever treatment, hydrotherapy, amytal and pentothal interviews, cisternals and spinals). As such, Powelson and Bendix indicate that the enmeshing of psychiatry within the carceral logic results in many prisoners being dissuaded from seeking psychiatric assistance, denied the care they require, or subjected to ethically questionable 'treatment.' The critical points raised by Powelson and Bendix provide a useful benchmark for reading through contemporary psychiatric discourse on 'prison psychiatry.'

Contemporary Psychiatric Discourse on 'prison Psychiatry'

Almost 70 years on from Powelson and Bendix's study, prison psychiatry is considered "an important part of institutional operations" (Collins et al., 2017: 34). Many contemporary commentators frame the prominence of psychiatry in prisons as an inevitable consequence of the high level of mental disorder and illness among imprisoned people.

Indeed, it is routinely stated that around two-thirds (60–80%) of people serving a prison sentence have a mental disorder and/or engage in substance misuse (see Konard et al., 2007, 2012). The wide-scale psycho-pathologisation of prisoners relates to changes in the psychometric assessment of prisoners (Appelbaum et al., 2001). Historically, surveys of psychiatric morbidity among prisons used narrow definitions of mental illness, which focused on major depressive disorder, bipolar disorder, schizophrenia, and other psychotic disorders. At the turn of the twentieth century, psychometric assessments were broadened to include other diagnoses, most notably (and controversially) personality disorder (McBride, 2017a). The effect of this was a doubling of the percentage levels of prisoners said to have a mental health condition (Appelbaum et al., 2001). This re-classification of a large proportion of prisoners as mentally disordered/ill greatly increased the ambit of psychiatric authority within prisons and amplified the salience of psychiatric knowledge, classification, and intervention in penal policy (McBride, 2017a). As such, contemporary psychiatric discourse is foreshadowed by a view of prisoners as inherently troubled persons with a plethora of psychiatric needs. This has resulted in considerable focus being placed on technical solutions, such as developing standardised psychiatric assessment on committal and the development of psychiatric interventions tailored to the prison context (see Konrad et al., 2007, 2012). Thus, changes in assessments procedures, which radically increased the rates of prisoners categorised as in psychiatric need, have led many contemporary commentators to sidestep the ‘social and political’ question of whether people with mental disorder/illness should be detained in prisons and focus on how best to ‘treat’ this troubled (sub-) population.

The normative operational principle underpinning contemporary psychiatric practice in prisons is the ‘principle of equivalence’, which asserts “therapeutic levels of care in the community should prevail in the care of incarcerated mentally disordered persons” (Konard et al., 2007: 111). As such, psychiatric care in prison is considered most effective when delivered by a multidisciplinary team of psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, and other mental health professionals (Appelbaum et al., 2001). Yet, owing to the comparatively low levels, and variable standards, of prison mental health services, most commentators are doubtful that most prisoners receive care that is appropriate and/or equivalent to that which is offered in the community (Konard et al., 2007; Till et al., 2014). Consequently, contemporary psychiatric care reasserts the theme of irreconcilability identified by Powelson and Bendix (1951), with many stressing how the ‘uniqueness’ of prison environments restricts the quality of treament provided (Till et al., 2014).

Contemporary commentators outline a range of institutional features that impair the practice of psychiatry in prison. System challenges, including limited healthcare budgets and overcrowding, are said to hamper the delivery of prison mental health services (Konrad et al., 2012). Rigid operational structures and tight security protocols, meanwhile, are identified as greatly affecting the delivery of psychiatric services. This is acutely apparent in pharmacy services, where the prescribing of psychopharmaceuticals is hindered by formula restrictions and dispensing procedures that are primarily geared towards preventing the diversion of medication for non-medical use (Collins, et al., 2017). Meanwhile, for psychiatric treatment to be effective within prisons it is acknowledged that custody staff have a role in supporting multidisciplinary mental health teams. However, collaboration between these different professional groups is often tainted by a lack of mutual respect, differences in occupational training, poor communication, and limited cooperation (Appelbaum et al., 2001; in line with the distinct orientations of psychiatry and custody described by Powelson and Bendix [1951]). The unique environmental constraints psychiatrists encounter within prisons are therefore acknowledged as eroding psychiatric practice in prison to the point whereby mental health services and supports are often rudimentary in comparison to equivalent services in the community.

Contemporary commentators highlight how psychiatric services in prisons are not just rudimentary, but also difficult to access due to custody status, concerns about confidentiality, fear of being perceived as weak or being seen as colluding with staff, confusion around treatment pathways, and concerns about staff qualifications (Collinset al., 2017; Till et al., 2014). Consequently, prisoners often only get treatment if they are perceived to be at risk of harm to self or others (Konrad et al., 2012). Access barriers are further compounded by the nature of the prison environment, with separation from family, the threat of physical harm, and solidarity confinement identified as major stressors for prisoners (Appelbaum et al., 2001; Konrad et al., 2012). This potent mixture of rudimentary services, access barriers, and environmental stressors results in many people experiencing an acute deterioration in their mental health while in prison, which can lead to self-injurious behaviour and suicide (Till et al., 2014). However, rather than such insights leading to calls for the radical transformation of the carceral system, they are used to underscore the importance of providing effective psychiatric interventions to ensure the safe operation of penal institutions (Collins et al., 2017).

In line with the theme of acculturation thoroughly discussed by Powelson and Bendix (1951), many contemporary commentators indicate that the prevailing ethos of security and discipline within prisons leans on prison psychiatrists, tilting them to practices of surveillance and control. This can involve prison psychiatrists being placed "in ethically questionable territory" and being asked to "carry out psychopharmacological or other medical interventions for which there is no primary medical indication, in order to allow judicial proceedings and the penal system to run smoothly" (Konrad et al., 2012: 378). In addition, to being pressured to 'do something' about prisoners' behavioural problems, psychiatrists are commonly required to participate in disciplinary proceedings and "work with administrators in determining sanctions" (Collins et al., 2017: 35). Although these insights point to the nefarious ways psychiatric practice is pushed towards aiding institutional security to the detriment of individual well-being, unlike Powelson and Bendix (1951), contemporary commentators reflect little on how the securitisation of psychiatric practice may, or may not, result in the acculturation of psychiatrists to the prevailing carceral logic. As such, within contemporary psychiatric discourse there is an almost total absence of consideration of the *iatrogenic potentialities of carceral psychiatry*.[2]

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[2] 'Iatrogenic' is used here to describe harm and illness caused by medical examination and/or treatment.

In fact, acculturation of psychiatrists to the prevailing logic of carcerality can be discerned *within* contemporary psychiatric discourse. For example, many contemporary commentators problematise prisoners experiencing emotional instability and psychological pain. Prisoners experiencing psychosis/depression are often identifed as potentially aggressive and violent, with prisoners diagnosed with antisocial personality disorder (claimed to be one-third of all prisoners) said to pose a particular danger (Konrad et al., 2012). Concerns around aggressive and dangerous behaviour have led to claims that "[s]ymptomatic inmates can impair the safe and efficient operation of a correctional facility" (Appelbaum et al., 2001: 1344). Appelbaum et al. (2001) go on to outline how the prison environment can overwhelm prisoners with limited coping skills and result in functional deterioration, infractions, and time on lock-up, which exacerbates the person's mental deterioration and leads to self-mutilation and suicide attempts. This, the authors Appelbaum et al. lament (2001: 1344), disrupts "the operation of the prison" and impairs safety and order within prisons by consuming time and resources. Such a perspective indicates acceptance that some prisoners who make suicidal gestures or attempts are manipulative, with those with "antisocial or sociopathic personalities […] more prone to manipulative attempts" (Konrad, 2012: 377). Collins et al. (2017) also warn that malingering and feigning illness is also a genuine concern. Manipulative prisoners, they suggest, exaggerate claims because it may benefit their legal situation, result in a lesser sentence, exonerate their guilt, support an appeal, enable them to access desired housing, entitle them to disability claims on release, enable them to avoid conflict, work, and disciplinary procedures, *and* to be prescribed medications. Consequently, the moralised judgement of prisoner actions, which Powelson and Bendix (1951) identified as integral to the culture of custody, is palpable within contemporary psychiatric discourse. This suggests that contemporary psychiatric discourse is uncritically adoptive of the logic of carcerality, to the point whereby the knowledge, practices, and technologies of psychiatry are unproblematically aligned with the operational aims of, and cultural tendencies within prisons. As Till et al., (2014: 180) suggest, the public health imperative of psychiatry is to improve and protect the psychological health of prisoners *and* assist “their decision to lead law-abiding, useful lives after release” (Till et al., 2014: 180). As such, ‘prison psychiatry’ may be better labelled ‘carceral psychiatry,’ since psychiatrists in prison do not simply aim to alleviate psychological distress and improve mental health among prisoners, but *also* consciously work to maintain security and discipline within prison as well as make society safer by making individual troubled persons more socially obedient.

It is striking that within the contemporary psychiatric discourse reviewed here there is no meaningful consideration of the acculturation of psychiatrists to carceral norms and the potential this has for unprofessional behaviour, inhumane/degrading treatment, and the unnecessary application of force by mental health professionals. Nor is there any discussion of how psychiatric diagnosis, labelling and medication operates within the system of surveillance and punishment used to manage and discipline prisoners. Ultimately, this points to a dehumanising perspective of prisoners and a lack of concern with how prisoners experience their encounters with psychiatrists.

Prisoners’ Encounters with Carceral Psychiatry

Iatrogenic Effects

The former prisoners who took part in interviews discussed how life within prison assaulted their mental health. Bruce, a former prisoner in his thirties, explained that he had adverse childhood experiences and in his adult life experienced depression. He had served multiple short sentences for non-violent crimes. He recounted one such sentence and how life in prison affected his mental health:

> I got lifted for two burglaries a lot of years ago. I admitted them when I was caught. How long did I spend on remand? Fourteen months. Of nothing. Smoking dope, taking drugs because at that time the only available option for you [on remand] was Maths and English GCSE, which I didn’t want to do. I got four years that time, but I’d done fourteen

> months on remand, so I had ten months left, it takes about two months to get through the system and then there is eight months [left of your sentence]. [...] Eight months is basically no time to do anything and by that time you are demoralised by the fact that you've been in prison so long. You're doing nothing but drugs all day because that's what you do. You have no other reason to get up in the morning except go looking for drugs because, I got addicted to this heroin substitute.

Being imprisoned for over a year on remand (unsentenced) meant Bruce had few opportunities to fill his days with meaningful and fulfilling activities. This is because most education and employment opportunities as well as therapeutic services and supports are denied to prisoners on remand, who may (if found not guilty) be removed from prison at any time. As a result, the finite opportunities and resources that exist in prison are directed at sentenced prisoners and geared towards the conditions and length of their sentence. Ultimately, it was this lack of educational, employment and therapeutic opportunities that led Bruce to become addicted to a readily available psychopharmaceutical drug.

Conor, who was in his forties and had served a long sentence for a violent offence, explained how during his time in prison he witnessed fellow prisoners experience a deterioration in their mental health. He explained how the psychopharmacological technologies employed to treat prisoners could have iatrogenic effects:

> People either sink or swim [in prison]. I found education, I had my support from my network of friends and family. I seen guys who I thought were level-headed begin to manifest mental health problems, paranoia, I think it comes with the boredom of not being able to fill your time constructively. I seen them getting hooked on tablets. [Fellow prisoner] was on all kinds of medication. The next time I saw him years later he was blown up fat and didn't know what day of the week it was. Like he had a lobotomy or something. I think it was the tablets over the years.

For Conor, the overreliance on psychopharmacology as the primary treatment modality for prisoners not only harmed individuals, but greatly affected the entire prison population by creating a cultural dependency on psychotropic medications:

> The drug culture in prison isn't heroin, cannabis and all that. The drug culture in prison is prescribed medication. Morphine tablets, any kind of opiate, that's the real problem in the prison system.

Chris, who was in his 50 s and served a long sentence for a violent crime, reasserted the point that many prisoners become addicted to psychopharmaceuticals while in prison. He argued that addiction to psychopharmaceuticals was a problem that is exported from prisons into communities, which results in people released from prison engaging in criminalised acts and getting sucked into a revolving door of short sentences:

> So it's actually starting in the jail and going [out into] community. So that's why I am saying [the prison system] creates monsters who come out. If you have the drugs in jail freely and you come out [and the drugs are] not there, what's the first thing on your mind to do? You go on the rob or break into houses to get what you want. There's fellas in there they're so hooked on drugs they go back in all the time because [drugs] is easier to get inside.

Acculturated Mistrust

Gerry, who was in his 40s and had been imprisoned for a non-violent offence, described how he felt the prevailing ethos of security and discipline within prisons leaned on mental health staff and bent their perceptions about prisoners. He described how the acculturation of mental health staff unfolded in practice:

> You have to recognise the insidious nature, the controlling nature of the institution. The poison touches every aspect of the institution such that it's very easy I believe for mental health staff to, and medical staff in general to, believe the worst of people because they hear it day-in, day-out from the prison officers.

Psychiatry's acculturation to the logic and norms of carcerality, Gerry felt, inevitably shaded the perceptions of psychiatrists, and led them to adopt the biases of prison staff. Consequently, he argued that many mental health staff came to view prisoners from an adversarial logic that framed prisoners as universally inclined towards dishonest and manipulative behaviour. The clinical mistrust of prisoners' intentions was further exacerbated by the perceived desirability of psychopharmacology, as Conor's experience shows:

> This guy used to tell me about the voices [he was hearing] and he was thinking of self-harming. So I was left in a bit of a dilemma here, what do I do with this guy? Couldn't very well tell the screws [prison officers], they are my enemy. […] So I went to the doctor […] and he said 'what can I do for you?' I said 'listen, I know a guy on the landing and he is speaking about self-harming and I think you maybe need to have a talk with him. I don't like going to the prison officers about it, I am telling you and I know you will keep this confidential.' He turned round and said to me 'are youse looking more tablets?' And I said 'listen, fuck off!' And got up and walked out. But I did see then the next day the psychiatric nurse took him off to the hospital building. […] I was very disappointed in the doctor's attitude. He thought we were playing the game. So a lot of the medical staff have to overcome their prejudice too.

An acculturated mistrust of prisoners' motives was considered to foreshadow most, if not all, clinical interactions between prisoners and psychiatrists. As Conor's tone indicates, this clinical mistrust is experienced as a fundamental betrayal, since it indicates an unfair bias that undermines the prisoners' capacity to act with integrity. Therefore, as Gerry suggests above, many prisoners come to view mental health staff as just another part of the carceral system that is intent on disciplining them.

Labels of Control

Former prisoners described how psychiatric diagnostic labels are used as a primary means through which psychiatrists exercise control over prisoners. Notably, personality disorder was identified as a label often used to classify prisoners considered troubling by prison authorities. As Chris explained:

> [The prison psychiatrist] said I had a personality disorder and then the [second psychiatrist] turned around to me and said 'no, you haven't.' And, [the third psychiatrist] said the same. I was originally diagnosed because it was easier to tag me than to admit that I couldn't be defeated. 'Cause I was stubborn, because I wouldn't speak to the ordinary prison officers and I wasn't a right run around of the mill of a prisoner. I just didn't like authority. So it was easy to tag me with something wrong with me. If you know what I mean? It was easy for their way of thinking. We can say he is a personality disorder or a mental case. [...] It's their way of staying controlled.

For Chris, acts of non-compliance and anti-authoritarian behaviour lead prisoners to be 'tagged' with a diagnosis of a mental disorder; and that such psychiatric classification strengthens prison authorities' legitimacy to manage and discipline troubling prisoners. Gerry likewise experienced being labelled with a personality disorder as a form of punishment for his 'difficult' and 'challenging' behaviour. He explained how after 26 one-hour sessions with a psychologist he was recommended for a 'cognitive self-change' programme designed for men with a history of violent crime and that he challenged this decision because he was in prison for his first and only criminal offence:

> It went bad from the start, I brought out my pen and she said 'what are you doing?' I said, 'if you are going to memorialise what we say here, just to keep things right, I'll keep my own notes.' She took offence to this because I think she saw this as a challenge to her authority. [...] She got very upset with me challenging why I was doing these courses and the interview was terminated. She basically blackmailed me that 'I could write you a bad report' and I said 'well I am writing this down

> myself so we can get an officer in as a third party witness'. She stormed off finally and after that interview, when I got the report, I found I had a personality disorder, which I didn't have before. Which really worried me because it was coming to the time that I would be due for my parole. This was far into my sentence. So what I had to do was see my solicitor about if we could get legal aid to get another psychologist in to write a different report to rubbish the first psychologist. But when I discussed it with my solicitor she said 'this is very bad. They've got you down here as a personality disorder'. And I said, 'well the outside psychologist we get what if he or she writes a report that agrees with the colleague?' The solicitor says, 'don't worry about it we pay them, they write what we tell them to write.' And I thought well the whole fucking thing is a racket. Of course, we got a higher psychologist in, trumped your woman's report with his report. Everything was sweet. […] As far as the personality disorder I believe I was given that label to suit your woman's ends, she wanted to punish me and this she thought would get me when she had the power to do it. […] They said I had a problem with authority. I don't think I had a problem with authority as such I think I had a problem with individuals in authority who I think were acting unjustly.

As Gerry's experience shows, mental health professionals have the potential to wield psychiatric diagnoses vindictively to satisfy their personal vendettas. Being labelled with a psychiatric diagnosis, particularly personality disorder, can have real and long-term consequences for prisoners since it will be considered a risk factor in relation to a person's release from prison (e.g., the person may be considered to pose a danger to others if diagnosed with anti-social personality disorder, or to themselves if diagnosed with borderline personality disorder). Ultimately, the threat of psychiatric labelling compels prisoners to moderate their behaviour in line with institutional rules and to comply with professional decisions even if they experienced them to be unjust. This underscores how the application of psychiatric diagnostic categories within prisons implicitly and explicitly aims to make prisoners more obedient and malleable to control.

Gerry noted that within the securitised logic of prison institutions people psychiatrically labelled are classified as a potential danger to the smooth operation of the institution. Gerry described how psychiatric labelling, as a result, legitimised the mobilisation of security techniques of isolation, segregation, and surveillance, rather than illicit therapeutic responses:

> The nature of the institution is that anyone who shows any signs of having any problems, which may threaten the stability of the institution is simply dealt with in a draconian way because the values and the security of the institution are absolutely paramount. […] If it is even seen that [prisoners] might be in that frame of mind [where they might harm themselves or others] they will simply be moved out of the general population to somewhere where they can be kept an eye on.

Psychopharmacological Technologies of Control

Former prisoners identified psychopharmacological technologies as another primary means through which psychiatrists exercise control over prisoners. Bruce explained how life in prison affected him psychologically to the point that he sought medical support, which resulted in him being offered debilitating psychopharmacological medicine:

> I went to the doctors in [prison] a couple of times because I was agitated, I was wound up, I was anxious and they stuck me on this blooming Chlorpromazine [an anti-psychotic]! Do you what? They give that to everybody. But, see how crap it makes you feel. […] I am not saying I should've been given Diazepam [anti-anxiety medication], but it wasn't even an option. The thing is when you get Diazepam you can still carry on your normal everyday tasks, it just sedates you a bit. You don't feel crap. The stuff they give you, sometimes you do get the impression that they give you it and they don't care how you actually feel, how you carry out your daily duties, tasks whatever, just as long as you are calm.

Bruce recognised that the medication available to him, and other prisoners, was greatly restricted due to security protocols designed to limit the supply of highly addictive medications. As a consequence of the securitised logic underpinning pharmacy options, Bruce was offered medication designed to treat psychotic disorders, as opposed to the anxiety he was experiencing. He found the medication given to him to have a pronounced sedative effect that resulted in drowsiness and tiredness. In this way, Bruce's experiences reflect how within the carceral logic debilitating psychopharmacological technologies are preferred by prison authorities as the effects of pacification produced align with operational demands for order.

Chris felt strongly that prisoners classified as difficult or disruptive were offered potent psychopharmacology to control their behaviour. As such, he felt psychiatric technologies were purposefully mobilised by prison authorities for their sedative, rather than therapeutic effects, in an attempt to control 'difficult' prisoners:

> When I was inside they tried to offer me every drug you could name. [They offered me] that liquid stuff, does your brains in. Calms ye right down, and you're sleeping all the time. I wouldn't take nothing. 'Cause I didn't need them. I could sleep perfectly. There was nothing wrong [with me] except I had a mind. And maybe that's what they didn't like.

Discussion

Since the 1990s, the British government has engaged in the unprecedent therapeutic reform of its carceral system, which has resulted in psychiatric knowledge, diagnostic categories, assessment instruments, and treatment technologies becoming embedded in prison policy and practice at an unprecedented scale (McBride, 2017a, 2020). Therapeutic prison reforms have been framed as morally pertinent because of psychiatry's claim to ethically driven practice that forefronts patients' health and well-being as well as the discipline's intervention modalities claim to scientificity. As such, therapeutic prison reforms have seductive liberal appeal because they claim the capacity to simultaneously protect and improve prisoner mental health, support prisoner rehabilitation and desistance from crime, *and* diminish the overreliance on negative security and disciplinary measures within prisons. In this chapter, I have shown how contemporary psychiatric discourse rearticulates this optimism in the capacity of therapeutic knowledge and technologies to make prisons less harmful and more rehabilitative. Consequently, the ongoing failings of prison mental health care are said to be due to systemic factors and the chaotic, needy and manipulative actions of prisoners. As such, contemporary psychiatric discourse is predominately orientated towards providing practical professional advice on how to negotiate the challenges of the prison environment, and to developing technical solutions to overcome the irreconcilability of psychiatry in prison.

Yet, through the narratives of former prisoners I have shown how the practice of psychiatry in prisons is unable to escape the effervescent securitised logic and punitive norms that permeate the carceral system. Consequently, psychiatrists become intimately embroiled in the control and disciplining of prisoners. As such, I argue there is a pressing need to move beyond acritical descriptions of 'prison psychiatry' and the challenges psychiatrists practicing in prisons face; and a moral imperative to critically reflect on 'carceral psychiatry' and the implications of psychiatrists acting as agents of control and discipline within contemporary carceral geographies. Moving forward there is thus scope for an intellectual project aimed at examining the heterogeneous permutations through which psychiatric activity-knowledge-power is contextually adopted and adapted to carceral logics of security and discipline. This will provide an understanding of the diversity of processes and practices through which psychiatry upholds and magnifies carceral power over troubled persons.

Such an intellectual project will reveal the extent to which carceral psychiatry operates to legitimise the carceral system as a site in which troubled people can/should receive therapeutic care and support. This will enable detailed considerations of the degree to which contemporary psychiatric discourse encourages cultural and financial investment in carceral systems. Further critical reflection on carceral psychiatry must thus be orientated to the ways in which therapeutic reforms legitimise the expansion of carceral systems and divert finite public funds away from housing, education, employment, health and welfare services in the community. Ultimately, there is a need within contemporary psychiatric discourse, and beyond, to consider how the activity-knowledge-power of carceral psychiatry emboldens the punitive capacity of the state, while simultaneously distracting from non-carceral measures capable of reducing the social inequality and marginalisation implicit in the biographies of people sent to prison.

References

Appelbaum, K. L., Hickey, J. M., & Packer, I. (2001). The role of correctional officers in multidisciplinary mental health care in prisons. *Psychiatric Services, 52*(10), 1343–1347.

Ben-Moshe, L. (2017). Why prisons are not ""The New Asylums."' *Punishment & Society, 19*(3), 272–289. https://doi.org/10.1177/1462474517704852

Brown, D. (2008). Giving voice: The prisoner and discursive citizenship. In T. Anthony & C. Cunneen (Eds.), *the critical criminology companion* (pp. 228–239). Hawkins Press.

Browne, B., & McBride, R.-S. (2015). Politically sensitive encounters: Ethnography, access and the benefits of 'hanging out.' *Qualitative Sociology Review, 11*(1), 34–50.

Collins, T. N., Avondoglio, J. B., & Terry, L. M. (2017). Correctional psychopharmacology: Pitfalls, challenges, and victories of prescribing in a correctional setting. *International Review of Psychiatry, 29*(1), 34–44. https://doi.org/10.1080/09540261.2016.1235017

Cooter, R. J. (1976). Phrenology and British Alienists, c. 1825–1845, Part II: Doctrine and practice. *Medical History*, *20*(2), 135–151.

Davis, A. (2003). *Are prisons obsolete?* Seven Stories Press.

Foucault, M. (1975 [1991]). *Discipline and punish: The birth of the prison.* Penguin.

Home Office. (1999). *Managing dangerous people with severe personality disorder: Proposals for policy development*. Home Office.

Home Office. (2002). *Justice for all*. Home Office.

Home Office. (2005a). *Forensic personality disorder: Medium secure and community pilot services*. Home Office.

Home Office (2005b). *Dangerous and Severe Personality Disorder (DSPD): High secure services for men.* Home Office.

Konrad, N., Arboleda-Florez, J., Jager, A. D., Naudts, K., Taborda, J., & Tataru, N. (2007). Prison psychiatry. *International Journal of Prisoner Health, 3*(2), 111–113. https://doi.org/10.1080/17449200701321498

Konrad, N., Welke, J., & Opitz-Welke, A. (2012). Prison psychiatry. *Forensic Psychiatry, 25*(5): 375–380. https://doi.org/10.1097/YCO.0b013e328356b7c3

McBride, R.-S. (2017a). On the advancement of therapeutic penality: Therapeutic authority, personality science and the therapeutic community. *Sociology of Health and Illness, 39*(7), 1258–1272.

McBride, R-S. (2017b). Towards hope, solidarity and re-humanisation. In S. Armstrong, J. Blaustein & A. Henry (Eds.), *Reflexivity and criminal justice: Intersections of policy, practice and research* (pp. 81–100). Palgrave Macmillan.

McBride, R.-S. (2018). A future without prisons: Science fiction, anarchism, and the abolition of prisons in the north of Ireland. *Irish Journal of Anthropolgy* (21), 102–115.

McBride, R.-S. (2020). Shifting Carceral formations: A Genealogy of Penal (Re) construction in the North of Ireland. In F. McCann (Ed.), *The carceral network in Ireland: History, agency and resistance* (pp. 47–74). Palgrave Macmillan.

Miller, P., & Rose, N. (1994). On therapeutic authority: Psychoanalytical expertise under advanced liberalism. *History of the Human Sciences, 7*(3), 29–64.

Pilgrim, D. (2001). Disordered personalities and disordered concepts. *Journal of Mental Health, 10*(3), 253–265.

Powelson, H., & Bendix, R. (1951). Psychiatry in prison. *Psychiatry, 14*(1), 73–86. https://doi.org/10.1080/00332747.1951.11022811

Reddy, S. (2002). Temporarily insane: Pathologising cultural difference in American criminal courts. *Sociology of Health & Illness, 24*(5), 667–687.

Rose, N. (1998). Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law, 5*(2), 177–195. https://doi.org/10.1080/13218719809524933

Rutherford, S. (2003). *The landscapes of public Lunatic asylums in England, 1808–1914*. Doctoral Thesis: De Montfort University, Leicester.

Scott, D., (2013). Visualising an Abolitionist Real Utopia: Principles, policy and praxis. In M. Malloch & B. Munro (Eds.), *Crime, critique and Utopia: Themes for a critical criminology*. Palgrave.

Sturge, G. (2020). *UK Prison population statistics*. Briefing Paper Number CBP-04334. House of Commons Library.

Till, A., Forrester, A., & Exworthy, T. (2014). The development of equivalence as a mechanism to improve prison healthcare. *Journal of the Royal Society of Medicine, 10*(5), 179–182. https://doi.org/10.1177/0141076814523949

Wacquant, L. (2009). *Punishing the poor: The Neoliberal government of social insecurity*. Duke University Press.

Wright, D. (1997). Getting out of the asylum: Understanding the confinement of the insane in the nineteenth century. *Social History of Medicine, 10*(1), 137–155. https://doi.org/10.1093/shm/10.1.137.PMID11619188

Yardely, A. (2008). Piecing together: A methodological bricolage. *Forum: Qualitative Social Research*, *9*(2): Art. 31. https://doi.org/10.17169/fqs-9.2.416

11

Cannabis Use and Mental Health: Paradoxes of Medicalization

William Dolphin and Michelle Newhart

Since the late 1990s, when the first "medical marijuana" laws were enacted by voter initiatives in the U.S., an increasing number of people from across the life span have adopted cannabis use to treat a broad range of medical conditions. As of 2021, at least 30 countries and almost all U.S. states allow the use of cannabis or a cannabis derivative as a

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[1] Estimation is required because not all U.S. states track medical cannabis patient numbers. California, the first and most populous state to allow medicinal use, does not require registration. In 15 states, anyone aged 21 years or older is not required to register with their state to gain legal access to cannabis, and research has shown that many of them are using cannabis to treat a medical problem (Bachhuber et al., 2019).

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treatment for specific conditions. More than 4.3 million people[1] participate in medical cannabis programs in the U.S. alone (MPP, 2020). Yet many of the medical professionals charged with gatekeeping those programs remain skeptical of its efficacy (Charuvastra et al., 2005), and not without reason. The clinical evidence for using cannabis in treatment is limited or nonexistent for most conditions; cannabis remains formally classified in the U.S. and most countries as having no use in medical treatment; and so-called recreational uses remain stigmatized. That legacy of the classification of cannabis as a drug of abuse makes it easy for physicians to dismiss cannabis success stories as anecdotal and the individuals who report them as unreliable. Of the many conditions people claim to treat successfully with cannabis, the most controversial are those associated with mental health. Here, at the intersection of cannabis use and mental health, is a contest between two seemingly contradictory views of cannabis—one that originates with authoritative outside observers classifying its effects as pathology, the other defined largely by laypersons' subjective experiences of effective self-medication.

Cannabis has long been associated with psychosis. Since the nascent days of psychiatry, doctors have said that its use can trigger insanity and that cannabis intoxication is itself a form of psychosis. Even today, citations to those nineteenth-century pronouncements are common, and many medical experts point to strong associations between cannabis use and a subsequent diagnosis of a psychotic or mood disorder as evidence that cannabis is the culprit (Di Forti et al., 2019; Hosseini & Oremus, 2019). That perceived risk is a reason doctors cite for resisting patient use of cannabis for any condition (Jacobs et al., 2019). Yet the evidence is far from straightforward. Clinical assessments are contradicted by patient accounts. Individuals with mental health problems use cannabis at much higher rates than the general population, but those individual users consistently report that cannabis eases their symptoms and helps them cope (Hides, 2012; Lobbana et al., 2010). In fact, of the millions of people who use cannabis therapeutically, roughly half say they do so to manage their mental health—most commonly anxiety and depression but also an array of other mental health complaints. This is consistent across multiple settings, including the U.S., Australia, New Zealand, and the United Kingdom (Lintzeris et al., 2020; Pledger et al., 2016; Sexton et al., 2016; Ware et al., 2005). Many people experiencing psychological distress perceive cannabis not as the source of their mental health problem but as a useful treatment for it (Fichtner & Moss, 2017). One way to understand the disjuncture between the views of medical professionals and the public is as a consequence of competing medicalizations.

Medicalization may arise from reframing deviant behavior as illness or disease by describing it in medical language and integrating it within medical institutions (Conrad, 2007). This process shifts the locus of social control to physicians and other medical professionals, who are tasked with bringing troubled people into "the stream of 'adjusted citizens'" (Gusfield, 2014). The process of medicalizing mental health was spurred by the accidental discovery in the 1950s and 1960s of medications that seemed useful for treating psychiatric conditions. The mechanisms of action of these drugs were (and remain) largely unknown, but their apparent effectiveness signaled a possible underlying biological dysfunction—consistent with the view of mental illness that emerged from the mid-twentieth-century discovery that neuro-syphilis psychosis, which was then common, could be cured by a course of antibiotics. With the shift in the late 1970s from a psychoanalytic paradigm to a statistically driven, biomedical model for mental health diagnoses—as adopted by the third edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980—mental health may be seen as completely medicalized (Bruce, 1999; Conrad & Barker, 2010; Conrad & Slodden, 2013; Davis, 2019). That is not to suggest that mental health diagnoses are uncontroversial; this chapter will explore in detail problems with the validity and reliability of such diagnoses as they are applied to cannabis users in many forms, from schizophrenia to use disorders.

In other cases of medicalization, such as with therapeutic cannabis use, the reclassification process is driven by affected individuals, who campaign for medical recognition of their condition or treatment as legitimately medical. Currently, cannabis exists in a limbo of partial medicalization, where therapeutic uses coexist uneasily with non-medical ones, and cannabis intoxication remains formally classified as a mental disorder. Once medicalization is complete, a medical framework is taken for granted and seems self-evident, but partial medicalization foregrounds the categorization as tentative and makes doctors and other professionals responsible for judging what fits the category and what does not. This power to label people as subject to institutional control is inherent in the organizations, agencies, and professions that constitute the troubled persons industry (Loseke, 2003, pp. 141–143), but with cannabis use and mental health, the enduring, multilayered stigmas complicate interpretations. Because there are ambiguities, categorizations are interpreted and applied locally in ways that are effectively arbitrary and capricious. In this context, the patient-driven medicalization of cannabis use may be seen as an insurgency built on localized resistance that challenges the authority of both medicine and law enforcement to categorize and control cannabis users.

This chapter explores the paradoxical views of medical professionals and laypersons on how cannabis use affects mental health, which may be explained in part by applying the concepts of system and lifeworld first proposed by Habermas. As Habermas distinguishes them, a "system" such as medicine or the law is constituted by a society's economy and government and carries out their imperatives following ostensibly rational, objective rules. This differs from the "lifeworld" of the everyday, where decisions rely on cultural and relational logics that assess risk and benefits by balancing objective criteria with personal identity and a pragmatic sense of "what works." As agents of a system tasked with treating troubled persons, psychiatrists and other physicians focus on system concerns such as treatment success, patient compliance, and institutional integrity. By contrast, the patients they treat are typically concerned with lifeworld considerations: How to balance symptom control and drug side effects to function, carry out roles, maintain relationships, and maximize "quality of life" (Britten, 2008).

Psychiatrists and their patients arrive at contradictory estimations of the role of cannabis in mental health for complex historical reasons. A review of some of those developments shows how the institutional medicalization of cannabis use as psychological pathology developed and is now being challenged by individuals seeking legitimacy for their use of cannabis in self-treatment. Two areas will receive close attention in this chapter: The contradictory interpretations of how cannabis use affects people diagnosed with schizophrenia, and problems with the diagnosis of cannabis use disorder in the context of medicinal use.

Stigma in a Realm of Scientific Uncertainty

Cannabis use and mental disorders occupy a nexus of scientific uncertainty. While much has been discovered over the past few decades, we lack a full scientific understanding of cannabis and its effects on the mind and body. Similarly, we lack answers to many fundamental questions about mental health. The absence of definitive evidence for basic aspects of each creates opportunities for social constructions to influence categorization and to stand in as a form of certainty, making those gaps less obvious and less problematic for practical decision making. The shift with the DSM-III to a standardized descriptive psychology imparted a stronger scientific and clinical identity to psychiatry, but the new clinical language obscured many enduring scientific uncertainties about most mental health problems. Validity could not be established for many of the constructs it employed for diagnosing conditions because the data simply did not exist (Carson, 1991; Greenberg, 2013). It was less clinical classification than naming scheme—nomenclature posing as nosology. This approach is rife with problems, not least for understanding cannabis use and its effects.

The effects from cannabis use have been classified as mental health disorders since the beginning of psychiatry (Moreau, 1973 [1845]). Early psychiatric researchers thought they might better understand the experience of psychosis by inducing altered mental states with large doses of cannabis (Ames, 1958; Moreau, 1973). The accounts of their experiments with cannabis, coupled with case studies of similarly naïve users under the influence of unusually high doses or multiple substances (Talbott & Teague, 1969), solidified the historical interpretation of its effects as part of the psychosis paradigm, where it has remained through evolving diagnoses and diagnostic criteria. Each of the DSM's five editions has pathologized cannabis use in multiple ways, including classifying "cannabis intoxication" as a mental disorder (American Psychiatric Association, 1952, 1968, 1980, 1994, 2013).

As cannabis use was popularized through the countercultural movements of the 1960s, it became of increasing interest to researchers and policy makers. Scientists identified in 1964 the chemical primarily responsible for cannabis' psychoactive effects, delta-9-tetrahydrocannabinol (THC), but researchers focused almost exclusively on elaborating its deleterious effects rather than its medical applications (Pertwee, 2006). This orientation informed the placement of cannabis in the most restrictive categories of drug scheduling regimes, defined by international treaties and laws in the U.S. and elsewhere as a highly dangerous drug of abuse with no current use in medical treatment. Now legally classified as more dangerous and less useful than cocaine or amphetamines, cannabis became "Public Enemy Number One" in the American "war on drugs" launched by President Richard Nixon in 1971. Criminalization of cannabis and other drugs was a useful tool to exert control on specific groups for political ends[2] and justified pumping billions of dollars into the troubled persons industries, from policing, courts, and correctional control to drug testing, addiction treatment, and counseling. Cannabis enforcement escalated dramatically in the U.S. in the 1990s, with highly disproportionate effects on communities of color (King & Mauer, 2006), even as citizen advocates, often from marginalized communities, began to carve out legal exceptions for medical use through ballot initiatives in several states.

The cultural affiliations and racial associations of cannabis shaped enduring stereotypes of its users as troubled persons, and the purported harms of cannabis use were reified in the language of science. For half a century, U.S. and international drug policy agencies have influenced research agendas and obstructed attempts to have cannabis rescheduled to legitimize medicinal uses. For instance, clinical research studies on cannabis in the U.S. must be approved by and receive research materials from federal agencies charged with preventing drug abuse. Those barriers

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[2] President Nixon's chief of staff publicly acknowledged that the "war on drugs" was primarily a means of targeting their political enemies, and that the administration knowingly lied to the public about drug risks (Baum, 2016).

to research on therapeutic applications, coupled with ample funding for delineating the harms and pathologies from cannabis use, have skewed the scientific literature in ways that can deceive doctors about the balance of evidence (Gupta, 2013). Analysis of the last two decades of cannabis research in the U.S., Canada, and the U.K. finds that research focused on the harms of cannabis received twenty times more funding than investigation of its therapeutic potential (Hudson, 2020).

Claims about the harms of cannabis use have focused increasingly on mental health—how it affects personality, behaviors, cognition, memory, and learning, and how it may exacerbate or cause conditions such as anxiety, depression, and schizophrenia. To use a crude but revealing measure, the number of published medical articles devoted to a connection between cannabis use and psychosis has increased dramatically over the past three decades,[3] increasing from fewer than 50 in the 1990s to more than 300 in the 2000s, before ballooning to over 1,300 in the 2010s. The trend line remains steep, with more than 175 such articles published in 2020. Of those, only four describe therapeutic potential for cannabis, and three of them are restricted to cannabidiol (CBD), which is not intoxicating. The others overwhelmingly describe a problematic relationship between cannabis use and psychosis and warn against its use by anyone with a mental health problem. This increased attention does not coincide with the development of conclusive or consistent evidence that cannabis use can cause or exacerbate mental disorders—even in schizophrenia, the condition receiving the most study (Gage et al., 2013). Nor is this dramatic increase mirrored by comparably increased interest in the association of other substances with psychosis, though there are many. For the same time period, the number of articles each decade on psychosis related to the use of cocaine, amphetamines, and alcohol doubled or less, as compared to the six-fold increase of those about cannabis and psychosis. The most obvious parallel trend to this increased concern about cannabis is not scientific discovery but expanding medicinal use and increasingly liberal policies, a social trend

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[3] As determined by a search of the medical database PubMed for the terms ‘psychosis’ and ‘cannabis’ or ‘marijuana’.

many medical articles comment on in framing the importance of their research.

Harm-focused scientific research and cultural stigma have been mutually reinforcing, yielding a distorted record of cannabis, its applications, and its risks. The medical system in which psychiatrists are trained and operate obstructs the path to integrating cannabis. The scientific research literature's focus on cannabis as a drug of abuse informs the clinical training of medical professionals, whose main understanding of cannabis is in the context of its potential negative physical, mental, and behavioral outcomes. Even though medical cannabis has now been legally available to millions of people since 1997, only 9% of medical school deans in the U.S. report that any medical cannabis training is included in their curriculum (Evanoff et al., 2017), and surveys of physicians-in-training in the U.S. and Canada consistently find that medical students lack knowledge and want more education on medical uses of cannabis (Chan et al., 2017; Evanoff et al., 2017; St. Pierre et al., 2020). Some residency programs in the U.S. are beginning to address this need, with many now including at least one hour of cannabis curriculum and a few providing clinical experiences, though program directors still assess their residents as insufficiently trained in this area (Philbrick et al., 2020).

Lack of training means psychiatrists and other physicians generally know little about the potential medical applications of cannabis, hampering their ability to provide information and make judgments about their patients' use of cannabis products (Chan et al., 2017; Kondrad & Reid, 2013; Sideris et al., 2018). Most psychiatrists and other physicians cannot answer basic questions about cannabis. A majority of Australian psychiatrists did not know the difference between THC and CBD—chemicals that produce diametrically different effects—and reported concerns about cannabis use leading to psychotic symptoms (Jacobs et al., 2019). Three out of four U.S. physicians, including psychiatrists, say they do not have enough information to answer questions about CBD, though more than 90% reported being asked about it by their patients (Greenhalgh, 2019). Given this professional uncertainty, it is not surprising that few psychiatrists endorse their patients' use of cannabis for mental health conditions.

The reluctance to add or adapt professional training to reflect changes in science, policy, and patient demand for information may stem from the multi-layered entrenchment that defines and defends a troubled persons industry that has cannabis users as clients. Some psychiatrists consider cannabis to be a form of complementary and alternative treatment that does not conform to pharmaceutical standards for consistency and purity, placing it outside the scope of psychiatry's current biomedical model of practice. Others consider it pseudoscience—snake oil that has no place in medicine because it threatens their patients' health. That view is sustained by the legal classification of cannabis as a dangerous drug of abuse with no currently accepted use in medical treatment.[4] One survey of psychiatrists' attitudes on cannabis found that while 40% might prescribe it in some cases, 11% would consider doing so only in pill form (Kweskin, 2013). The "only in pill form" qualification suggests an attempt to meet system expectations in an environment of incomplete medicalization. Standardization of medicines is critical to prescribing, and cannabis and products made from it have been quite variable historically, though commercially available cannabis products in regulated environments are subject to testing and labeling requirements to ensure purity and consistency (Corroon et al., 2020). "Pill form" does not just signify standardization. "Pill" differentiates forms of cannabis produced by pharmaceutical companies, which are part of the formal system of medicine by definition, from those produced outside institutional boundaries. The distinction is based on a threat not to health but to the medical system.

Most doctors are not comfortable discussing cannabis with their patients and resist providing the paperwork to participate in medical cannabis programs (Karanges et al., 2018; Lombardi et al., 2020; Pergam et al., 2017; Philpot et al., 2019). Across specialties, physicians in the U.S. are less supportive of medical cannabis than the general public. In 2004, only 36% of doctors expressed support for it being a legal medical option (Charuvastra et al., 2005), as contrasted with 80% public support in a national poll two years before, which has risen to around

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[4] That determination was made decades before the discovery of the primary receptor system on which cannabinoids operate, and despite more than 2,000 years of documented medicinal use in China and India (Brand & Zhao, 2017; Russo, 2005).

90% as of 2019. (Pew Research Center, 2019; Quinnipac University, 2019; Stein, 2002; Wronski, 2019). Even in Colorado, a state that has been at the forefront of making cannabis legally available, a majority of physicians oppose it being a legal option (Kondrad & Reid, 2013). Clinicians express concern with the inconsistent evidence of risks and benefits from cannabis use. A 2017 review of the therapeutic uses of cannabis in psychiatric treatment within the mental health literature points to the "prominence of mental health" among the reasons medicinal cannabis is used, and acknowledges its potential for use in treatment of conditions such as PTSD, while also noting a "dearth of high-quality evidence" to justify such use (Walsh et al., 2017).

Incomplete medicalization leaves physicians in a fraught relationship with cannabis. They often have little domain-specific expertise on the therapeutic applications of cannabis but must fill an authoritative role and protect institutional prerogatives when dealing with patients who ask them about it—as many now do, often to their doctor's dismay (Philpot et al., 2019). Without training or formal protocols for incorporating cannabis products into patient care, health professionals often supplement their scientific understanding with pre-existing opinions based on their personal experience or the experiences of those in their family or social circles (Kondrad & Reid, 2013). Physician attitudes are also influenced by what their patients tell them about medicinal cannabis use—or don't. While doctors report increasing questions about CBD and cannabis, many patients fear being stigmatized by their doctor for even broaching the subject (Newhart & Dolphin, 2019). The difficulty in predicting the opinion of medical professionals may explain why one study found that roughly half of patients who use cannabis medicinally don't tell their primary care physicians about it (Kondrad & Reid, 2013).

Claims about the problematic nature of cannabis use and its effects still dominate the scientific literature, allowing ongoing work to advance claims about the harms of cannabis use with ostensible certainty. This is the case across many claims: Cannabis intoxication is transient psychosis; it can trigger schizophrenia; it lowers IQ and cognitive function; it impairs motor skills in dangerous ways; even casual adolescent experimentation increases the risk of long-term mental health problems. Yet each of these claims is based on weak or limited evidence and has been challenged by contrary evidence. The mischaracterization of the degree of certainty that may be claimed based on studies with obvious limitations or bias is another form of resistance to revising the system's interpretation of cannabis. Cannabis is far from unique in this respect. As Gusfield (1981) noted about the portrayal of the risks of drinking and driving: "the body of knowledge […] begins as uncertain, inconsistent, and inaccurate. Almost from the moment of conception, it is fashioned into a public system of certain and consistent knowledge in ways which heighten its believability and its dramatic impact" (53). For any physician, even considering—much less accepting—the therapeutic potential of cannabis means challenging the system that defines and empowers their professional identity.

Cannabis Use as Pathology

As mentioned at the onset of this discussion, the medicalization of mental health has been advanced in the successive editions of the DSM, and each edition has classified effects of cannabis use as mental maladies. The cannabis-related psychiatric diagnoses fall into two categories: substance use disorders and psychotic disorders. As with other instances of medicalization, these classifications have helped reframe deviant behaviors as illness (in this case, the social problem of cannabis use) and bring them under the control of medical professionals and institutions (Conrad, 2007). Understanding the effects of cannabis use as psychosis or substance use disorder may lessen the sense of individual responsibility for the associated use behaviors and help shield them from moral judgment. However, the medical model also tends to reduce attention paid to social-structural factors, decontextualizing behavior, and bringing the focus of concern to the individual (Conrad & Schneider, 1998 [1980]). Partial or incomplete medicalization further burdens individuals with the responsibility to establish their cannabis use behaviors as legitimate (Newhart & Dolphin, 2019). Whether it is judged as legitimate by others is often based on social-structural factors associated with beliefs about use, including age, race, gender, and social class.

In the current diagnostic manual, DSM-5, the substance use diagnoses in question include *Cannabis Use Disorders* (with separate diagnoses for mild or moderate to severe); *Cannabis Use Disorders in remission* (also either mild or moderate to severe); and *Cannabis Withdrawal Syndrome*. Psychotic effects include *Cannabis Intoxication* and *Cannabis-Induced Psychotic Disorder,* which are often understood as on a continuum that leads to schizophrenia. Substance use disorders and psychosis may seem quite different, but there is substantial overlap between the diagnosis of CUD and other mental disorders. The frequency of these dual diagnoses is used to argue a causal relationship between problematic cannabis use and psychological difficulties, but in what follows we will argue that it may instead reflect fundamental misunderstandings of cannabis use behaviors and effects.

Cannabis Use and Schizophrenia

Schizophrenia is rare, affecting between 0.25% and 0.64% of the global population, but it has been the subject of intense scrutiny in the psychiatric literature because its devastating effects can include disability and premature death (NIMH, 2018). Whether schizophrenia is one condition or many remains unclear; nor is there consensus on which factors associated with it, such as migration and childhood trauma, contribute to its development. What is clear is that substance use is strongly associated with schizophrenia, and not just cannabis. Persons diagnosed with the disorder are far more likely than the general public to be heavy users of tobacco, alcohol, stimulants, and narcotics. Historically, they also tend to be dissatisfied with pharmaceutical treatment options, which many patients and their families view as harmful, and seek alternatives with fewer side effects (Harrington, 2019, p. 181). Some see cannabis as one such alternative.

Four major findings have dominated the psychiatric literature about the relationship between cannabis and schizophrenia. First, high rates of cannabis use are found among those diagnosed with schizophrenia. Second, there are strong associations between cannabis use and subsequent schizophrenia diagnoses. Third, findings indicate a dose–response effect in which more cannabis use correlates with greater likelihood of a schizophrenia diagnosis. Fourth, the ability to induce transient psychotic-like symptoms in experimental studies by having non-psychotic people ingest cannabis indicates that the two conditions share characteristics (Zammit et al., 2012). The cognitive effects of cannabis use are linked to the symptoms of schizophrenia, as are perceptual alterations such as sensitization to sensory experiences (Solowij, 2018). Correlation is not causation, but statistical analysis of the prevalence and timing of cannabis use relative to symptom onset leads many researchers to argue that cannabis use causes schizophrenia in individuals who would not otherwise develop it (e.g., Castle et al., 2012).

The claim that cannabis use causes or worsens schizophrenia has been disseminated as if it is an established fact. It is not (e.g., Gage et al., 2013; Ksir & Hart, 2016). Arguments in support of the theory take recourse to case studies, brain imaging, and sophisticated statistical analyses of both longitudinal cohort data and large-scale surveys of self-reported drug-taking behaviors. Much of this evidence can seem compelling, yet the theory of causation has been directly tested by the expansion of cannabis use. If cannabis use caused schizophrenia in individuals who would not otherwise develop it, a corresponding rise in the incidence rate of schizophrenia would be seen in those countries where use among young people increased since the late 1960s (Hickman et al., 2007). Instead, studies indicate that the incidence of schizophrenia has been either stable or declining (Degenhardt et al., 2003; Frisher et al., 2009; Macleod et al., 2004). Similarly, if cannabis use caused schizophrenia, a difference in cannabis use rates between countries would produce a parallel difference in schizophrenia rates. People in Iceland, Ghana, and Canada, for instance, are 200 times more likely to use cannabis than people in Singapore, China, and Qatar. Yet there is no significant difference in how likely people in each of these countries are to be diagnosed with schizophrenia (Charlson et al., 2018; Jablensky, 2000).

The absence of population-level effects of increasing cannabis use on schizophrenia incidence rates invites inventive explanations from experts defending the causal paradigm. Consider the counterargument offered by Zammit, Arseneault, Cannon, and Murray in the second edition of *Marijuana and Madness*, a critically acclaimed, award-winning edited volume from Cambridge University Press. The authors proffer three possibilities. First, they suggest that the incidence rate might be measured incorrectly because diagnostic standards and hospital admission practices change over time (Zammit et al., 2012). To the extent that institutionalization has been used as a proxy for measuring schizophrenia diagnoses, a change to outpatient mental health care will affect that data, but admissions rate is not the only available measure. National health systems and insurance plans in the U.S. collect diagnostic information that are likely to reveal any increases, irrespective of hospital practices, and schizophrenia is a source of sufficient concern to ensure surveillance. Increased rates of alternative mental health diagnoses have been noted, suggesting that those who may have been diagnosed with schizophrenia in the past are not today, but that says more about the validity problems of the diagnostic criteria than anything about the effects of cannabis use. Second, Zammit et al. argue that not enough time may have passed since cannabis use became more prevalent for the increased cases of schizophrenia to appear2012. The window for that explanation to be plausible is long past. The increase in cannabis use rates among teens and young adults began more than 50 years ago, making people in the leading edge of that wave well more than 60 years old today, but onset of schizophrenia is typically late adolescence or early adulthood, with a median age of 20 for diagnoses for males (American Psychiatric Association, 2013) and prevalence peaking around age 40 (Charlson et al., 2018). Third, and most remarkably, the authors speculate that cannabis may have, in fact, created more cases of schizophrenia, but other unidentifiable risk factors may have been simultaneously reduced to just such a degree that they would “nullify the effects of increasing cannabis use” (Zammit et al., 2012, p. 180). This, the authors concede, “is not possible to know”—a perfect coincidence of counterbalancing factors for which, conveniently, there can be no evidence. These divergent attempts at explaining why more cannabis use does not result in more schizophrenia diagnoses illustrate how system “logic” can be twisted to serve institutional paradigms. Rationality gives way to rationalization, even in the hands of noted experts operating from a position of institutional privilege—or perhaps particularly then.

Recent meta-analyses of the research literature on the cannabis-schizophrenia connection have found that much of it is low quality, and the literature that remains does not definitively establish a causal relationship; in fact, there is substantial evidence for reverse causation—meaning the mental health issues drive the cannabis use (Gillespie & Kendler, 2020). Much of the argument for causation relies on timing: Some teens who use cannabis go on to develop schizophrenia (Carney et al., 2017). Yet, as Ksir and Hart (2016) note, that sequence "merely reflects the typical course of development," with cannabis use often beginning in adolescence and schizophrenia symptoms surfacing in early adulthood. For some predisposed individuals, cannabis use and psychosis may simply develop in parallel (McLaren et al., 2010), along with other disorders and "problem behaviors" (Ksir & Hart, 2016). This model acknowledges that cannabis use does not take place isolated from other social and cultural influences, and that schizophrenia is linked to a wide number of variables, which include a heritable component as well as environmental factors such as exposures to toxins and childhood trauma. In this view, cannabis use has no defined relationship to the person's mental disorder. Instead, both are more likely to occur among individuals who have endured a biological insult and resultant stress, or stress caused by social circumstances or trauma.

Self-treating Schizophrenia with Cannabis

Others have suggested that cannabis use among individuals diagnosed with schizophrenia and other mental disorders may be explained as self-medication, even when heavy use precedes diagnosis (Bizzarri et al., 2009; Hazekamp & Pappas, 2014; Khantzian, 1987, 1997; Pettersen et al., 2013). Almost all people diagnosed with schizophrenia have difficulty managing "negative symptoms" such as anxiety, depression, and difficulty socializing. These negative symptoms are typically more debilitating than "positive symptoms" such as hallucinations and delusions. While antipsychotic drugs often reduce positive symptoms, a common lament in the literature is the absence of effective treatment options for negative symptoms (e.g., Erhart et al., 2006; Harvard, 2006).

Those diagnosed with schizophrenia or schizotypal disorder who also use cannabis report that it helps them cope and relieves the negative symptoms (Bizzarri et al., 2009; Dekker et al., 2009; Gregg et al., 2007; Hides, 2012; Mueser et al., 1995; Schaub et al., 2008; Schofield et al., 2006). The unusually high prevalence of cannabis use among this group prior to diagnosis has been used to argue against the self-medication hypothesis; however, the onset or increase of use may be related to self-managing the onset of prodromal symptoms—bothersome signs of the impending problem that do not yet meet the diagnostic threshold. Continuing use among those suffering symptoms of schizophrenia is explicitly tied to a desire to enhance quality of life and reduce negative emotions, as it is for persons with other forms of psychological dysfunction and distress (Dekker et al., 2009; Gregg et al., 2007; Moitra et al., 2015).

Individual reports of improvement are supported by case studies and emerging clinical research that also indicate cannabis and cannabinoids may play a role in treating schizophrenia (Coulston et al., 2011; Manseau & Goff, 2015; Schwarcz et al., 2009). Evidence is mixed and inconclusive, but the expansion of clinical research into this area has led to identification of physical biomarkers that are tentatively linked to both schizophrenia and the function of the endogenous cannabinoid system (ECS), the master regulatory system that is engaged by cannabis use (Gupta & Kulhara, 2010; Müller-Vahl & Emrich, 2008). Brain inflammation has been identified in schizophrenia-diagnosed persons (Müller et al., 2015), and oxidative stress is implicated in neuropsychiatric disorders, including anxiety, depression, and schizophrenia (Salim, 2014). The phyto-cannabinoids THC and CBD both exert powerful anti-inflammatory and anti-oxidative effects and are neuroprotective (Bilkei-Gorzo, 2012; Manseau & Goff, 2015; Skaper & Di Marzo, 2012). Autoimmune dysfunction may also play a role in the development of schizophrenia (Chaudhry et al., 2020). The ECS is a critical regulator of immune function, and phyto-cannabinoids have been shown to suppress the immune response (Almogi-Hazan & Or, 2020).

The first clinically focused systematic review of cannabis across major psychiatric disorders found limited evidence for the use of CBD in treatment of anxiety and promising indications for its use as an adjunctive treatment of schizophrenia (Sarris et al., 2020). Basic research is beginning to explain how CBD affects the ECS, suggesting explanations for its capability to produce antipsychotic effects comparable to the most commonly used pharmaceuticals (Mandolini et al., 2018). Despite its connection to cannabis, CBD is emerging as an alternative antipsychotic as effective as conventional medications but with far fewer side effects (Fakhoury, 2016; Iseger & Bossong, 2015; Leweke et al., 2009; Schubart et al., 2014; Zuardi et al., 2012, 1995). Indications for the treatment of schizophrenia with CBD are particularly promising (Deiana, 2013; McGuire et al., 2018; Morgan & Curran, 2008).

Cannabis Out of Context: DSM Use Disorders

Among the concerns about people who use cannabis is that they may misuse or abuse it and develop a dependence or other use disorder. In the U.S., Cannabis Use Disorder (CUD) is estimated to affect between 1.5 and 2.5% of adults, or roughly 3 to 5 million Americans (Compton et al., 2019; Hasin et al., 2016). Use disorders are DSM mental health diagnoses, but they overlap to a remarkable degree with the diagnosis of other mental disorders (Hasin et al., 2016; Kedzior & Laeber, 2014; Lev-Ran et al., 2013; Moitra et al., 2015). That strong association lends itself to a perception that one is the consequence of the other, but problems with CUD diagnostic criteria may play a role. A medical user maintaining a consistent, self-determined dosing schedule may, to an outside observer, be indistinguishable from a dependent drug user. Indeed, many medical users of cannabis "depend" on cannabis to manage symptoms that might otherwise be debilitating. Persons who use cannabis in conjunction with psychological distress consistently say they do so to cope with unpleasant emotions, be more sociable, and enhance their lives, with some reporting relief of specific symptoms or side effects (all of which sounds like therapeutic use), but their behavior is nonetheless likely to be diagnosed as disorder (Spencer et al., 2002). The problem is one of poor diagnostic validity stemming from a failure to consider the context and motivations for cannabis use—what it means for the person using it.

The DSM-III adopted an atheoretical biomedical model that reframed mental health problems as "discrete, disease-like entities," a move that ostensibly made context immaterial to diagnosis. (Harrington, 2019; Robinson & Adinoff, 2016; Surís et al., 2016; Whooley, 2019). Nonetheless, the DSM has historically allowed for consideration of the context of medical use of a drug when diagnosing substance abuse or use disorders. The first and second editions of the DSM excluded prescribed medications entirely from substance abuse diagnoses (American Psychiatric Association, 1952, 1968). The DSM-III explicitly acknowledged that its classifications of substance use varied based on cultural factors, and some diagnostic criteria were excluded when a substance was prescribed. Those differences in criteria used to assess the effects of prescribed and non-prescribed substances persist through DSM-5.

The DSM's atheoretical approach has obscured its underlying values (Sadler et al., 1994). The unacknowledged social forces can be seen perhaps most vividly in one of the criteria historically employed to diagnose substance abuse and dependence: legal problems. Used in DSM-III and DSM-IV (American Psychiatric Association, 1980, 1994), the legal problems criterion made the diagnostic system "vulnerable to powerful, swiftly changing social forces such as the tightening of laws," which meant that the "actions of a legislature in a particular state can determine the number of residents who met DSM-III criteria for a mental disorder" (Rounsaville et al., 1986). Medicinal cannabis use intensifies the quandary this creates for physicians and individuals they treat, with considerable consequence. A study conducted before any medical cannabis laws had been enacted found that 44% of U.S. oncologists had recommended to at least one patient that they use cannabis illegally to control chemotherapy-related vomiting (Doblin & Kleinman, 1991). That means their patients who complied with their doctor's advice (behavior the medical system always seeks to enforce) were simultaneously making themselves vulnerable to legal trouble and, consequently, a mental disorder diagnosis. Between the year the first state medical cannabis law went into effect in 1997 and 2013, the year the "legal problems" criterion was abandoned in the DSM-5 revision, an individual's state of residence could determine whether a cannabis use disorder was diagnosed. For some, diagnosis hinged on emerging changes in social policy, not symptoms. The legal problems criterion was removed in DSM-5, but validity problems remain, especially with medicinal use.

A DSM-5 use disorder is not even a syndrome with a specific combination of symptoms; instead, it is "a very broad and heterogenous condition" that can be found based on "over 2000 combinations of diagnostic criteria" (Saunders, 2017, p. 230). Cannabis use presents particular challenges for assessment by outside observers, as seen in researcher's attempts to validate CUD as defined in recent editions of the DSM in relation to the International Classification of Diseases (ICD) standard. For instance, a study of interrater reliability comparing the DSM-IV and ICD-10 found no agreement[5] between the two systems in clinical assessments of cannabis abuse (Rounsaville et al., 1993, p. 343). DSM-5 fares little better. DSM-5 criteria find double the number of problem users than ICD-11, and produce "far higher" rates of serious cannabis use problems than DSM-IV (Lago et al., 2016).

In troubled persons industries, a critical job of "system actors" (i.e., those who work within these industries) is identifying their clients through categorization—legitimizing the fit between the person's behavior and a defined social problem (Loseke, 2003, p. 141). Yet, whatever concerns for cannabis use disorder clinicians may have, the classification systems do not agree on who these troubled people may be. Given how consequential such a categorization is for the person so labeled, this is disturbing. More alarming is the institutional response to these inconsistencies. Rather than conceding that the validity and reliability problems of the classification system may cast doubt on the disorder as a category, the inconsistencies are explained away with claims that diagnostic systems are successfully identifying different groups of problem users, so the appropriate choice of which classification system to use may depend on "the population of interest" (Lago et al., 2016). In other words, the clinician may pick whichever criteria creates a client.

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[5] The Cohen's Kappa coefficient of interrater reliability was 0.15, an astonishingly low rate of agreement that indicates less than 4% of the diagnoses are reliable.

Problems Assessing CUD in Medicinal Cannabis Users

The limitations of the purportedly atheoretical diagnostic tools for assessing Cannabis Use Disorder (CUD) are especially clear when looking at the assessment of medical cannabis users. The atheoretical approach excludes social contexts and individual motivations for behaviors related to cannabis.[6] Yet the legal problems criterion is not the only one that violates two definitional requirements of diagnosis under the DSM: (1) that the condition involves psychological or biological dysfunction, and (2) that purported symptoms did not reflect social conflict or societal attempts to control behaviors (Wakefield & Schmitz, 2011). Social conflict also often underlies "symptoms" such as disagreements with family members about substance use. Both social and familial disapproval may contribute to intense anxiety or excessive use (Robinson & Adinoff, 2016), but these are not harms caused directly by a dysfunction; they are social consequences of a stigmatized behavior. The failure to take into account either the context of an individual's behavior or their intention—what those behaviors mean to that person—makes these diagnostic criteria prone to producing "false positives" (Wakefield & Schmitz, 2011).

Another challenge from incomplete medicalization is evident in the difference in how DSM diagnostic criteria are applied to people using prescribed pharmaceutical medications versus those who use cannabis on the recommendation of a physician. Unlike prior editions of the DSM that did not acknowledge the possibility of any legitimate cannabis use, the DSM-5 suggests that "[a]lthough medical uses of cannabis remain controversial and equivocal, use for medical circumstances should be considered when a diagnosis is being made" (American Psychiatric Association, 2013, p. 512), and those circumstances may affect a clinician's assessment of tolerance and withdrawal symptoms in diagnosing CUD. This guidance, qualified as it is with explicit skepticism of the legitimacy

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[6] The DSM-5 is not the only assessment tool that fails to consider substance use behaviors in context. Analysis of the World Health Organization's ASSIST instrument shows that it also suffers from an over-emphasis on frequency of cannabis use, a failure to consider quantities consumed on a given day, and a rejection of the contexts for substance use, i.e. networks and environment (Asbridge et al., 2014).

of medicinal cannabis, does not preclude diagnosing the medical user with cannabis use disorder. Nor does it provide any direction about what the consideration for medicinal use might reasonably constitute. Because nonmedical uses exist alongside medical ones, the blurred boundaries between medical and problematic uses of cannabis are subject to interpretation in the clinical context (Reid, 2020). By contrast, when opioids are prescribed, the DSM-5 flatly directs clinicians to exclude tolerance and dependence from the diagnostic criteria. The difference in assessing a use disorder related to opioids versus cannabis reflects social forces and perceived legitimacy, not clinical differences. Perception of legitimacy is key when clinicians are directed to rely on their subjective discretion.

The DSM-5 exclusion of dependence and tolerance criteria for prescribed drugs acknowledges the lived reality of persons who rely on potentially addictive substances for symptom relief, but it also marks a boundary between system and lifeworld substance use. So long as a substance is provided and consumed within the boundaries of institutional medicine, negative effects are deemed acceptable. Cannabis users are not afforded the same contextual consideration, even though tolerance, dependence, and dangerous side effects are much more pronounced with many pharmaceutical drugs. The chronic use of opioids, for instance, produces physical adaptations that result, without fail, in unpleasant withdrawal symptoms with cessation.[7] By contrast, cannabis withdrawal syndrome is mild, on par with caffeine withdrawal, and it affects fewer than one in five frequent users and, intriguingly, fewer than half of those judged dependent (Bahji et al., 2020; Hasin et al., 2016). The variability and relatively low incidence of withdrawal among chronic cannabis users call into question its validity as a criterion for identifying a disorder and highlights the problem of reasoning by analogy from substances such as alcohol, as we will discuss next.

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[7] Cannabis can function as an "exit drug" from opioid dependence by easing withdrawal (Armentano, 2017). Availability of legal medicinal cannabis is associated with a reduction in opioid prescriptions (Bradford et al., 2018) and fewer fatal opioid overdoses (Averett & Smith, 2019). Research indicates an "opioid sparing" effect of cannabis use (Nielsen et al., 2017), and people living with chronic pain effectively substitute cannabis for opioids (Lucas, 2012; Lucas & Walsh, 2017).

The most common criterion for arriving at a CUD diagnosis is "use in dangerous contexts" (Blanco et al., 2008). Much of the conventional wisdom on cannabis use and its risks reflects reasoning by analogy from alcohol use (Rounsaville et al., 1993, p. 344), consistent with the DSM's history of making no distinctions between types of substance disorders (Saunders et al., 2007). Yet there are crucial differences in behavioral effects of cannabis and other intoxicants, particularly alcohol. Comparing cannabis with alcohol is fundamentally faulty. Alcohol intoxication is categorically different in its effects, impairing judgment at least as quickly as it degrades motor skills, which can heighten risk by increasing recklessness. By contrast, cannabis intoxication produces less motor skill impairment than alcohol and more self-awareness. As a result, cannabis users tend to overestimate their motor impairment and act more cautiously, not less (Sewell et al., 2009). Gusfield (1981) demonstrated the many ways that accident risk and scientific certainty are overstated in relation to alcohol to justify criminalizing drinking-driving. Such claims are considerably more exaggerated with cannabis, and the driving impairment laws even more arbitrary and draconian.

There is no consensus on the accident risk associated with cannabis use—far from it. A comprehensive accident study conducted by the U.S. National Highway Transportation Safety Administration found no association between cannabis use and car wrecks (after adjusting for factors such as age and gender), in contrast to a considerable correlation with alcohol use that is consistent with a host of studies (Lacey & Compton, 2016). Studies in Canada and the U.K. similarly concluded that cannabis use was not culpable for traffic accidents (CSSCID, 2002; Sexton et al., 2000), and at least one review found cannabis use may reduce accident risk (Bates & Blakely, 1999). Researchers have attempted to provide an evidence-based answer to the risks of driving under its influence, yet there are two prominent problems with that evidence. Experimental studies often rely on highly unrealistic conditions to show negative effects, such as compelling participants to consume more cannabis than they otherwise would. Observational studies that find associations between cannabis use while driving and accidents often fail to account for confounding demographic factors, or misunderstand cannabinoid chemistry, or both (e.g. (Asbridge et al., 2012). As an example, cannabis use is most common among young men,[8] who also happen to be the cohort most likely to drive dangerously and have accidents. If data is unadjusted for age and gender, it may misleadingly suggest cannabis use is at fault (Lacey & Compton, 2016; Rogeberg & Elvik, 2016). Many studies of drivers involved in accidents also reflect misunderstanding or ignorance of how long cannabinoids and their metabolites can be found in blood and urine following use. Because cannabinoids are lipids, they are stored in fat cells and slowly released at detectable levels long after any intoxication has passed—30 or more hours for THC blood tests and 2 weeks or more for metabolite urine tests (Hartman & Huestis, 2014). As a result, studies of accident-involved drivers are often not reporting on an association with cannabis intoxication, since that is not what their tests measure. Nonetheless, studies alleging cannabis contributes to vehicle accidents are widely cited and contribute to clinical observers judging driving to meet the DSM criterion for dangerous behaviors. The likelihood of being judged a dangerous cannabis user can be compounded by per se driving impairment laws that use the presence of low levels of THC metabolites as dispositive proof of intoxication, so individuals who consumed cannabis days earlier and were completely sober at the time of the test can be convicted of driving under the influence and diverted to drug treatment.

CUD Treatment and Social Control

What counts as legitimate substance use can be dramatically different from the perspective of system and lifeworld, physician and patient. Only substances recognized by authoritative agencies and used as directed by professionals enjoy the imprimatur of legitimacy. The same substance manufactured or used outside of that framework is inescapably problematic. Take, for instance, the current clinical consensus on how to treat cannabis withdrawal syndrome. Withdrawal syndromes are a critical

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[8] The demographics are changing quickly as older adults and women adopt cannabis use, often for the management of health and wellbeing.

characteristic of defining substance dependence. For drugs of abuse, mitigating withdrawal through behavioral or chemical means can improve abstinence rates. For cannabis, researchers have sought treatments that minimize or eliminate cannabis withdrawal symptoms, particularly cravings. Psychotherapy and Cognitive Behavioral Therapy (CBT) are prevalent in treatment, but so is the search for pharmacotherapies. The panoply of drugs used in the treatment of other substance use disorders has been tried for CUD to virtually no effect.[9] The pharmacotherapy identified as most promising by at least a dozen systematic reviews is simply substituting a pharmaceutical THC product for cannabis (Benyamina et al., 2008; Copeland & Pokorski, 2016; Danovitch & Gorelick, 2012; Gorelick, 2016; Hart, 2005; Hoch et al., 2019; Marshall et al., 2014; Nielsen et al., 2019; Nordstrom & Levin, 2007; Sherman & McRae-Clark, 2016; Vandrey & Haney, 2009; Walther et al., 2016). The case studies and trials reviewed involved two different THC-containing products: dronabinol (Marinol®), a pure synthetic THC capsule, and nabiximols (Sativex®), a cannabis extract with a one-to-one ratio of THC and CBD, delivered via an oral-mucosal spray. The natural cannabis extract is identified by one review as "[t]he most innovative and promising pharmacotherapy currently being explored" (Copeland & Pokorski, 2016). A randomized clinical trial allowed participants to self-administer up to 113 mg of THC daily, and recommended future studies use higher doses to treat dependence (Trigo et al., 2018). These are large doses of THC by most measures. Many regulated cannabis markets have set 10 mg as a single dose or "serving size," and 5 mg has been proposed as a standard dose (Volkow & Weiss, 2020). Participants in this trial reported, not surprisingly, that using a dozen or more standard doses of THC per day reduced or eliminated cannabis craving.

The solution to the most problematic use of cannabis is, ironically, to supply its primary components in pharmaceutical packaging. The system advocacy for substituting either a pharmaceuticalized cannabis extract or laboratory-produced synthetic THC, both available only by prescription, for cannabis products a person is obtaining on their own demonstrates

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[9] The exception is gabapentin, a drug used to treat nerve pain and seizures which shows modest potential but can have serious adverse side-effects (Nielsen et al., 2019).

the degree to which cannabis use is construed within a framework of medicalized social control. What matters is not the substance or its effects but who controls dosing decisions and its manufacture and sale. Cannabinoid medications manufactured by pharmaceutical companies, such as dronabinol and nabiximols, carry the mantle of fully medicalized legitimacy. The use disorder they are being prescribed to treat involves production and procurement of those same cannabinoids outside the bounds of recognized medical industries. Regulatory oversight of drug manufacture has obvious benefits, but contradiction here is notable: The use behaviors and effects of the substance represent opposite things based on who exerts control—the individual users versus doctors and pharmaceutical companies. The difference between classifying the consumption of THC as, on the one hand, a mental disorder, and on the other, as the most effective treatment for that very disorder is another instance of top-down medicalization and resistance to lifeworld legitimacy; in other words, the maintenance of professional medical control over patients. Standardized formulations with specific dosage instructions satisfy the system by imposing apparent order on behaviors that are defined as disordered.

Resolving the Paradoxes

The disconnect between doctors and patients around cannabis use in the context of mental health is key to the paradoxes of cannabis medicalization. One reason doctors cite for rejecting cannabis as a medicine, despite patient testimonials, is a lack of clinical evidence about its effects and mechanisms of action. Yet psychotropic medications are routinely prescribed with little to no understanding of their mechanisms of action or even their effects. The medications most commonly used historically were discovered largely by accident, and there remains little to no evidence that they act directly on any biological pathology, as Moncrieff and others have pointed out (Moncrieff, 2014; Moncrieff & Cohen, 2005). The medications prescribed to treat mental disorders do not appear to "fix chemical imbalances"—to use a popular characterization. Nor do they cure any underlying cause. In general, they show dismayingly limited effectiveness, and what efficacy psychiatric medications have may well derive entirely from the psychoactivity of those drugs: their ability to alter mood and shift cognitive and emotional states in ways that redirect the person's attention from troubling thoughts or feelings (Moncrieff, 2018, 2018b; Moncrieff et al., 2013). In other words, psychiatric medications may provide relief—when they provide any benefit at all—because of qualities they share with cannabis.

When asked, people who choose cannabis for managing mental health report that they do so because it has comparable or superior efficacy to pharmaceutical options with better-tolerated side effects. Many criticize the available pharmaceutical options due to their negative impact on quality of life and their higher risks of dependence or of physiological harm when used over time. Patients see cannabis as part of the solution, not the problem. Until recently, such reports were largely dismissed because many doctors interpret cannabis use as problematic behavior and deem drug users and people with mental disorders unreliable witnesses to their own experience. For well over a century, the effects of cannabis use have been medicalized as pathology, and the burgeoning literature linking it to psychosis indicates the continued investment of the medical profession in the classification of cannabis as a dangerous, psychosis-inducing drug of abuse and cannabis users as "troubled persons." One psychiatrist's response to a professional association survey on recommending cannabis to patients is telling: "Let's be real. People want 'medical marijuana' because they feel less discomfort WHEN THEY ARE HIGH" (Kweskin, 2013). The scare quotes, all-caps, and use of the word *high* each work to delegitimize the therapeutic effects of cannabis in stigmatizing ways—all while acknowledging it can provide relief from suffering. Acknowledging that cannabis may have any potential in treatment is more than just reclassifying something nonmedical as medical. A re-valuation of cannabis by medical professionals requires a personal and moral reckoning as much as a professional assessment of new information.

As a part of the troubled persons industries, mental health practitioners are particularly influenced by the ideological reach of the drug war and its interpretations of cannabis use and risks. Any meaningful assessment of the harms of cannabis use cannot be restricted to a narrow consideration of psychological and physiological effects and ignore the stigma these social categorizations have imposed and continue to impose. Psychiatric classifications are complicit in placing cannabis users on the side of "disordered" persons who threaten the social order. Scientific uncertainty has allowed social forces to shape research incentives and interpretations of evidence around cannabis in ways that have distorted the scientific literature on which "system logic" relies. Being "on drugs" is often conflated with being "crazy" in justifying the social consequences imposed on users, from stigma and marginalization to mass incarceration and police killings of suspects (Hart, 2020). A critical evaluation of the evidence makes clear that the public health cost of any possible increased incidence of psychosis is dwarfed by the magnitude of the harms inflicted on cannabis users by draconian drug laws (DeVylder et al., 2020). The case of cannabis use and mental health demonstrates some of the problems with treating human science as atheoretical and free from social context.

Ironically, cannabis may emerge as a solution to recent critiques of psychiatry. Those critiques have noted how few novel approaches to mental health treatment have emerged since pharmacotherapy gained ascendancy, and expressed concern with the side effects and social costs of reliance on those pharmaceutical medications (Harrington, 2019). Since cannabis operates on the ECS, the master homeostatic regulatory system that has been implicated in mood disorders and schizophrenia, it may be addressing underlying problems in a way that current psychiatric medications are not (Micale et al., 2015; Saito et al., 2010; Skosnik, 2011). Certainly, many patients think so, and their expanding self-directed use of cannabis to manage mental health disrupts conventional medical control. The paradoxical medicalizations of cannabis and mental health mark a critical inflection point for psychiatry. A recalibration of psychiatry's claims to mental health harms of cannabis use that better aligns with the evidence and risk assessments of other substances would remove a linchpin in its classification as a drug too dangerous to use. How the contest between system and lifeworld evaluations of cannabis use in the context of mental health is reconciled will shape the paradigm shift to a post-prohibition conception of cannabis and its role in medicine and society.

References

Allan, G., Ramji, J., Perry, D., Ton, J., Beahm, N., Crisp, N., . . . Lindblad, A. (2018). Simplified guideline for prescribing medical cannabinoids in primary care. *Can Fam Physician, 64*(2), 111–120.

Almogi-Hazan, O., & Or, R. (2020). Cannabis, the endocannabinoid system, and immunity—The journey from the bedside to the bench and back. *International Journal of Molecular Sciences, 21*, 4448. https://doi.org/10.3390/ijms21124448

American Psychiatric Association. (1952). *Diagnostic and statistical manual of mental disorders*. American Psychiatric Association.

American Psychiatric Association. (1968). *Diagnostic and statistical manual of mental disorders* (2nd ed.). American Psychiatric Association.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Ames, F. (1958). A clinical and metabolic study of acute intoxication with cannabis sativa and its role in the model psychoses. *Journal of Mental Science, 104*(437), 972–999. https://doi.org/10.1192/bjp.104.437.972

Armentano, P. (2017). The evidence is overwhelming: Cannabis is an exit drug for major addictions, not a gateway to new ones. *Alternet*. http://www.alternet.org/drugs/evidence-overwhelming-cannabis-exit-drug-major-addictions-not-gateway-new-ones

Asbridge, M., Duff, C., Marsh, D. C., & Erickson, P. G. (2014). Problems with the identification of 'problematic' cannabis use: Examining the issues of frequency, quantity, and drug use environment. *European Addiction Research, 20*(5), 254–267. https://doi.org/10.1159/000360697

Asbridge, M., Hayden, J. A., & Cartwright, J. L. (2012). Acute cannabis consumption and motor vehicle collision risk: Systematic review of observational studies and meta-analysis. *BMJ, 344*, e536. https://doi.org/10.1136/bmj.e536

Averett, S., & Smith, E. (2019). Medical marijuana laws and their effect on opioid related mortality. *Economics Bulletin, 39*(1).

Bachhuber, M., Arnsten, J. H., & Wurm, G. (2019). Use of cannabis to relieve pain and promote sleep by customers at an adult use dispensary. *Journal of Psychoactive Drugs*, 2159–9777. https://doi.org/10.1080/02791072.2019.1626953

Bahji, A., Stephenson, C., Tyo, R., Hawken, E. R., & Seitz, D. P. (2020). Prevalence of cannabis withdrawal symptoms among people with regular or dependent use of cannabinoids: A systematic review and meta-analysis. *JAMA Network Open, 3*(4), e202370–e202370. https://doi.org/10.1001/jamanetworkopen.2020.2370

Bates, M. N., & Blakely, T. A. (1999). Role of cannabis in motor vehicle crashes. *Epidemiologic Reviews, 21*(2), 222–232. https://doi.org/10.1093/oxfordjournals.epirev.a017998

Baum, D. (2016, April). Legalize it all: How to win the war on drugs. *Harper's Magazine*. https://harpers.org/archive/2016/04/legalize-it-all/

Baumrucker, S., Mingle, P., Harrington, D., Stolick, M., Carter, G. T., & Oertli, K. A. (2011). Medical marijuana and organ transplantation: Drug of abuse, or medical necessity? *The American Journal of Hospice & Palliative Care, 28*(2), 130–134. https://doi.org/10.1177/1049909110393644

Becker, H. S. (1953). Becoming a marihuana user. *American Journal of Sociology, 59*(3), 235–242.

Benyamina, A., Lecacheux, M., Blecha, L., Reynaud, M., & Lukasiewcz, M. (2008). Pharmacotherapy and psychotherapy in cannabis withdrawal and dependence. *Expert Review of Neurotherapeutics, 8*(3), 479–491. https://doi.org/10.1586/14737175.8.3.479

Bilkei-Gorzo, A. (2012). The endocannabinoid system in normal and pathological brain ageing. *Philosophical Transactions of the Royal Society of London - Biological Sciences, 367*(1607), 3326–3341. https://doi.org/10.1098/rstb.2011.0388

Bizzarri, J. V., Rucci, P., Sbrana, A., Miniati, M., Raimondi, F., Ravani, L., … Cassano, G. B. (2009). Substance use in severe mental illness: Self-medication and vulnerability factors. *Psychiatry Research, 165*(1-2), 88-95. https://doi.org/10.1016/j.psychres.2007.10.009

Blanco, C., Ogburn, E., Pérez de Los Cobos, J., Lujan, J., Nunes, E. V., Grant, B., … Hasin, D. S. (2008). DSM-IV criteria-based clinical subtypes of cannabis use disorders: Results from the National Epidemiological Survey on Alcohol and Related Conditions (NESARC). *Drug Alcohol Depend, 96*(1–2), 136–144. https://doi.org/10.1016/j.drugalcdep.2008.02.008.

Bradford, A. C., Bradford, W. D., Abraham, A., & Bagwell Adams, G. (2018). Association between US state medical cannabis laws and opioid prescribing in the Medicare Part D population. *JAMA Internal Medicine, 178*(5), 667–672. https://doi.org/10.1001/jamainternmed.2018.0266

Brand, E. J., & Zhao, Z. (2017). Cannabis in Chinese medicine: Are some traditional indications referenced in ancient literature related to cannabinoids? *Frontiers in Pharmacology, 8*, 108. https://doi.org/10.3389/fphar.2017.00108

Britten, N. (2008). *Medicines and society: Patients, professionals and the dominance of pharmaceuticals*. Palgrave Macmillan.

Bruce, M. (1999). Mental illness as psychiatric disorder. In C. S. Aneshensel & J. C. Phelan (Eds.), *Handbook of the sociology of mental health* (pp. 37–55). Kluwer Academic/Plenum.

Carney, R., Cotter, J., Firth, J., Bradshaw, T., & Yung, A. R. (2017). Cannabis use and symptom severity in individuals at ultra high risk for psychosis: A meta-analysis. *Acta Psychiatrica Scandinavica, 136*(1), 5–15. https://doi.org/10.1111/acps.12699

Carson, R. C. (1991). Dilemmas in the pathway of the DSM-IV. *Journal of Abnormal Psychology, 100*(3), 302–307. https://doi.org/10.1037//0021-843x.100.3.302

Castle, D. J., Murray, R. M., & D'Souza, D. C. (Eds.). (2012). *Marijuana and madness* (2nd ed.). Cambridge University Press.

Chan, M. H., Knoepke, C. E., Cole, M. L., McKinnon, J., & Matlock, D. D. (2017). Colorado medical students' attitudes and beliefs about marijuana. *Journal of General Internal Medicine, 32*(4), 458–463. https://doi.org/10.1007/s11606-016-3957-y

Charlson, F. J., Ferrari, A. J., Santomauro, D. F., Diminic, S., Stockings, E., Scott, J. G.… Whiteford, H. A. (2018). Global epidemiology and burden of schizophrenia: Findings from the global burden of disease study 2016. *Schizophrenia Bulletin, 44*(6), 1195–1203. https://doi.org/10.1093/schbul/sby058

Charuvastra, A., Friedmann, P. D., & Stein, M. D. (2005). Physician attitudes regarding the prescription of medical marijuana. *Journal of Addictive Diseases, 24*(3), 87–93. https://doi.org/10.1300/J069v24n03_07

Chaudhry, I. B., Husain, M. O., Khoso, A. B., Husain, M. I., Buch, M. H., Kiran, T … & Husain, N. (2020). A randomised clinical trial of methotrexate points to possible efficacy and adaptive immune dysfunction in psychosis. *Translational Psychiatry, 10*(1), 415. https://doi.org/10.1038/s41398-020-01095-8

Compton, W. M., Han, B., Jones, C. M., & Blanco, C. (2019). Cannabis use disorders among adults in the United States during a time of increasing use of cannabis. *Drug Alcohol Depend, 204*, 107468. https://doi.org/10.1016/j.drugalcdep.2019.05.008

Conrad, P. (2007). *The medicalization of society*. The Johns Hopkins University Press.

Conrad, P., & Barker, K. K. (2010). The social construction of illness: Key insights and policy implications. *Journal of Health and Social Behavior, 51*(S), S67-S79.

Conrad, P., & Schneider, J. (1998 [1980]). *Deivance and medicalization: From badness to sickness*. Temple University Press.

Conrad, P., & Slodden, C. (2013). The medicalization of mental disorder. In C. S. Aneshensel, J. C. Phelan, & A. Bierman (Eds.), *Handbook of the sociology of mental health.* Springer.

Copeland, J., & Pokorski, I. (2016). Progress toward pharmacotherapies for cannabis-use disorder: An evidence-based review. *Subst Abuse Rehabil, 7*, 41–53. https://doi.org/10.2147/sar.S89857

Corroon, J., MacKay, D., & Dolphin, W. (2020). Labeling of cannabidiol products: A public health perspective. *Cannabis and Cannabinoid Research.* https://doi.org/10.1089/can.2019.0101

Coulston, C. M., Perdices, M., Henderson, A. F., & Malhi, G. S. (2011). Cannabinoids for the treatment of schizophrenia? A balanced neurochemical framework for both adverse and therapeutic effects of cannabis use. *Schizophrenia Research and Treatment, 2011*, 501726. https://doi.org/10.1155/2011/501726

CSSCID, Canadian Senate Special Committee on Illegal Drugs. (2002). *Cannabis: Summary report: Our position for a Canadian public policy*. https://sencanada.ca/content/sen/committee/371/ille/rep/repfinalvol1-e.htm

Danovitch, I., & Gorelick, D. A. (2012). State of the art treatments for cannabis dependence. *Psychiatric Clinics of North America, 35*(2), 309–326. https://doi.org/10.1016/j.psc.2012.03.003

Davis, J. E. (2019). *Chemically imbalanced*. University of Chicago Press.

Degenhardt, L., Hall, W., & Lynskey, M. (2003). Testing hypotheses about the relationship between cannabis use and psychosis. *Drug and Alcohol Dependence, 71*(1), 37–48. https://doi.org/10.1016/S0376-871600064-4

Deiana, S. (2013). Medical use of cannabis. Cannabidiol: A new light for schizophrenia? *Drug Test Anal, 5*(1), 46–51. https://doi.org/10.1002/dta.1425

Dekker, N., Linszen, D. H., & De Haan, L. (2009). Reasons for cannabis use and effects of cannabis use as reported by patients with psychotic disorders. *Psychopathology, 42*(6), 350–360. https://doi.org/10.1159/000236906

DeVylder, J. E., Mittal, V. A., & Schiffman, J. (2020). Balancing the public health costs of psychosis vs mass incarceration with the legalization of cannabis. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2020.2591

Di Forti, M., Quattrone, D., Freeman, T. P., Tripoli, G., Gayer-Anderson, C., Quigley, H … van der Ven, E. (2019). The contribution of cannabis use to variation in the incidence of psychotic disorder across Europe (EU-GEI): A multicentre case-control study. *The Lancet Psychiatry, 6*(5), 427-436. https://doi.org/10.1016/S2215-036630048-3

Doblin, R., & Kleinman, M. (1991). Marijuana as antiemetic medicine: A survey of oncologists' experiences and attitudes. *American Journal of Clinical Oncology, 9*(7), 1314–1319. https://doi.org/10.1200/JCO.1991.9.7.1314

Erhart, S. M., Marder, S. R., & Carpenter, W. T. (2006). Treatment of schizophrenia negative symptoms: Future prospects. *Schizophrenia Bulletin, 32*(2), 234–237. https://doi.org/10.1093/schbul/sbj055

Evanoff, A. B., Quan, T., Dufault, C., Awad, M., & Bierut, L. J. (2017). Physicians-in-training are not prepared to prescribe medical marijuana. *Drug and Alcohol Dependence, 180*, 151–155. https://doi.org/10.1016/j.drugalcdep.2017.08.010

Fakhoury, M. (2016). Could cannabidiol be used as an alternative to antipsychotics? *Journal of Psychiatric Research, 80*, 14–21. https://doi.org/10.1016/j.jpsychires.2016.05.013

Fichtner, C. G., & Moss, H. B. (2017). Medical marijuana and mental health: Cannabis use in psychiatric practice. *Psychiatric Times, 34*(5).

Frisher, M., Crome, I., Martino, O., & Croft, P. (2009). Assessing the impact of cannabis use on trends in diagnosed schizophrenia in the United Kingdom from 1996 to 2005. *Schizophrenia Research, 113*(2–3), 123–128. https://doi.org/10.1016/j.schres.2009.05.031

Gage, S. H., Zammit, S., & Hickman, M. (2013). Stronger evidence is needed before accepting that cannabis plays an important role in the aetiology of schizophrenia in the population. *F1000 medicine reports, 5*, 2. https://doi.org/10.3410/m5-2

Gillespie, N. A., & Kendler, K. S. (2020). Use of genetically informed methods to clarify the nature of the association between cannabis use and risk for schizophrenia. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2020.3564

Gorelick, D. A. (2016). Pharmacological treatment of cannabis-related disorders: A narrative review. *Current Pharmaceutical Design, 22*(42), 6409–6419. https://doi.org/10.2174/1381612822666160822150822

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry*. Blue Rider Press.

Greenhalgh, T. (2019, November 5). We surveyed HCPs about CBD: 6 key takeaways. *Psychiatry Advisor*. https://www.psychiatryadvisor.com/home/topics/mood-disorders/depressive-disorder/we-surveyed-hcps-about-cbd-6-key-takeaways/

Gregg, L., Barrowclough, C., & Haddock, G. (2007). Reasons for increased substance use in psychosis. *Clinical Psychology Review, 27*(4), 494–510. https://doi.org/10.1016/j.cpr.2006.09.004

Gupta, S. (2013). Why I changed my mind on weed. *CNN.com*. August 8, 2013. http://www.cnn.com/2013/08/08/health/gupta-changed-mind-marijuana/

Gupta, S., & Kulhara, P. (2010). What is schizophrenia: A neurodevelopmental or neurodegenerative disorder or a combination of both? A critical analysis. *Indian Journal of Psychiatry, 52*(1), 21–27. https://doi.org/10.4103/0019-5545.58891

Gusfield, J. R. (1981). *The culture of public problems: Drinking-driving and the symbolic order*. The University of Chicago Press.

Gusfield, J. R. (2014). Constructing the ownership of social problems: Fun and profit in the welfare state. *Social Problems, 36*(5), 431–441. https://doi.org/10.2307/3096810

Harrington, A. (2019). *Mind fixers: Psychiatry's troubled search for the biology of mental illness*. W.W. Norton.

Hart, C. L. (2005). Increasing treatment options for cannabis dependence: A review of potential pharmacotherapies. *Drug and Alcohol Dependence, 80*(2), 147–159. https://doi.org/10.1016/j.drugalcdep.2005.03.027

Hart, C. L. (2020). Exaggerating harmful drug effects on the brain is killing black people. *Neuron, 107*(2), 215–218. https://doi.org/10.1016/j.neuron.2020.06.019

Hartman, R. L., & Huestis, M. A. (2014). Re: “Trends in alcohol and other drugs detected in fatally injured drivers in the United States, 1999–2010.” *American Journal of Epidemiology, 180*(8), 862–863. https://doi.org/10.1093/aje/kwu251

Harvard Medical School. (2006). The negative symptoms of schizophrenia [Newsletter]. *Harvard Mental Health Letter*. https://www.health.harvard.edu/newsletters/harvard_mental_health_letter/2006/july

Hasin, D. S., Kerridge, B. T., Saha, T. D., Huang, B., Pickering, R., Smith, S. M … Grant, B. F. (2016). Prevalence and correlates of DSM-5 cannabis use disorder, 2012-2013: Findings from the national epidemiologic survey on alcohol and related conditions-III. *Am J Psychiatry, 173*(6), 588–599. https://doi.org/10.1176/appi.ajp.2015.15070907

Hazekamp, A., & Pappas, G. (2014). Self-medication with cannabis. In R. G. Pertwee (Ed.), *Handbook of Cannabis*. Oxford University Press.

Hickman, M., Vickerman, P., Macleod, J., Kirkbride, J., & Jones, P. B. (2007). Cannabis and schizophrenia: Model projections of the impact of the rise in cannabis use on historical and future trends in schizophrenia in England and Wales. *Addiction, 102*(4), 597–606. https://doi.org/10.1111/j.1360-0443.2006.01710.x

Hides, L. K., Mueser, D. J., Kim, T. (2012). Understanding cannabis use in schizophrenia. In D. Castle, R. M. Murray, & D. C. D’Souza (Ed.), *Marijuana and madness* (2nd ed., pp. 218–224). Cambridge University Press.

Hoch, E., Niemann, D., von Keller, R., Schneider, M., Friemel, C. M., Preuss, U. W … Pogarell, O. (2019). How effective and safe is medical cannabis as a treatment of mental disorders? A systematic review. *European Archives of Psychiatry and Clinical Neuroscience, 269*(1), 87–105. https://doi.org/10.1007/s00406-019-00984-4

Hosseini, S., & Oremus, M. (2019). The effect of age of initiation of cannabis use on psychosis, depression, and anxiety among youth under 25 years. *Canadian Journal of Psychiatry, 64*(5), 304–312. https://doi.org/10.1177/0706743718809339

Hudson, J. (2020). *Hellth analysis of cannabis research in the US*. https://hellth.com/#/cannabis/initial-results-us

Iseger, T. A., & Bossong, M. G. (2015). A systematic review of the antipsychotic properties of cannabidiol in humans. *Schizophrenia Research, 162*(1–3), 153–161. https://doi.org/10.1016/j.schres.2015.01.033

Jablensky, A. (2000). Epidemiology of schizophrenia: The global burden of disease and disability. *European Archives of Psychiatry and Clinical Neuroscience, 250*(6), 274–285. https://doi.org/10.1007/s004060070002

Jacobs, N. I., Montebello, M., Monds, L. A., & Lintzeris, N. (2019). Survey of Australian psychiatrists' and psychiatry trainees' knowledge about and attitudes towards medicinal cannabinoids. *Australasian Psychiatry, 27*(1), 80–85. https://doi.org/10.1177/1039856218803675

Karanges, E. A., Suraev, A., Elias, N., Manocha, R., & McGregor, I. S. (2018). Knowledge and attitudes of Australian general practitioners towards medicinal cannabis: A cross-sectional survey. *BMJ Open, 8*(7), e022101. https://doi.org/10.1136/bmjopen-2018-022101

Kedzior, K. K., & Laeber, L. T. (2014). A positive association between anxiety disorders and cannabis use or cannabis use disorders in the general population—A meta-analysis of 31 studies. *BMC Psychiatry, 14*(136), 1–22.

Khantzian, E. J. (Ed.). (1987). *The cocaine crisis*. Plenum Press.

Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry, 4*(5), 231–244. https://doi.org/10.3109/10673229709030550

King, R., & Mauer, M. (2006). The war on marijuana: The transformation of the war on drugs in the 1990s. *Harm Reduction Journal, 3*(1), 6. https://doi.org/10.1186/1477-7517-3-6

Kondrad, E., & Reid, A. (2013). Colorado family physicians' attitudes toward medical marijuana. *The Journal of the American Board of Family Medicine, 26*(1), 52–60. https://doi.org/10.3122/jabfm.2013.01.120089

Ksir, C., & Hart, C. L. (2016). Cannabis and psychosis: A critical overview of the relationship. *Current Psychiatry Reports, 18*(2), 12. https://doi.org/10.1007/s11920-015-0657-y

Kweskin, S. (2013). The dope on medical cannabis: Results of a survey of psychiatrists. *The Psychiatric Times*.

Lacey, J. H., Kelley-Baker, T., Berning, A., Romano, E., Ramirez, A., Yao, J., Moore, C., Brainard, K., Carr, K., Pell, K.„ & Compton, R. (2016). *Drug and alcohol crash risk: A case-control study (Report no. DOT HS 812 355)*.

Lago, L., Bruno, R., & Degenhardt, L. (2016). Concordance of ICD-11 and DSM-5 definitions of alcohol and cannabis use disorders: A population survey. *The Lancet Psychiatry, 3*(7), 673–684. https://doi.org/10.1016/S2215-0366(16)00088-2

Lev-Ran, S., Le Foll, B., McKenzie, K., George, T. P., & Rehm, J. (2013). Cannabis use and cannabis use disorders among individuals with mental illness. *Comprehensive Psychiatry, 54*(6), 589–598. https://doi.org/10.1016/j.comppsych.2012.12.021

Leweke, F. M., Koethe, D., Pahlisch, F., Schreiber, D., Gerth, C. W., Nolden, B. M … Piomelli, D. (2009). Antipsychotic effects of cannabidiol. *European Psychiatry, 24*, S207. https://doi.org/10.1016/S0924-933870440-7

Lintzeris, N., Mills, L., Suraev, A., Bravo, M., Arkell, T., Arnold, J. C … McGregor, I. S. (2020). Medical cannabis use in the Australian community following introduction of legal access: The 2018–2019 online cross-sectional cannabis as medicine survey (CAMS-18). *Harm Reduction Journal, 17*(1), 37. https://doi.org/10.1186/s12954-020-00377-0

Lobbana, F., Barrowclough, C., Jeffery, S., Bucci, S., Taylor, K., Mallinson, S … Marshall, M. (2010). Understanding factors influencing substance use in people with recent onset psychosis: A qualitative study. *Social Science & Medicine, 70*(8), 1141–1147. https://doi.org/10.1016/j.socscimed.2009.12.026

Lombardi, E., Gunter, J., & Tanner, E. (2020). Ohio physician attitudes toward medical cannabis and Ohio's medical marijuana program. *Journal of Cannabis Research, 2*(1). https://doi.org/10.1186/s42238-020-00025-1

Loseke, D. R. (2003). *Thinking about social problems: An introduction to constructionist perspectives* (2nd ed.). Aldine de Gruyter.

Lucas, P. (2012). Cannabis as an adjunct to or substitute for opiates in the treatment of chronic pain. *Journal of Psychoactive Drugs, 44*(2), 125–133. https://doi.org/10.1080/02791072.2012.684624

Lucas, P., & Walsh, Z. (2017). Medical cannabis access, use, and substitution for prescription opioids and other substances: A survey of authorized medical cannabis patients. *International Journal of Drug Policy, 42*, 30–35. https://doi.org/10.1016/j.drugpo.2017.01.011

Macleod, J., Oakes, R., Copello, A., Crome, I., Egger, M., Hickman, M … Davey Smith, G. (2004). Psychological and social sequelae of cannabis and other illicit drug use by young people: A systematic review of longitudinal, general population studies. *Lancet, 363*(9421), 1579–1588. https://doi.org/10.1016/s0140-673616200-4

Mandolini, G. M., Lazzaretti, M., Pigoni, A., Oldani, L., Delvecchio, G., & Brambilla, P. (2018). Pharmacological properties of cannabidiol in the treatment of psychiatric disorders: A critical overview. *Epidemiol Psychiatr Sci, 27*(4), 327–335. https://doi.org/10.1017/s2045796018000239

Manseau, M. W., & Goff, D. C. (2015). Cannabinoids and schizophrenia: Risks and therapeutic potential. *Neurotherapeutics, 12*(4), 816–824. https://doi.org/10.1007/s13311-015-0382-6

Marshall, K., Gowing, L., Ali, R., & Le Foll, B. (2014). Pharmacotherapies for cannabis dependence. *The Cochrane database of systematic reviews, 12*, CD008940. https://doi.org/10.1002/14651858.CD008940.pub2

McGuire, P., Robson, P., Cubala, W. J., Vasile, D., Morrison, P. D., Barron, R., … Wright, S. (2018). Cannabidiol (CBD) as an adjunctive therapy in schizophrenia: A multicenter randomized controlled trial. *Am J Psychiatry, 175*(3), 225–231. https://doi.org/10.1176/appi.ajp.2017.17030325

McLaren, J. A., Silins, E., Hutchinson, D., Mattick, R. P., & Hall, W. (2010). Assessing evidence for a causal link between cannabis and psychosis: A review of cohort studies. *The International Journal on Drug Policy, 21*(1), 10–19. https://doi.org/10.1016/j.drugpo.2009.09.001

Micale, V., Tabiova, K., Kucerova, J., & Drago, F. (2015). Role of the endocannabinoid system in depression: From preclinical to clinical evidence. In *Cannabinoid modulation of emotion, memory, and motivation* (pp. 97–129).

Moitra, E., Christopher, P. P., Anderson, B. J., & Stein, M. D. (2015). Coping-motivated marijuana use correlates with DSM-5 cannabis use disorder and psychological distress among emerging adults. *Psychology of Addictive Behaviors, 29*(3), 627–632. https://doi.org/10.1037/adb0000083

Moncrieff, J. (2014). The medicalisation of "ups and downs": The marketing of the new bipolar disorder. *Transcultural Psychiatry, 51*(4), 581–598. https://doi.org/10.1177/1363461514530024

Moncrieff, J. (2018). Against the stream: Antidepressants are not antidepressants—An alternative approach to drug action and implications for the use of antidepressants. *Bjpsych Bull, 42*(1), 42–44. https://doi.org/10.1192/bjb.2017.11

Moncrieff, J. (2018b). Author's reply. *BJPsych bulletin, 42*(3), 131–132. https://doi.org/10.1192/bjb.2018.34

Moncrieff, J., & Cohen, D. (2005). Rethinking models of psychotropic drug action. *Psychotherapy and Psychosomatics, 74*(3), 145–153. https://doi.org/10.2307/48510862

Moncrieff, J., Cohen, D., & Porter, S. (2013). The psychoactive effects of psychiatric medication: The elephant in the room. *Journal of Psychoactive Drugs, 45*(5), 409–415. https://doi.org/10.1080/02791072.2013.845328

Moreau, J.-J. (1973). *On hashish and mental disease* (H. Peters, Trans.). Raven. (Original work published 1845)

Morgan, C. J., & Curran, H. V. (2008). Effects of cannabidiol on schizophrenia-like symptoms in people who use cannabis. *British Journal of Psychiatry, 192*(4), 306–307. https://doi.org/10.1192/bjp.bp.107.046649

MPP, Marijuana Policy Project. (2020). Medical marijuana patient numbers. Retrieved July 6, 2020 from https://www.mpp.org/issues/medical-marijuana/state-by-state-medical-marijuana-laws/medical-marijuana-patient-numbers/

Mueser, K. T., Nishith, P., Tracy, J. I., DeGirolamo, J., & Molinaro, M. (1995). Expectations and motives for substance use in schizophrenia. *Schizophrenia Bulletin, 21*(3), 367–378. https://doi.org/10.1093/schbul/21.3.367

Müller-Vahl, K. R., & Emrich, H. M. (2008). Cannabis and schizophrenia: Towards a cannabinoid hypothesis of schizophrenia. *Expert Review of Neurotherapeutics, 8*(7), 1037–1048. https://doi.org/10.1586/14737175.8.7.1037

Müller, N., Weidinger, E., Leitner, B., & Schwarz, M. J. (2015). The role of inflammation in schizophrenia. *Frontiers in Neuroscience, 9*, 372–372. https://doi.org/10.3389/fnins.2015.00372

Newhart, M., & Dolphin, W. (2019). *The medicalization of marijuana: Legitimacy, stigma, and the patient experience*. Routledge.

Nielsen, S., Gowing, L., Sabioni, P., & Le Foll, B. (2019). Pharmacotherapies for cannabis dependence. *Cochrane Database Syst Rev, 1*(1), CD008940. https://doi.org/10.1002/14651858.CD008940.pub3

Nielsen, S., Sabioni, P., Trigo, J. M., Ware, M. A., Betz-Stablein, B. D., Murnion, B., … Le Foll, B. (2017). Opioid-sparing effect of cannabinoids: A systematic review and meta-analysis. *Neuropsychopharmacology, 42*(9), 1752–1765. https://doi.org/10.1038/npp.2017.51

NIMH, National Institute of Mental Health. (2018, May). *Schizophrenia*. Retrieved August 1, 2020 from https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml

Nordstrom, B. R., & Levin, F. R. (2007). Treatment of cannabis use disorders: A review of the literature. *The American Journal on Addictions, 16*(5), 331–342. https://doi.org/10.1080/10550490701525665

Pergam, S. A., Woodfield, M. C., Lee, C. M., Cheng, G.-S., Baker, K. K., Marquis, S. R., & Fann, J. R. (2017). Cannabis use among patients at a comprehensive cancer center in a state with legalized medicinal and recreational use. *Cancer, 123*, 4488–4497. https://doi.org/10.1002/cncr.30879

Pertwee, R. G. (2006). Cannabinoid pharmacology: The first 66 years. *British Journal of Pharmacology, 147* (Suppl 1), S163–S171. https://doi.org/10.1038/sj.bjp.0706406

Pettersen, H., Ruud, T., Ravndal, E., & Landheim, A. (2013). Walking the fine line: Self-reported reasons for substance use in persons with severe mental illness. *Int J Qual Stud Health Well-Being, 8*, 21968. https://doi.org/10.3402/qhw.v8i0.21968

Pew Research Center. (2019). Pew Research Center's American trends panel, wave 53. https://www.pewresearch.org/wp-content/uploads/2019/11/FT_19.11.08_Marijuana_Topline-For-Release.pdf

Philbrick, A. M., Danner, C., Oyenuga, A., Pereira, C., Ricco, J., & Wendling, A. L. (2020). Education and attitudes on medical cannabis in family medicine residency programs. *Family Medicine, 52*, 730–735. http://journals.stfm.org/familymedicine/2020/november-december/philbrick-2020-0206

Philpot, L. M., Ebbert, J. O., & Hurt, R. T. (2019). A survey of the attitudes, beliefs, and knowledge about medical cannabis among primary care providers. *BMC Family Practice, 20*(1), 17. https://doi.org/10.1186/s12875-019-0906-y

Pledger, M., Martin, G., & Cumming, J. (2016). New Zealand health survey 2012/13: Characteristics of medicinal cannabis users. *New Zealand Medical Journal, 129*(1433), 25–36.

Quinnipac University. (2019, March 6). U.S. voters oppose Trump emergency powers on wall 2–1 Quinnipiac University national poll finds; 86% back Democrats' bill on gun background checks. https://poll.qu.edu/images/polling/us/us03062019_uenh42.pdf

Rai, H. S., & Winder, G. S. (2017). Marijuana use and organ transplantation: A review and implications for clinical practice. *Current Psychiatry Reports, 19*, 91. https://doi.org/10.1007/s11920-017-0843-1

Reid, M. (2020). A qualitative review of cannabis stigmas at the twilight of prohibition. *Journal of Cannabis Research, 2*(1). https://doi.org/10.1186/s42238-020-00056-8

Robinson, S. M., & Adinoff, B. (2016). The classification of substance use disorders: Historical, contextual, and conceptual considerations. *Behavioral Sciences (basel, Switzerland), 6*(3), 18. https://doi.org/10.3390/bs6030018

Rogeberg, O., & Elvik, R. (2016). The effects of cannabis intoxication on motor vehicle collision revisited and revised. *Addiction, 111*(8), 1348–1359. https://doi.org/10.1111/add.13347

Rounsaville, B. J., Bryant, K., Babor, T., Kranzler, H., & Kadden, R. (1993). Cross system agreement for substance use disorders: DSM-III-R, DSM-IV and ICD-10. *Addiction, 88*(3), 337–348. https://doi.org/10.1111/j.1360-0443.1993.tb00821.x

Rounsaville, B. J., Spitzer, R. L., & Williams, J. B. (1986). Proposed changes in DSM-III substance use disorders: Description and rationale. *American*

Journal of Psychiatry, 143(4), 463–468. https://doi.org/10.1176/ajp.143.4.463

Russo, E. (2005). Cannabis in India: Ancient lore and modern medicine. In R. Mechoulam (Ed.), *Cannabinoids as therapeutics* (pp. 1–22). Birkhäuser Verlag.

Sadler, J. Z., Hulgus, Y. F., & Agich, G. J. (1994). On values in recent American psychiatric classification. *Journal of Medicine and Philosophy, 19*(3), 261–277. https://doi.org/10.1093/jmp/19.3.261

Saito, V. M., Wotjak, C. T., & Moreira, F. A. (2010). Pharmacological exploitation of the endocannabinoid system: New perspectives for the treatment of depression and anxiety disorders. *Revista Brasileira De Psiquiatria, 32*, S7–S14.

Salim, S. (2014). Oxidative stress and psychological disorders. *Current Neuropharmacology, 12*(2), 140–147. https://doi.org/10.2174/1570159X11666131120230309

Sarris, J., Sinclair, J., Karamacoska, D., Davidson, M., & Firth, J. (2020). Medicinal cannabis for psychiatric disorders: A clinically-focused systematic review. *BMC Psychiatry, 20*(1), 24–24. https://doi.org/10.1186/s12888-019-2409-8

Saunders, J. B. (2017). Substance use and addictive disorders in DSM-5 and ICD 10 and the draft ICD 11. *Current Opinion in Psychiatry, 30*(4), 227–237. https://doi.org/10.1097/YCO.0000000000000332

Saunders, J. B., Schuckit, M. A., Sirovatka, P. J., & Regier, D. A. (2007). *Diagnostic issues in substance use disorders: Refining the research agenda for DSM-5*. American Psychiatric Association.

Schaub, M., Fanghaenel, K., & Stohler, R. (2008). Reasons for cannabis use: Patients with schizophrenia versus matched healthy controls. *Australian & New Zealand Journal of Psychiatry, 42*(12), 1060–1065. https://doi.org/10.1080/00048670802512016

Schofield, D., Tennant, C., Nash, L., Degenhardt, L., Cornish, A., Hobbs, C., & Brennan, G. (2006). Reasons for cannabis use in psychosis. *Australian & New Zealand Journal of Psychiatry, 40*(6–7), 570–574. https://doi.org/10.1080/j.1440-1614.2006.01840.x

Schubart, C. D., Sommer, I. E., Fusar-Poli, P., de Witte, L., Kahn, R. S., & Boks, M. P. (2014). Cannabidiol as a potential treatment for psychosis. *European Neuropsychopharmacology, 24*(1), 51–64. https://doi.org/10.1016/j.euroneuro.2013.11.002

Schwarcz, G., Karajgi, B., & McCarthy, R. (2009). Synthetic delta-9-tetrahydrocannabinol (dronabinol) can improve the symptoms of schizophrenia. *Journal of Clinical Psychopharmacology, 29*(3), 255–258. https://doi.org/10.1097/JCP.0b013e3181a6bc3b

Sewell, R. A., Poling, J., & Sofuoglu, M. (2009). The effect of cannabis compared with alcohol on driving. *The American Journal on Addictions, 18*(3), 185–193.

Sexton, B. F., Tunbridge, R. J., Brook-Carter, N., Jackson, P. G., Wright, K., Stark, M. M., & Englehart, K. (2000). *Cannabis and driving: A review of the literature and commentary*. Transport Research Library (Great Britain).

Sexton, M., Cuttler, C., Finnell, J. S., & Mischley, L. K. (2016). A cross-sectional survey of medical cannabis users: Patterns of use and perceived efficacy. *Cannabis and Cannabinoid Research, 1*(1), 131–138. https://doi.org/10.1089/can.2016.0007

Sherman, B. J., & McRae-Clark, A. L. (2016). Treatment of cannabis use disorder: Current science and future outlook. *Pharmacotherapy, 36*(5), 511–535. https://doi.org/10.1002/phar.1747

Sideris, A., Khan, F., Boltunova, A., Cuff, G., Gharibo, C., & Doan, L. V. (2018). New York physicians' perspectives and knowledge of the state medical marijuana program. *Cannabis Cannabinoid Research, 3*(1), 74–84. https://doi.org/10.1089/can.2017.0046

Skaper, S. D., & Di Marzo, V. (2012). Endocannabinoids in nervous system health and disease: The big picture in a nutshell. *Philosophical Transactions of the Royal Society of London. Series B, Biological Sciences, 367*(1607), 3193–3200. https://doi.org/10.1098/rstb.2012.0313

Skosnik, P. (2011). Cannabinoids and the cerebellum: A potential role in the development of psychosis. In D. Castle, R. M. Murray, & D. C. D'Souza (Eds.), *Marijuana and madness* (2nd ed., pp. 144–159). Cambridge University Press.

Solowij, N. (2018). Psychotomimetic and cognitive effects of cannabis use in the general population. In M. T. Compton & M. W. Manseau (Eds.), *The complex connection between cannabis and schizophrenia* (pp. 129–155). Academic Press.

Spencer, C., Castle, D., & Michie, P. T. (2002). Motivations that maintain substance use among individuals with psychotic disorders. *Schizophrenia Bulletin, 28*(2), 233–247. https://doi.org/10.1093/oxfordjournals.schbul.a006934

St. Pierre, M., Matthews, L., & Walsh, Z. (2020). Cannabis education needs assessment among Canadian physicians-in-training. *Complementary Therapies in Medicine, 49*, 102–328. https://doi.org/10.1016/j.ctim.2020.102328

Stein, J. (2002, October 28). The new politics of pot. *TIME*. https://www.cnn.com/2002/ALLPOLITICS/10/28/timep.politics.pot.tm/index.html

Surís, A., Holliday, R., & North, C. S. (2016). The evolution of the classification of psychiatric disorders. *Behavioral Sciences, 6*(1), 5. https://doi.org/10.3390/bs6010005

Talbott, J. A., & Teague, J. W. (1969). Marihuana psychosis. Acute toxic psychosis associated with the use of cannabis derivatives. *JAMA, 210*(2), 299–302. https://doi.org/10.1001/jama.210.2.299

Trigo, J. M., Soliman, A., Quilty, L. C., Fischer, B., Rehm, J., Selby, P., … Le Foll, B. (2018). Nabiximols combined with motivational enhancement/cognitive behavioral therapy for the treatment of cannabis dependence: A pilot randomized clinical trial. *PLoS One, 13*(1), e0190768. https://doi.org/10.1371/journal.pone.0190768

Vandrey, R., & Haney, M. (2009). Pharmacotherapy for cannabis dependence: How close are we? *CNS Drugs, 23*(7), 543–553. https://doi.org/10.2165/00023210-200923070-00001

Volkow, N. D., & Weiss, S. R. B. (2020). Importance of a standard unit dose for cannabis research. *Addiction, 115*(7), 1219–1221. https://doi.org/10.1111/add.14984

Wakefield, J. C., & Schmitz, M. F. (2011). The challenge of measurement of mental disorder in community surveys. In D. Pilgrim, A. Rogers, & B. Pescosolido (Eds.), *The SAGE handbook of mental health and illness* (pp. 26–48). SAGE Publications Ltd.

Walsh, Z., Gonzalez, R., Crosby, K., Thiessen, S., & M., Carroll, C., & Bonn-Miller, M. O. (2017). Medical cannabis and mental health: A guided systematic review. *Clinical Psychology Review, 51*, 15–29. https://doi.org/10.1016/j.cpr.2016.10.002

Walther, L., Gantner, A., Heinz, A., & Majić, T. (2016). Evidence-based treatment options in cannabis dependency. *Deutsches Ärzteblatt International, 113*(39), 653–659. https://doi.org/10.3238/arztebl.2016.0653

Ware, M. A., Adams, H., & Guy, G. W. (2005). The medicinal use of cannabis in the UK: Results of a nationwide survey. *International Journal of Clinical Practice, 59*(3), 291–295. https://doi.org/10.1111/j.1742-1241.2004.00271.x

Whooley, O. (2019). *On the heels of ignorance: Psychiatry and the politics of not knowing*. University of Chicago Press.

Wronski, L. (2019). *Axios|Surveymonkey poll: Marijuana*. https://www.surveymonkey.com/curiosity/axios-marijuana-poll/

Zammit, S., Arseneault, L., Cannon, M., & Murray, R. (2012). Does cannabis use cause schizophrenia? The epidemiological evidence. In D. Castle, R. M. Murray, & D. C. D'Souza (Eds.), *Marijuana and madness* (2nd ed., pp. 169–183). Cambridge University Press.

Zuardi, A. W., Crippa, J. A. S., Hallak, J. E. C., Bhattacharyya, S., Atakan, Z., Martín-Santos, R., … Guimareas, F. S. (2012). A critical review of the antipsychotic effects of cannabidiol: 30 years of a translational investigation. *Current Pharmaceutical Design*, 5131–5140.

Zuardi, A. W., Morais, S. L., Guimarães, F. S., & Mechoulam, R. (1995). Antipsychotic effect of cannabidiol. *The Journal of Clinical Psychiatry, 56*, 485–486.

12

Mental Health Categories and the Construction of Cultural Identities in the United States and New Zealand

Charles W. Nuckolls

Introduction

Do the formal assessment tools and measures used in New Zealand mental health services inadvertently reinforce the ethnic stereotypes they officially contest? Discussions to date have focused mostly on Maori ethnicity, and research has focused on those elements of "being Maori" deemed most important or most worthy. One felicitous outcome has been the development of *kaupapa* ("by Maori for Maori") health systems, based on the proposition that non-indigenous medical knowledge poorly serves Maori clients. But there is more to this than meets the eye. This chapter concerns the degree to which new "culturally sensitive" assessment measures construct or reinforce older, more stereotypic images—both Maori and Pakeha (European descendants)—in the process of negotiating the status of troubled persons.

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Background Considerations

We begin by examining the cultural construction of psychiatric categories in the United States. This will advance the topic in three ways. First, the American system is based on a dialectic of competing cultural values, especially in evaluating personality. These values are "interdependence" and "independence," and they have been noted as key components of American culture since Tocqueville (2000). American psychiatry represents a dialectic between these competing values, displaced from mainstream culture and realized in the form of medical diagnostic categories. Could the same be true in New Zealand, that is, could similarly dialectically related values construct the classification of mental disorders in the New Zealand system?

Second, cultural values in opposition to each other are not recognized by people on the ground as historically and culturally contingent. Rather, people define them as natural or intrinsic to the order of things. The opposition is played out as if values, thus naturalized, reflect the inevitable organization of troubled persons as real-world objects. This is not surprising, since the opposition is an uncomfortable one, and sets up a kind of "sociological ambivalence" (Merton, 1976) that is partially resolved by projecting the opposition onto objects in the real world that are deemed naturally opposed to each other. Troubled persons are thus constructed out of the same basic materials that are used to construct identities in general, with a heavy emphasis on what Bateson would call the "schizomogenic" relationship between indigenous (Maori) and European settler (Pakeha) types.

A favorite example of Gregory Bateson's was the marital relationship. Marriage becomes problematic, even painful, if husband and wife engage dialectically by acting out the qualities that make them different. The husband who tries to live up to the social expectation that he should be rugged and individualistic might become demonstrably aggressive, even brutal, in relation to his wife. She then moves in the opposite direction, becoming more and more needy and dependent. The two reinforce each other as each new manifestation on one side of the dialectic calls forth a corresponding but opposite manifestation on the other side. Bateson did not stop with marriage, but used the logic of dialectical opposition, or "schizmogenesis," to interpret behavior across a variety of domains, including the relationship between Israelis and Palestinians (Bateson, 2000). Could psychiatric classification in New Zealand develop out of a similar dialectic, in terms of ethnicity wherein the opposition between Maori and Pakeha is converted into a discourse on troubled persons?

Third, accentuation of a value and its expression in gender, ethnicity, or anything else, is realized in mnemonic form as a kind of prototype or exemplar. Why? The reason could be that it is more easily remembered and transmitted in that form. A prototype presents the value allocated to it in strikingly memorable form, so that, for example, the screen persona of "John Wayne" becomes a handy mnemonic for prototypic American-style rugged individualism. Does that mean that every man is, or should be, a John Wayne in order to fully realize the value allocated to him? The answer, fortunately, is no, but that does not mitigate the effectiveness of the prototype as a standard against which to evaluate behavior. (I am no John Wayne, for example, nor do I wish to be.) But to deny that his image functions as an evaluative prototype for me (and for members of my generation) would be to miss an essential element in the dialectic of values.

Finally, psychiatry's focus on the individual forecloses aetiologies based on the social and political construction of mental health categories that define trouble persons as actors in a cultural drama. It is as if the system were saying, "let's blame the individual," instead of attending to the social and political antecedents of psychiatric disorders. Social causes require social solutions. However, the spurious focus on the individual allows social causes to escape notice, and even better, sustains the pharmaceutical industry by developing drug treatments whose effects are centered exclusively on the individual. If the "individual" as such were shown to be a social creation, then it would shift the locus of diagnosis and treatment to "social facts," as Durkheim called them. And since drugs are prescribed for troubled persons, but not for groups, this would diminish the industry's claim to be treating mental disorders at their source. There is, to put it simply, no money in that.

"Interdependence" is no less valued, even though it occupies the opposite extreme to the John Wayne type (Nuckolls, 1998, 2018). A prototypic interdependent character is realized in a number of publicly recognized personalities. Usually this character is female—the better to play itself off against the male independent type. As an example, one could point to Mother Teresa, elevated to sainthood now that her selfless acts are recognized as divinely inspired. She constantly admonished people to work together, to put aside individual differences for the common good. Mother Teresa is valued because of her capacity to put other people's interests first, and she is valued in this role, even though it defines her as the categorical opposite to the rugged individual.

Where opposing values mutually define and constrain each other, as in the American case, it is impossible to choose between them, since both are viewed as necessary and right. There can be no permanent victory for either side. But ambivalence, by its nature, is uncomfortable. It seeks resolution in some form. That is why personalities like those of John Wayne and Mother Teresa function so well as what Devereux called "social cynosures"—that is, as powerfully condensed symbols that represent the long-standing opposition in American culture between independence and interdependence (Devereux, 1980). By locating these values in real or fictional characters, Americans in effect pretend that it is the characters *themselves* that oppose each other and *not* the values they represent. Such a pretense is socially useful, especially if it serves to conceal the historically contingent development of these values. For if such a contingency were admitted, it would suggest the possibility of intervention and change, and that is not what American psychiatry wishes to contend, especially these days, with the increasing emphasis on the individual as the locus of mental health concerns. As Cohen (this volume) points out, the disguise American psychiatry wears effectively protects an industry that allows only one treatment modality, and seals off the social and political dynamics of mental health from recognition and scrutiny.

The Personality Disorders in American Psychiatry

How do these dynamics work themselves out in mental health classification in the United States? The *Diagnostic and Statistical Manual of Mental Disorders*, currently in its fifth edition, suggests possible answers (American Psychiatric Publishing, 2013) .The DSM distinguishes between two broad categories of mental disorders, Axis One and Axis Two. The first refers to the principle clinical disorders, such as mania and depression, that are assumed to be of temporary duration. They are "states" of being, and thus, in principle, treatable and curable. Axis Two disorders, by contrast, are personality "traits" and thus less susceptible to psychiatric intervention.

The personality disorders include "dependent," "histrionic," and "borderline," types that are, to one extent or another, needy and demand attention. Significantly, these disorders are diagnosed much more frequently among women. Personalities such as "narcissistic," "paranoid," and "antisocial," on the other hand, are diagnosed more often among men, and refer to types that are independent, usually excessively so: Men who either fear the manipulations of others or seek to manipulate others for their own benefit, or who view themselves as naturally so superior that they require nothing from others except adoration (First, 2013). Of the ten Axis Two personality disorders, six are closely associated with gender—something that psychiatrists recognize, but cannot explain except with vague hand waving in the direction of a someday-to-be realized biological account (Millon & Everly, 1984; Nuckolls, 1998). They differ from each other chiefly in the extent to which they intensify the values of interdependence or independence. By "interdependence" I refer to the values and attributes white Americans commonly associate with social interconnectedness and cooperation. The cultural value of interdependence is historically associated with women (Dijkstra, 1988; Nuckolls, 1992). This is a historical fact, not a "natural" one, and its development over time can be traced in media all the way from poetry to portraiture (Nuckolls, 1998).

The History of Cultural Values Encoded in Psychiatric Categories

Opposed to interdependence is independence, associated with freedom and the quality of rugged individualism. The cultural value of independence is historically associated with men in Western Europe and North America. The relationship between interdependence and independence is dialectical—that is, they construct each other in a never-ending spiral of mutual differentiation (Millon, 2011; Millon & Millon, 2014; Nuckolls, 2018). Imagine, for a moment, that interdependence and independence were *not* separate, but were so closely bound up with each other, especially when it came to gender. The seventeenth-century portraiture of Frans Hals is a good place to see this at work: Dutch burghers and their wives are represented together, at the same level, with neither one dominating the landscape. Over the course of a century and more, the political economies of western Europe underwent a remarkable transformation (Laslett, 2000; Macpherson, 1962; Stone, 1983). Two forces, closely intertwined, were at work. The first was the enclosure movement, whereby lands formerly held in common for farming and pasturage, were settled with exclusive use rights in the hands of the aristocracy and emerging bourgeoisie (Linebaugh, 2014). Those who previously used the lands in common were forced out. Large sections of the countryside were depopulated. This is correlated with a striking differentiation in gender roles, especially in northern Europe. Men went to the cities where industrialization had begun to soak up excess labor into the mills, mines, and manufacturing shops. Women moved to the peripheries of the great industrial towns, like Manchester, where increasingly their role came to be defined in purely domestic terms, as keepers of children and tenders of household (Honeyman, 2000). In this way, what had been a unified domestic unit of production, shared by women and men, underwent dissolution and differentiation. To women was allocated the role of domestic nuns, dependent on their husbands, and to men was allocated the role of rugged and hard working individuals, working miles from home in the emerging industrial centers. The difference between the two may have been minimal at first, but over time they grew more extreme, until, by the end of the Victorian period, men and women (especially in the middle classes) occupied wholly different realms. The difference, by that point, had been located out of history and culture and into nature, thereby concealing it origin in historical circumstances. In that form the gender difference was assumed to be the outcome of processes that were grounded in physical reality, not in the vicissitudes of culture, politics, and history. The individuation of mental disorders and the elision of social causes have their beginnings here, and point the way to the development of mental disorders as "natural" (as opposed to socially created) conditions, whose sole locus of treatment must be the troubled person.

As we have seen, the effect of the bifurcation of values and their allocation by gender is to conceal their arbitrariness by locating historically configured values in the seemingly changeless certitudes of nature. Once there, gendered values are more difficult to challenge, and although they do change, there is nevertheless surprising continuity over time. Another factor is more general, and to understand why it helps to recall Melanie Klein's concept of "splitting." Psychologically, when we confront divergent aspects of ourselves, or of other people, we sometimes deal with the ambivalence by "splitting" opposing values, then projecting them onto different external agencies (Klein, [1946] 1975). We can then "pretend"—without consciously realizing it—that the opposition is external to ourselves and does not come from within. It is a defense against the otherwise uncomfortable feelings the opposition would engender. Values like interdependence and independence are locked in such an ambivalence-producing opposition. People admire both, and at various times may act out one or the other. In real life, this may be difficult to realize, but in fantasy, no limits need apply, and men are free to take on the hyper masculinized traits of a John Wayne or a Clint Eastwood. Splitting them averts the psychological distress that would arise if they remained too closely interconnected. In this case, gender serves as the vehicle of splitting, with men receiving the split-off and projected value of independence and with women receiving the value of interdependence. They remain in uneasy truce with each other even while, at other times, they act out mock battles.

Two Examples

Psychiatric categories listed as Axis II disorders are highly distilled renderings of opposed cultural values that have been allocated to gender in order to prevent conscious awareness that such values are politically and historically conditioned. The "borderline" personality, for example, defines the troubled person as intensely needy, but neediness is simply the pathological expression of an otherwise positive social value: interdependence. The same is true of the "paranoid" personality disorder, an intensification of the American cultural value of independence that is expressed pathologically in the fear that others are trying to take away one's all-important individualism. The paranoid must be constantly on guard against intrusions into his personal domain of self-control.

How do American psychiatrists learn the Axis II disorders, or to be more specific, what kind of memory encodes them so that they are available at the time of diagnosis? The answer is that personality types are represented in dense narrative bundles, or stories, that function as prototypes. In other words, the Axis II psychiatric category represents *in extreme form* the value allocated to it. A prototype is not an average; it does not represent a distillate of all the characteristics that make up the typical example of a thing. There are very few, if any, men in American culture that fulfill the prototype the movie industry imagines as the John Wayne type of man. That does not matter. The John Wayne type can still serve as a receptacle of the value of independence. In that form it functions as an implicit standard against which living male patients, in all their varieties, are compared. A man is diagnosed as narcissistic, paranoid, or antisocial the more completely he conforms to or exceeds in intensity the category exemplar. It does not take a long time to diagnose by means of a cultural category, especially when it is encoded in visual form. My research in a psychiatric hospital over a two year period demonstrated that the length of time, from the moment a new patient sits down to the moment the psychiatrist writes down on a form the DSM disorder code amounts to all of 42s (Nuckolls, 1998).

Officially, however, visual prototype-matching is not how it is supposed to work. Diagnosis is said to follow a careful symptom-by-symptom analysis, and the result follows, logically and inevitably, when the right number of symptoms are deemed present. But if categories are organized around prototypes, and not as simple lists of symptoms, then the process would unfold very differently. A man is diagnosed paranoid the more closely his overall behavior—especially his appearance—conforms to the cultural prototype. A clue that this is in fact the case is revealed in the kind of written guides psychiatrists often carry with them. There is a pocket-size edition of the DSM-V that contains all the categories and lists of common features. American psychiatrists, in my observation, do not typically use it. Instead, they use a small *vade mecum,* a pocket-sized edition of one of the DSM-5 case books. Cases are presented as narrative vignettes, no more than a paragraph each. There are no laundry lists of clinical features—implicitly recognizing, one might say, that human memory is not organized in this fashion. Here is an example of the "paranoid personality" from one of the pocket editions:

> An 85-year-old man named Peter Grace is seen by a social worker at a senior citizen's center for evaluation of health care needs for Mr. Grace and his bedridden wife … Mr. Grace has never been treated for mental illness, and in fact has always claimed to be "immune to psychological problems" and to act only on the basis of "rational" thought. He had a moderately successful career as a lawyer and businessman. He has been married for 60 years, and his wife is the only person he has ever trusted. He has always been extremely careful about revealing anything about himself to others, assuming that they are out to take something away from him. He refuses obviously sincere offers of help from acquaintances because he suspects they have underlying motives. Mr. Grace never reveals his identity to a caller without first questioning the person as to the nature of his or her business. Throughout his life there have been numerous occasions on which he has displayed exaggerated suspiciousness, sometimes of almost delusional proportions … (First et al., 2017: 393)

The patient exhibits the classic features of paranoid personality disorder, including a "pervasive suspiciousness of other such that their motives are interpreted as malevolent" (DSM-5: 649). The fact that he is old is incidental, unless the idea is to show that personality disorders are deeply seated and impervious to change. The paranoid personality conforms to the American model of hyper-individualism, but instead of seeking praise, as the narcissist does, the paranoid focuses on defending himself against intrusion or interference, no matter how benign. In the teaching hospital where I conducted ethnographic fieldwork, the favorite exemplar of the paranoid was a fictional character who would only leave his well-guarded homestead wearing a tin-foil hat to protect him from "them" and their magic ray-guns. The attending physicians (and senior training psychiatrist) preferred, not a vignette, but a simple two-word name, "Jack Nicholson." To be called a "Jack Nicholson" type meant to represent all the typical features of the paranoid personality in one, tight mnemonic bundle. (Presumably what they had in mind was Nicholson's role in *The Shining*). Everybody on staff, including the residents in training, knew what he meant; several would even write "J.N." in their case histories, right next to the patient's name.

The paranoid type is so well established in American culture that it became the subject of the one of the most famous sociological tracts published in the twentieth century: *The Paranoid Style in American Politics*, published in 1952 by Richard Hofstader. American politics, said Hofstader, is "an arena for uncommonly angry minds," and many are dominated by what he calls the "paranoid style." There is no other word that adequately evokes the qualities of "heated exaggeration, suspiciousness, and conspiratorial fantasy" (Hofstader, 2000: 503). Add to this systematic delusions of persecution and fantasies centered on the perception of personal greatness, and we recognize the foundation of McCarthyism, which even in 1952 terrified Hofstader. But the paranoid style has roots that go back all the way to the founding of the nation, and before. There is therefore nothing new about the paranoid style Hofstader identifies, except that the style has become more noticeable in political terms. In 1952, he called it "old and recurrent," and while it comes in waves, the style "appears to be all but ineradicable" (Hofstader, 2020: 505). Although Hofstader noted with alarm the tendency of Americans to resort to conspiracy theory, he never assumed it could be more than a minority phenomenon. Nowhere in his book does he allow himself to imagine a day when the paranoid style could become dominant—say, in the election of a president with pronounced fascist tendencies. Barry Goldwater in 1964 came as close as any politician had (up to that date,) and he was soundly defeated by Lyndon Johnson. The outcome of the 2016 presidential election probably would have been inconceivable to Hofstader.

Now, the second example of a personality prototype that becomes a psychiatric category is from the opposite end of the spectrum: The excessively needy and interdependent person. Invariably, the presiding exemplar is female. The following vignette, “Coquette,” has appeared in every edition of the DSM case manual since 1985, making it something of an old favorite, at least among a psychiatric establishment that is still predominantly male:

> Carla Peter is a 30-year-old cocktail waitress, who sought treatment with a clinical psychologist after breaking up with her 50-year-old boyfriend. Although initially she was tearful and expressed suicidal thoughts, she brightened up within the first session and became animated, dramatic, and coquettish with the male interviewer. During the intake interviews, she was always attractively and seductively dressed, wore carefully applied facial makeup, and crossed her legs in a revealing fashion. Ms. Peters related her story with dramatic inflections and seemed very concerned with the impression she was making on the interviewer. Although she often cried during sessions, her grief appeared to be without depth and mainly for effect. Several times she asked that the next appointment be changed to accommodate her plans; when this was not possible, she became anxious and depressed and expressed the feeling that her therapist must not like her. Ms. Peters’ history reveals that she is frequently the life of the party and has no problem making friends, although she seems to lose them just as easily and feels lonely most of the time. People apparently accuse her of being selfish, immature, and unreliable. She is often late for appointments; borrows money which she rarely returns; and breaks dates on impulse or if someone more attractive turns up. She is competitive with and jealous of other women, believes that they are catty and untrustworthy, and is known for being particularly seductive with her friends’ boyfriends. (First et al., 2017: 386–387)

The patient is needy and dependent, but incapable of maintaining long-term relationships. She enjoys the company of men, and goes to great lengths to project a seductive ("coquettish") demeanor. The psychiatric term for her is "histrionic." Interestingly, it is here, in the personality disorders, that the word once most closely associated with early psychiatric practice, "hysteria," survives in the terminological repertoire. But who exactly is the histrionic?

The female histrionic plays a role opposite to her male counterpart, the paranoid. She represents the value allocated to her, interdependence, a value that achieves classic expression in contrast to the male paranoid. The overly dependent female needs everyone, but cannot sustain relationships, while he needs no one, and is suspicious of everyone. It is important to recognize that this dialectic includes more than just one contrast set. In fact, there are two more (female and male) on each side of the line. On the female side, there are a total of three: "dependent personality disorder," "histrionic personality disorder," and "borderline personality disorder." They exist along a dependency spectrum, varying in terms of orientation and intensity, and represent different degrees of dependence. So-called "borderlines," for example, are considered the most troublesome, since they engage in attention-getting behavior that may include self-harm and threats of suicide. American psychiatrists do not "like" borderlines, and prefer not to treat them. That is because of their reputation of pitting psychiatric staff against one another in carefully staged but artificial disputes that she orchestrates. At the opposite end of the spectrum, with the least extreme and disturbing behavior, is the simple "dependent personality." All three dependency disorders (dependent, histrionic, borderline) are exemplified in the psychiatric *vade mecum* by women, because women represent the cultural value of social interdependence. In American history, if one were to choose the media personae best known for their ability to enact the role of socially interdependent woman, the list would probably include Clara Barton, Helen Keller, and Eleanor Roosevelt. Elsewhere I argue that these personae take on effectiveness by virtue of their power to represent versions of the archetypal model of constructive interdependency—The Virgin Mary, mother of Christ (Nuckolls, 1996).

Likewise, on the male side, there is an analogous spectrum that runs through three modes, differing from each other mainly in intensity and direction. At the low end is the "narcissistic personality disorder," the man who so perfect in his individuality—or so he thinks—that he neither expects to receive empathy from others or to give it in return. Narcissists rarely seek therapy. Why should they, since they represent a self-sustaining personality that requires little reinforcement? In the middle of the spectrum is the paranoid, a man more extremely independent than the narcissistic, and whose psychological energy is directed outward as a protection against other people's interference. He, too, rarely seeks out psychiatric intervention, although he may receive it if his delusions of persecution call attention to him on the part of public authorities. Finally, at the most extreme end on the independence value spectrum is the "antisocial" (formerly known as the "psychopath.") He needs other people, but only in order to manipulate them into achieving his own ends. Then they can be dropped and discarded. In the case manuals, used-car salesmen have always figured prominently as exemplars. But when I interviewed a group of young psychiatrists in their first year of residency, in the late 1980's, they mostly had a public figure in mind: Donald Trump.

The foregoing is sufficient to show that psychiatric categories do not stand alone. Rather, they exist in a system centered on gender-based values in dialectical relationship to each other. The Axis II, "personality disorders," bear this out. Here I have considered just six of the ten disorders. Since the system is essentially a commentary on values allocated to gender, it is not surprising that half of them are specific to men and half are specific to women. The gender-based "nature" of values—male independence and female interdependence—seem to render the categories non-arbitrary; they exist in a world where things are simply given in nature. Values projected onto gender therefore take on or assume the same "given-ness," so that inquiries into the culture or history of such values seem misdirected, or just pointless.

Toward New Zealand

However, just because the American system happens to construe psychopathology through gender does not mean that every classification does likewise. Even within the English-speaking world there are major differences. New Zealand is a case in point. The country's medical system uses the DSM, the manual developed and used in the United States, and psychiatrists are trained, like their American counterparts, in DSM nosology. One would therefore expect that whatever differences exist would be minor. Personality disorders are diagnosed, but in my observation—in one large teaching hospital on the north island—they appear less frequently in case notes, and hardly ever as the primary diagnosis. Instead, the so-called Axis I disorders, like schizophrenia, depression, anxiety, and bipolar disorder, are more common. The social concomitants of Axis I disorders are not so much related to gender as they are to the social categories of "race" and "ethnicity." To put it simply: What the American system achieves through projection onto gender, the New Zealand system accomplishes using ethnicity as the target of projected cultural values.

New Zealand makes an important distinction between "indigenous" (Maori) and "European" (Pakeha) populations. Arguably, the two are more distinct as category structures than ever before, with the introduction of the "Waitangi Process" whereby Crown (government) lands are ceded back to Maori *iwi*s (tribes) and *hapu*s (lineage groups) in a long-belated attempt to fulfill the terms of the 1840 Treaty of Waitangi. Beneficiaries must be able to provide proof of their Maori identities. This is usually accomplished by means of the extensive genealogies Maoris elders have passed down to children and grandchildren. That is not to say, however, that the process is without problems. People who are "genetically" Maori may nevertheless fail to qualify because they lack knowledge of Maori *tikanga* (traditions). Many who might otherwise qualify voluntarily opt out of consideration because they do not wish to be considered indigenous. (About 18.5% of Maori are not aware of, or do not identify with, their *iwi* affiliations. Cain et al., 2017: 64). This is especially common among the urban population of Auckland, where roughly one quarter of all Maori live. There have been attempts to create urban *marai*s (ritual centers) for unaffiliated people who may be of Maori descent. Their success has been limited. And then there are Pakehas (people of European, usually British descent) who suddenly discover a remote ancestor who might have been Maori (Kokutai, 2004). This is often enough to justify a process of "going native," whereby people otherwise "white" by language and tradition seek to assimilate to one or more Maori *iwi*s. Some tribes are responsive to this kind of effort. Others are less so, especially when the Waitangi Process has settled on them ownership of significant resources. Claiming the status of a tribal member without the rudiments of tribal identity (e.g., genealogy) might suggest that one's motivation is largely material in nature. It is, nevertheless, possible to replace one ethnic identity with another, and we see more and more of it as Maori ethnicity loses its stigma and takes on increasingly positive connotations.

More and more books are published every year describing the cultural systems that make them distinctively Maori. This goes far beyond the nose-touching and head-smelling rituals that were (and still are) considered distinctive markers of Maori protocol. And it is more than the long lists of cultural "traits" enumerated by early anthropologists, like Elsdon Best and Peter Buck, in the style of their intellectual forebears, James Frazer and Franz Boaz. Let us be cautious: The slow demise of list-based, enumerative anthropology did *not* mean the notion of culture as a tally of features ceased to be popular. On the contrary. Any book on Maoritanga today is just as likely as its predecessors a century ago to present Maori culture as a list of traits. Nor should we conclude that fetishistic enumerations constitute an imposition on, rather than a reflection of, the deeply held beliefs of today's proud Maori descendants. This is a point to which we shall return. If, then, we dispense with the notion of culture as a list of traits—as most anthropologists today have done—we can adopt a more organic approach and ask, is there a set of contrasts that defines the cultural system? The answer is in the contrast introduced earlier: The two ethnicities, Maori and Pakeha. We can see this process at work in the definition of troubled persons.

In New Zealand Maori are diagnosed with schizophrenia (and other psychotic disorders) at a rate several times that of people of white European descent (Pakehas). Second, Maori are subject to extensive use of compulsory treatment orders—that is, they are "sectioned" and involuntarily confined (Allen & Smith, 2001). Third, Maori are more likely to be prescribed antipsychotic medications, and at higher doses, than non-Maori while controlling for clinical variables including severity and diagnosis (Kumar et al., 2008). The reason this conforms to expectation is because the same can be said about all of the nations termed "neo-Britains" by New Zealand historian James Belich (2011), including the United States, Australia, Canada, and New Zealand. Indigenous populations throughout this world are routinely found to be "troubled." What these nations share in common is an ethos—by no means uncontested or of a piece—dominated by the English language and English governing institutions. Opposite to that, but helping by contrast to define it, is the indigenous population—the "Indians," the "Aborigines," the Maori. It is easy to project values onto a dialectical opposite when that opposite has little or no power, and lacks what its counterpart defines as civilization. As a social category, then, the Maori do not differ much from their counterparts in other neo-British settler societies. They were, and still are, to an extent, viewed as primitive and aggressive.

Like Native Americans, however, the Maori are also considered hallowed repositories of human wisdom—the kind of wisdom that only those who live in close proximity to the natural world and relatively uncontaminated by urban industrialization still possess. This is the romantic view, and it would seem that every neo-Britain establishes a similar contrast between its white settlers and the country's "natives." This happens in phases. First, the indigenous peoples are ruthlessly defeated, as the Maori were during the New Zealand Wars of the 1860's. Then, over the course of decades, Maori were forced to undergo assimilation to mainstream settler society. Mandatory schooling in English was the first step, equally effective both in North America and New Zealand. Although as a percentage their number has been increasing, the Maori who speak *te Reo* fluently is still less than 4% (although up to 20% understand some spoken Maori). Once reduced to a level of subservience and deprived of their own language, Maori were forced to serve as a foil to modern society and its increasingly demystified belief systems. The indigenous folk become agents of healing, while the triumphant settler society—now suffering the dyspeptic anomie of capitalist modernity—tries to come to terms with "the world it has lost" (Durkheim, 2014; Laslett, 2000). The natives of North America, Australia, and New Zealand (among others) must "agree" to play this role, and many have done so, producing the world over vast cottage industries dedicated to providing succor to the jaded white man now fully alienated from what Marx called his "species-being." Commercial enterprises, ostensibly based on native wisdom, purvey a motley assortment of essential oils and relieving tonics. But this is not the full story. For although the concept of savage "nobility" flourishes, so, too, does its opposite: The native as violent, intoxicated, sex-obsessed, and out-of-control. An example from New Zealand is Alan Duff's *Once Were Warriors*, a 1985 novel (and then movie) that addresses Maori gang violence as a pathological realization of the once noble warrior ethos. Cut off and alienated from their traditional social setting, young urban Maori, unable to compete in the Pakeha world, turn instead to gangs such as the "Mongrel Mob," "Black Power," and the "Hells Angels." (The names are direct borrowings from the American west coast). The gangs function, Duff suggests, as substitute communities of solidarity supported by crime and drug-dealing.

The two images of *Maoritanga*—the exquisite Pacific islander at home with nature and the brutal savage only one step removed from cannibalism—assumed prominence in reaction to the colonial encounter. On the one hand, the British were impressed by the Maori sense of community. Solidarity realized itself in the *marai*, ritually centered on the ancestral house (*wharanui*) and associated grounds where entry and exit are governed by strict rules of protocol. Each *hapu* (linage group) is supposed to have its own *marai,* and it is to this place and its people that the individual owes primary loyalty. On the other hand, there is the image of the violent Maori with its roots deep in traditional warfare. The subjugation of the Maori in the second half of the nineteenth century changed this image, from one that threatened the settler community to one that indirectly represented Maori (and even Pakeha) aspirations for recognition and sovereignty, independent of the British Crown. The ceremonial war dance known as the *haka* is probably the best known example of this appropriation. It no longer functions solely as a symbol of Maori identity but has undergone assimilation to settler culture, and now represents New Zealand as a whole in relation to other countries, especially in sports. In my observation, the men and women who participate, wild-eyed and tongues protruding, are made up at least half by Pakeha youth, and not just Pakeha but also of immigrants from China, India, and elsewhere in Polynesia. Despite increasing sensitivity to cultural appropriation, Maori are generally comfortable with this, seeing the *haka* as a rite of national unity and as proof of their own integral role in nation-building.

Pakehas find themselves ambivalently predisposed to their own European-derived identity, especially when it seems to have gotten them into trouble. The ecological crisis is a case in point—a calamity occasioned by the industrialization spawned in the West and then transmitted worldwide by trade and colonialism. On the one hand, the crisis is dismissed as simple collateral damage, the price that must be paid to savor the fruits of capitalism. On the other hand, capitalism itself is defined as a perverse creation that must be dismantled so that we can return to an ecologically balanced existence. The fact is that white New Zealanders favor aspects of *both* images, the one of the peace and communal cooperation, and the other of machine production and continuous accumulation. Since it is impossible to reconcile the two, people split them, allocating their opposing values to different external entities. This allows them to pretend, not only that these external entities are different, but also that the difference between them is grounded in nature, not culture. The indigenous population—whether in North America or New Zealand—serves as a receptacle for the split-off aspects of the value system that cluster together to form the noble savage, whereas those aspects of the value system that represent individualism and private enterprise locate themselves in a mirror set of symbols, from "Cecil Rhodes" to "Steve Jobs."

How does someone become a receptacle for split-off values? The answer to that question would take us too far afield, although it would probably take the form of the psychological case histories Obeyesekere presents in his analysis of Sri Lankan ecstatic mediums (1981) In any case, the case study below functions according to the same dynamic. Its construction as a model of personhood is drawn directly from its capacity to represent the two sides of New Zealand character typology. One is "the native," a projection onto the Maori of values and attitudes closely bound up with settler culture's image of the wild and the free. In the extreme, however, this image represents a wildness that is dangerous, the savage mind gone crazy. The Maori schizophrenic is effective as a symbol of contrast because of his/her power to encapsulate these extreme positions. Of course, the dialectic requires an equal and opposite cultural construction. In New Zealand, this is the Pakeha who is so flamboyantly "white" he or she becomes the ludicrous extension of values the Pakeha represents: Reserved, self-controlled, and with the stiff upper lip he or she inherited from the Pakehas' British settler ancestors. In the next section, we examine these constructs in the context of New Zealand psychiatry's formal assessment tools and training practices.

The New Zealand Study

The purpose of this study was to examine the cultural correlates of mental health diagnosis in Aortearoa/New Zealand, and in particular the construction of ethnicity in formal assessment tools. The study was conducted in several locations, mainly in the North Island, and focused on training sessions wherein clinical team members (psychiatrists, psychologists, psychiatric nurses, and social workers) are introduced to the MH-SMART mental health assessment system. The Mental Health Standard Measures of Assessment and Recovery (MH-SMART) Outcomes Initiative is a New Zealand national initiative which aims to support recovery from psychiatric illness by promoting and facilitating the development of an outcomes-focused culture in the mental health sector. The MH-SMART was established in order to achieve these ends:

1. Develop a process to identify and implement the suite of standard measures. The context of this project is to enable District Health Board provider-arm services to identify and implement standard measures.
2. Facilitate the development of a sector where the use of standard measure of consumer outcomes is an integral part of the overall mental health clinical, cultural, and support framework.
3. Ensure responsiveness to Maori in all aspects of the Initiative.

A key objective of the system is to insure inter-rater reliability among mental health professionals. Training sessions are generally all-day affairs, conducted by a trainer, and provide instruction for a group of 10–15 individuals. By the end of the day, it is expected, trainees are supposed to find themselves in agreement on the major criteria for assessing mental status. They will be equipped to complete the standardized forms the government uses to compile health statistics.

The training program proceeds from the premise that attendees should learn diagnostic criteria and how to apply them. In this regard, the program in New Zealand does not differ from its counterparts in the United States. However, there is much more to the process than diagnostic criteria. More important, I will argue, are the clinical vignettes presented on DVD. These provide encapsulated narratives that describe in condensed form the most salient attributes of the major psychiatric disorders. When students leave the training program, they reported to me remembering the vignettes much better than they do the lists of formal criteria. This is no different from what I observed in the United States study (Nuckolls, 1998).

The New Zealand system recognizes culture as a key variable in determining the applicability of its diagnostic criteria. The special status of Maori custom is repeatedly emphasized, as in the following statement concerning Maori concept of the healthy family (*whanau ora*):

> Reflective of our own world views of health, the concept of Whanau Ora become our *korowai* for recovery. Recovery is not conceptualized as an individualistic process, focused solely on the attainment of individual autonomy. Whanau ora is much broader than that and rests within a context of inclusiveness, collectiveness and interdependence. This context recognizes that pathways to wellbeing need to be focused on building whanau capacity. (MH-Smart Outcomes Initiative, 2005: 1)

However, the MH-SMART system stresses that its Maori cultural perspective is not intended "to be representative of, or to represent the totality of *tangata motuhake/whaiora* experience." It goes on to say that a "one-size fits all approach is never useful" and even admonishes the reader "to remember this" (2005: 1).

It is not the case, of course, that by incorporating what it considers Maori cultural understandings the MH-SMART system has been unselective. On the contrary, as the statement above makes plain, those aspects of Maori culture the system considers most relevant are values of collective interdependence. Other values, presumably, could have been chosen as signature attributes of Maori custom. The system's formulators, for example, might have chosen to examine the healthcare correlates of the long-standing historical rivalries between various Maori *iwi*s ("tribes.") The MH-SMART does not consider these factors, and indeed there may be reasons for not doing so. One is reminded of the displays at the Te Papa national museum in Wellington: References to the 1840 Treaty of Waitangi abound, but in the large museum section devoted to Maori culture there is no reference to Maori warfare or intertribal disputes, and certainly no reference to Maori cannibalism. And although the museum possesses hundreds of Maori war tomahawks, none are on display for the public to see. Like the Te Papa museum's directors, the MH-SMART system's designers never explain why they made the choices they did. But we are surely entitled to wonder about the underlying logic.

Later I will suggest that it depends as much on the construction of Pakeha identity as it does on Maori identity. Pakeha culture being what it is, however—a thing that is ignored or rejected even by its members—the dialectics of identity in New Zealand are largely hidden from view. Indeed, political sensitivities make it difficult for anyone not an outsider to the system to describe its structure. For now, let us consider the construction of Maori identity through the medium of the MH-SMART training system used in district health boards throughout the country and promoted by the national government.

Maori Cultural Images of Troubled Persons

The following case comes from the written profile of a patient the MH-SMART system considers prototypic of the kind health care providers are likely to encounter.

> Maria is a 44-year-old, separated Maori woman currently living alone in subsidized rental accommodation and supporting herself on a sickness benefit. She has four adult children who are independent ad one dependent child. Her 12-year-old son is under the care of Child Youth and Family Services and lives with her oldest daughter. Maria has supervised

> access visits to her 12-year-old son. She has a long history of involvement with mental health services. For the past six years Maria has been seen by her local community mental health service. Four weeks ago, at her request, Maria transferred to the Kaupapa Maori Mental Health Service. Maria has experienced five admissions to the psychiatric unit, the most recent being 12 months ago. She has a diagnosis of Bipolar Affective Disorder and is under Section 29 of the Mental Health Act. During periods of relapse Maria describes her mood as being elevated, she is overactive, agitated, and disorganized in her thinking and behavior. She describes becoming irritable, verbally demanding, abusive, and physically abusive toward members of the public. She does not experience delusions or hallucinations. She has minor problems with her memory in that she occasionally forgets appointments, although she now has a diary. She does not use illicit drugs or drink alcohol. Due to her past behavior during relapses, Maria is well known to local Police and a range of community agencies and services. She has been refused entry to food outlets and will only be seen by specific people in various agencies. (MH-Smart, 2005: 1)

This is the written summary of the case. Students in the MH-SMART training session can refer to it if necessary. Of greater importance is the cinematic vignette in which Maria (or, rather, the actor representing her) acts out her encounters with case workers. There are, in fact, two vignettes. In the first, Maria discusses her case with a case manager for Child and Family Services. The case worker is a middle-aged white woman, red-cheeked and overweight, who speaks the rounded vowels my informants associate with the elite dialectic of an upper-crust Pakeha neighborhood in Auckland. The case worker, who is never named, responds to Maria's concerns with monotonous requests that Maria become "calm." Maria does not become calm. In fact, with every effort of the red-cheeked case worker to restore civility and order, Mari grows more agitated, finally slamming her fist on the desk that separates her from the case worker and demanding to know "what she must do" to get her child back.

Here we see two of the standard images of Maori and Pakeha in dialectical opposition to each other. The Maori woman is seen as angry and prone to aggression by her white interlocutor, while the Pakeha woman comes across as excessively cool and collected. The purpose of the vignette, however, is not to leave these images unquestioned. On the contrary: The whole point is to suggest that Maria, while clearly in need of psychiatric services, is justified in feeling that her needs are not being met. She has not been seen as a troubled person whose Maori cultural assumptions should be recognized. The Pakeha case worker, meanwhile, is presented as someone totally oblivious to these needs, and whose attitude is mostly of condescension, but also of fear. One gets the impression that she is happy to remain behind her desk, as far away from the patient as possible. Her body is rigid and her tone becomes more clipped and measured as the interaction deteriorates.

The subsequent vignette shows Maria in the very different setting of a Kaupapa oriented clinic, where her case worker—a Maori man—sits next to her and develops a rapport based on shared cultural understandings. There is no desk separating them. In the background, through the window, the viewer can see both a body of water (possibly a river) and a mountain—both key symbols in the Maori-oriented landscape that recall aspects of ritual whereby Maori establish their identities on being introduced or entering a *marai* for the first time. The Maori image is presented in its full negative stereotype only to be reconstructed on the basis of its now acknowledged cultural assumptions. What appears to be anger is recast as frustration at the system's unwillingness to define the Maori family as the legitimate unit for therapeutic intervention. The Pakeha, on the other hand, remains completely unreconstructed: The best the Pakeha case worker can do, in other words, is to shut up.

Pakeha Cultural Images

The Maori identity constructed in MH-SMART system is the increasingly conventional one that represents Maoris as emotionally frustrated collectivists who are lost and misunderstood in a New Zealand dominated by autonomous individualists who are blind to cultural differences. The contrast is hardly unique to New Zealand. The same tension exists almost everywhere neo-British values encounter the indigenous "other." It is tantamount to cliché, especially in the description of cultural misunderstandings between British and South Asians, or Americans and

Japanese. I would go so far as to say we do not need the indigenous "other" in order for this dialectic to reveal itself. As we have seen, the opposition between individualism and collectivism was well established in the Anglophone West long before the first colonial encounter. It probably dates back to the beginning of the seventeenth century (Nuckolls, 1998). But with colonialism, it found a new stage on which to project the standard parts in stereotypic encounters of opposition.

For that to happen, the oppositional dynamic requires maintenance and fine tuning, which means that institutions, like the New Zealand health service, must constantly update their ethnic stereotypes to make sure they are relevant. This is somewhat easier to do in the case of Maori, since concepts like *tangata motuhake*, *whaiora*, and *whanau* are strongly promoted in a host of training documents. The work of culture has to proceed at a somewhat subtler level in the case of Pakeha, since New Zealanders of European descent are sensitive to the possibility that calling attention to Pakeha culture (as historian Michael King did) could present them as cultural chauvinists (Bell, 1996). It is therefore possible that the work is done chiefly through the medium of Moari-ness, with statements about Maori culture implicitly deployed as a means of representing and reinforcing a particular image of its Pakeha partner in contrast.

To return to the clinical vignette: What is the unreconstructed Pakeha image this story (and many others like it) uses to powerful effect as a foil to highlight the dimensions of Maori cultural awareness?

There are many "kinds" of Pakehas, from the so-called "Southern" type whose masculine expression is synonymous with rugged individual to the so-called "Raglan Tribe" whose surfer informality represents the ultimate expression of the relaxed Kiwi. These are not the Pakehas represented in the MH-SMART system, however, because the contrast this system needs to develop is between family-centered Maori collectivism and neo-British autonomous individualism. For that the most serviceable Pakeha image is also one of the oldest—the one associated culturally and historically with the Auckland suburb known as Remuera.

The case worker in the vignette, for example, speaks with what my local informants describe as a pronounced Remuera accent, full of well-rounded vowels and private school elitism. Remuera is a residential suburban area within Auckland city, about four kilometers to the southeast of the city center. According to the 2001 census, Remuera has a population of 6,324. It is not a big place, but its size belies its cultural significance. Traditionally occupied by the higher-income bracket, especially on its "Northern Slopes" (a term that refers to the part of Remuera north of Remuera Road) the suburb is regarded as the stereotypical retreat of the rich in popular New Zealand thought, and is therefore used as a name to describe this income group—usually in disparaging tones. The term "Remuera tractor," for example, is a common nickname for upmarket SUV vehicles. Remuera is also home to many well-known New Zealanders including Paul Holmes and the late Sir Edmund Hillary.

One can speak of the Remuera "type" as a cultural image that exerts an influence disproportionate to its population because Remuera is not a place but a state of mind. What are its characteristics? The Remuera type speaks in the rounded vowels characteristic of those with elite school educations of the British model. They are said to have an acute awareness of social hierarchy and an untroubled sense of entitlement to a place at its top. Central to its attitude is a life lived to strict social rules and behavior through which one declares belonging to the Remuera group. The inverse of entitlement is the Remuera group's sense of obligation to contribute to the world in some way. It is seen as a duty of privilege—the patrician instinct of noblesse oblige. As Caldwell and Brown point out:

> The Remuera tribe was once the embodiment of New Zealand's ruling class in every area. But with every post-colonial generation, its influence has fallen away. These days the Remuera tribe has ceded political and culture-making power to the Grey Lynn and North Shore tribes. But the Remuera tribe remains a powerful force in our society. It runs some of the most lucrative areas of the New Zealand economy like a well-voweled secret society – our elite law firms, financial sector institutions, and the boardrooms of our largest corporations are all enclaves of Remuera tribe members, on the look-out for the next person-like-them to do business with. (2008: 65)

Why was this type of Pakeha chosen for the vignette? The answer is Remuera type's ability to set up a maximum set of contrasts to the Maori patient represented in the vignette. If Maori are represented as displaced and frustrated collectivists, then their counterpart ethnicity needs to be represented as over-confident individualists. What is a confident individualist like? She is someone who understands personal boundaries and, most importantly, remains calm even when those boundaries are breached. "Calmness," in fact, much more than abstract values associated with individualism, is the most relevant contrast feature. This is what makes Pakeha identity the legitimate offspring of the British stiff upper-lip. Do all Pakeha identify with this value? No, nor do they need to: It is sufficient for it to exist as a powerful trope, always and invariably associated with white settler colonialism. In that form, one has a choice—to adopt the identity as one's own or to reject it. And it is quite possible that the majority of Pakeha do reject it. A cultural value does not have to be believed in in order of it to exert strong effects.

Conclusion

The origins of the word "Pakeha" are not well understood, as Pellew (1995) notes. Pellow reported that many people associate Pakeha with derogatory meanings such as "white pig," "white maggot," or "white pus" (Pellew, 1995: 55). There is a lively debate, in any case, on whether or not it means anything (Oliver & Vaughn, 1991; Scott, 1985). In a sense, the invisibility of Pakeha culture is understandable, since, as a dominant group, most Pakeha do not have a strong, shared conception of their own culture or lifestyle. As Thomas and Nikora note, "Thus is may be difficult for such Pakeha to accept the choice of Maori people to maintain their own distinctive culture and lifestyle" (Thomas & Nikora, 1996: 249). In a sense, however, their acceptance is already guaranteed in very nature of their own distinctiveness—a feature borne of the process by which Maori and Pakeha construct themselves and each other. As Avril Bell sees it, "Pakeha are not only adopting a Maori word but one which constructs themselves as the Other" (1996: 154).

The fact that mental health diagnosis proceeds from assumptions firmly grounded in a dialectic of values does not mean that the bearers of such values, Maori and Pakeha, accept them without difficulty. In fact, Maori researchers have offered trenchant critiques of "structuralist explanations that reinforce fixed binary categories" (Hoskins, 2017: 98). Such categories are found to be too deterministic, often asserting the simplistic view that because Pakehas historically enjoy greater access to power the Maori therefore have none. Hoskins reminds us that we must avoid casting all Maori as colonized victims who lack agency (2017). In any case, the relationship between Pakeha and Maori remains mutually self-defining. This may be a source of frustration to some, but as long as New Zealand defines itself as "bi-cultural" the situation is unlikely to change. Each side in the relationship remains available as a cynosure for the values that have been allocated to it: Civil individualism to the Pakeha and tribal interdependence to the Maori. Were this ever to change, we would probably know it. Maori defined as "troubled" would no longer be diagnosed disproportionately with psychotic disorders, and the discourse on bi-culturalism would lose some of its emotional salience—as would the MH-Smart system and its grounding in the long-standing opposition of values allocated to ethnicity.

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References

Allen, M., & Smith, V. (2001). Opening Pandora's box: the practical and legal dangers of involuntary outpatient commitment. *Psychiatric Services, 52*(3), 342–346.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of the mental disorders* (5th ed.). American Psychiatric Publishing.

Bateson, G. (2000). *Steps to an ecology of mind*. University of Chicago Press.

Belich, J. (2011). *Replenishing the Earth: The settler revolution and the rise of Angloworld*. Oxford University Press.

Bell, C. (1996). *Inventing New Zealand: Everyday myths of Pakeha identity.* Penguin.

Cain, T., Kahu, E., & Shaw, R. (2017). *Turanga Wae Wae: Identity and belonging in aeotearoa New Zealand*. Massey University Press.

Caldwell, J., & Brown, C. (2008). *8 tribes: The hidden classes of New Zealand*. Wicked Little Books.

Devereux, G. (1980). Normal and abnormal. In B. Gulati & G. Devereux (Trans.), *Basic problems of ethnopsychiatry*. University of Chicago Press.

Dijkstra, B. (1988). *Idols of perversity*. Oxford University Press.

Durkheim, E. (2014). *The division of labor in society*. Free Press.

First, M. (2013). *DSM-5 handbook of differential diagnosis.* New York American Psychiatric Publications.

First, M., Skodol, M., Williams, J., & Spitzer, R. (2017). *Learning DSM-5 by case example*. American Psychiatric Publications.

Hofstader, R. (2000). *The paranoid style in American politics*. New York: Library of America.

Hofstader, R. (2020). *The paranoid style in American politics.* In S. Wilentz (Ed.), *Richard Hofstader*. The Library of America.

Honeyman, K. (2000). *Women, gender, and industrialization in England, 1700–1870.* Red Globe Press.

Hoskins T. (2017). A provocation for Kaupapa Maori. In T. Hoskins & A. Jones (Eds.), *Critical conversations in Kaupapa Maori*. Huia Publishers.

Klein, M. ([1946] 1975). Notes on some schizoid mechanisms. In M. Klein (Ed.), *Envy and gratitude and other works 1946–1963.* Free Press.

Kokutai, T. (2004). The problem of defining an ethnic group for public policy: Who is Maori and why does it matter? *Social Policy Journal of New Zealand, 23*, 86–100.

Kumar, S., Mark, A., & Browne, O. (2008). Usefulness of the construct of social network to explain mental health service utilization by the Maori population in New Zealand. *Transcultural Psychiatry, 45*(3), 439–454.

Laslett, P. (2000). *The world we have lost—Further explored*. Routledge.

Linebaugh, P. (2014). *Stop, thief! the commons, enclosures, and resistance.* PM Press.

Macpherson, C. (1962). *The political theory of possessive individualism.* Oxford University Press.

Merton, R. (1976). *Sociological ambivalence and other essays*. Free Press.

MH-Smart Outcomes Initiative. (2005). *MH-Smart education and training program.* https://www.tepou.co.nz/uploads/files/resource-assets/Tuituia.pdf

Millon, T. (2011). *Disorders of personality*. Wiley.

Millon, T., & Everly, G. (1984). *Personality and its disorders: A biosocial learning approach*. Wiley.

Millon, T., & Millon, C. (2014). *Personality disorders in modern life*. Wiley.

Nuckolls, C. (1996). *The cultural dialectics of knowledge and desire.* University of Wisconsin Press.

Nuckolls. (1992). Toward the cultural history of the personality disorders. *Social Science & Medicine, 35*(1), 37–47.

Nuckolls, C. (1998). *Culture: A problem that cannot be solved*. University of Wisconsin Press.

Nuckolls, C. (2018). Paradox and dialectic in cultural knowledge systems: From cosmological science to South Indian kinship. In M. Farjoun, W. Smith, A. Langley, & H. Tsoukas (Eds.), *Dualities, dialectics, and paradoxes in organizational life*. Oxford University Press.

Obeyesekere, G. (1981). *Medusa's hair*. Chicago: University of Chicago Press.

Oliver, P., & Vaughn, G. (1991). How we see one another. *Journal of Intercultural Studies, 12*, 17–38.

Pellow, J. (1995). *Pakeha ethnicity, culture and identity: An examination of ethnic consciousness in aotearoa/New Zealand sociology* (University of Waikato, unpublished thesis Master of Arts).

Scott, B. (1985). *Letter to the Pakeha caucus of the Waitangi coalition, August 1, project Waitangi*. In Project Waitangi Inc. records.

Stone, L. (1983). *Family, sex, and marriage in England 1500–1800*. Harper.

Thomas, D. R., & Nikora, L. W. (1996). From assimilation to biculturalism: Changing patterns in Maori-Pakeha relationships. Chapter 15. In D. R. Thomas & A. Veno (Eds.), *Community psychology and social change: Australian and New Zealand perspectives*. Palmerston North, New Zealand: Dunmore Press.

Tocqueville, A. (2000). *Democracy in America*. Mayer.

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Conclusion

Michael Dellwing and Martin Harbusch

Troubled Persons and the Theaters of Clarity and Fluidity

Psychiatric categorizations and classifications have been remarkably successful in recent decades. As this volume has shown, much of this success happened outside of the psychiatric profession: in schools, social work, universities, senior homes, prisons, workplaces, and families, and even in communities and circles of friends. The "travel" of psychiatric concepts has turned citizens from worlds far beyond psychiatry into "troubled persons", has turned everyday feelings into "symptoms",

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and quite understandable frustration, disgruntledness, and despair into medical pathologies. This medicalization offers a facade of science and objectivity for the evaluation and judgment of people and their actions for a wide variety of life-world dynamics.

The official narrative has long held that the expansion of psychiatric diagnoses is only the result of better recognition mechanisms, where a large historical "dark figure" of putative "unrecognized" cases was merely transformed into an ever-larger group of officially "recognized" cases, with "much work left to do", setting the stage for further pathologization. That image relies, of course, on an exceedingly simplistic frame, where it is 0 or 1, or rather 0–0, 0—1, or 1—1: a disease carrier or not, recognized or not. While a medical structure allows for no other construction, the "expansion" of psychiatry is a much more complicated affair. Critical discussions have pointed to the expansion of psychiatric categories and the fluidity of these categories to be widely applicable (Kirk & Kutchins, 1992, 1997). But it is not only a creeping expansion of the hegemony of medical narratives that displace more casual descriptions of nervousness, frustration, uncertainty, and despair. Not only, also, is there no objective need to medicalize these phenomena. Not only, as well, does their medicalization delete much of the complexity, contextuality, and humanity of rich life-world phenomena when they are condensed to a mere question of healthy/sick. What has added to the complexity in recent years is that psychiatry as an institution is less and less involved in this medicalization.

Psychiatry has expanded and retreated at the same time: It may be the last remaining island that allows a theater of certainty in a life-world with a plurality and diversity that makes it otherwise difficult to be judged under a single umbrella. Schools, social work, homes, and families have always been strongly normative, with strong ideas of "social desirability", ideas that are becoming more and more precarious with the diversification and pluralization of life-worlds and their practices. Institutional determinations of desirability as applied by these institutions can no longer be taken for granted and based on any shared social acceptance on a purely normative basis, but the conflicts of everyday life still arise in them. Psychiatry has provided a final retreat these theaters of clarity for social desirability. At the same time, this widespread use of psychiatry has exploded the ability of psychiatry proper to adjudicate it; it could never muster the resources, as is quite evident in the eternal waiting lists for therapy spots.

The fluidity of psychiatry is an effect of its use, not an inherent attribute, and its classification is not a pure creation of psychiatry alone. It is demand-flexible in the sense that it has reacted to this increased use by making it easier to use its categories without the active participation of psychiatric actors. The widespread use has, in a sense, created a second-layer solution on psychiatry's structure, where psychiatric actors are only used to settle what has been transacted on the second layer long before, and what has been and will be transacted with much more utilization of resources apart from psychiatry, so that the base layer psychiatric structure needs to only "certify" these transactions.[1]

Expansion

How did psychiatry achieve this remarkable feast to include ever more everyday conflicts and troubles? The answer often includes a version of the pairing of expansion on the one hand with the fluidity of psychiatric narratives on the other. Expansion, as the classification catalogue has been amended and grown time and time again to include ever more everyday phenomena, bringing a widening of psychiatric descriptions, adding to the ubiquity of psychiatry; fluidity, as these criteria often remain vague enough to easily be interpreted to "fit" onto a wide variety of social conflicts.

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[1] This is somewhat similar to financial systems, where second- and third-layer systems handle a large number of transactions that are packaged and compressed to be certified by the base-layer systems, e.g. VISA transactions in a store that are managed by VISA and do not entail the transfer of funds at this point in time; the actual transfer happens bundled and compressed in a later interaction with a deeper settlement layer. Bitcoin and the lightning network have a similar dynamic.

Life-World Expansion

Psychiatry—initially—provided the institutions that deal with people whose everyday actions fall so far outside the field of common understanding that there are “no motives left to catch up with them”, as Castel (1988) describes it. That means: people do things, yet we do not understand their motives and their explanations make no sense to us. This made psychiatry a parallel track of adjudication, next to the law, which dealt with cases that motives could “catch up with”, where reactions seem absurd to the established frame of reference, and incomprehensible acts seem potentially dangerous, both to those who are doing them and to others. Castel (1988) notes that psychiatry (among others) initially deals with problems of the family; these problems are divided between problems of order within the family which family members cannot resolve and symbolic order problems outside the family, as the family reputation suffers from association with the unpredictable and disorderly. Thus, medicalized psychiatry in the eighteenth century took on a legitimation role: the “madmen” continued to remain prisoners in the turmoil of the revolution even as the legal basis of the royal edicts vanished. Psychiatry here solved a “management problem” (p. 21). It also solved a human problem: psychiatry “secured” disorders which came about in situations when people represented a danger to themselves or others—but primarily to themselves. This was done with the appearance of a humanistic need to help these people to lead normal lives, even if the tension was not a natural one, but rather stemmed from nonconformity to everyday expectations or expectation fulfillment (or even the lack thereof). Nevertheless, it provided a conceptual apparatus along with this appraisal.

This, however, requires a stable frame of expectation and motive-attribution. It requires a stable power structure, historically often patriarchal structures in which men could decide what was appropriate and understable activity for women and the young in the household, and social stratification in which actors high in the “hierarchy of credibility” (Becker, 1967) could adjudicate appropriate behavior in public spheres. It is already doubtful if those orders were particularly stable in the eighteenth century, the period for which Castel writes this particular account, and such a tight hold on the language of conformity is even more dubious today. Psychiatry, psychology, social work, and educational science provide administrative solutions which allow a specific form of social control to be applied to social conflicts and override these pluralities (in fact, to pick out one judgment and give it a medical crown; it is not so much overriding as it is privileging one actor), which can be used to strengthen the individual-centered image of the free and rational individual by pathologizing his outburst or disruptions in the expectations of others. Once unleashed, the forces of psychiatric classification made themselves autonomous and are now creating wider and wider populations, which previously had not been seen as problematic and gain no legitimation through their recent pathologizing, that are pushed into treatment, and therefore "deficient", situations. The most ubiquitous example in this context is attention deficit disorder, which has turned millions of children, primarily in the United States, into psychiatric cases (Shachak et al., 2013).

In any case, it is a dialogue between expectations in power relations throughout society, and a psychiatric practice that interacts with these expectations certifies judgments of "strangeness" in interaction with the complex life-world in which they arise. There is much interactional conflict, with many judgments on them, far too many for any institution to be able to profess a clear categorization. The medical narrative pours concrete on this field of diversity and pluralism of judgment.

The narrative that psychiatry expanded due to a fluidity of its classifications not only runs into a problem, seeing how psychiatry has tried, internally, to achieve the exact opposite, a "fixation" of the discourse to *limit* diagnostic spread. It also runs into the sociological problem that any determination of categorization remains an intersubjective, non-quantifiable, non-objective process.

A Critical Sociology of Success and a Sociology Critical of Success

Psychiatry's success has outgrown psychiatry. It is curious that, in a world that is putatively ever more diverse and ever more accepting of difference, the needs to control deviance through medical vocabulary has grown so exponentially. On the one hand, increased diversity increases interpersonal conflicts that cannot be adjudicated morally any longer; psychiatry translates them into terms of "acceptable attention", "acceptable emotion", individualizing social conflicts as "internal struggle". At the same time, rifts in the social structure make (well-justified) disaffection with the social order ever more available. Psychiatry takes recourse to cheap and simplistic narratives in which "social media" or "phones" cause mental illness—an easy explanation that not only echoes the moral judgments of older generations without having to admit it openly, but also glosses over the fact that worldwide connectedness makes the malaises of late capitalism and the desperation of large parts of the world's population ever more visible to ever larger segments of members of all societies, and fatalism and desperation appear as quite rational reactions to this increased knowledge. Psychiatry has not expanded all by itself; social strife and conflict in meaning has, with especially younger generations not only suffering under bleak prospects for the future, but also under a discursive rift in which older generations and the institutions dominated by them discount and devalue their lifeworlds' realities. In psychiatry, this is more than clearly visible in the psychiatrization of video games (Dellwing & Tietz, 2019), the psychiatrization of digital sexual interaction that has not only been completely normalized in younger generations, but are understood as this generation's sexual liberation (Hasinoff, 2015) and resistance against centralized structures in schools under the label of "oppositional defiant disorder" (Kirk & Kutchins, 1992) and, more generally, Attention Deficit (Shachak et al., 2013). What has expanded is the "fighting zone", and institutions are calling in psychiatry at a level unmanageable for the organization; psychiatry has accommodated this call by expanding and opening up categorizations in ways that allow these other social control institutions to easily deputize themselves and use psychiatry as a certifier of conflict decisions made long before first contact with a psychiatric actor.

Whitaker's studies (2010, 2011) provide the victims of drug treatment an opportunity to present their harrowing experiences with this treatment to the public; public resistance movements against the American Psychiatric Association collect allegations from psychiatry victims. Resistance studies such as that of Linda Morrison (2009) demonstrate how psychiatric patients resist the social control occurring today in institutions, primarily through pharmaceuticals (see also Gomory et al., 2013). Once unleashed, the forces of psychiatric classification ate their way through other institutions and are now creating wider and wider populations, which previously had not been seen as problematic and gain no legitimation through their recent pathologizing, that are pushed into treatment, and therefore "deficient", situations.

Psychiatric categories have colonized the life-world, and have taken their status as tools to reproduce and support everyday social expectations (Goffman, 1971) and social power hierarchies (Castel, 1988; Cohen, 2016) with them. Sociological treatments have noted this problem early on: "psychiatric illness was treated with suspicion by sociologists and their interest turned to social processes, which led to labelling and diagnosis, and the social consequences of psychiatric practice". (Pilgrim & Rogers, 2005: 230). Centered on the individual and its internal workings, psychiatry has long invited critical treatments that severely doubted its simplistic ontology. Especially critical and Marxist positions attempted to uncover the complicity of psychiatric practice in the maintenance of dominant and oppressive ideas of social normality (e.g. Basaglia, 1985; Cooper, 1980; Mechanic, 1969). On the other side of critical attention, sociologists tried to shed light on psychiatric practice as a process, a set of practices aiding a construction of intersubjective reality: Rather than assail psychiatry for perpetuating oppressive normalities, as critical sociology did, these constructionist and interpretivist sociologists started from the assumption that some reality had to be constructed, that none are "real" and therefore none are "false consciousness;" psychiatry, then, was merely one element of a wider social world in which different actors were competing, and cooperating, in the construction of normal reality (Conrad & Schneider, 1980; Grusky & Pollner, 1981; Scheff, 1975). Especially Goffman's work shows how psychiatry serves to maintain and defend the normalities of social groups, especially families and the workplace, when actors leave their "place" (1971). This one element was no longer able to deal with the wide variety of "defenses of normality" it was suddenly tasked with; it expanded to education, social work, law enforcement, gerontological services and many other fields in which populations are managed. Psychiatry could not keep up with this resource demand; especially psychoanalysis and interactive therapy is woefully unable to muster the person power to adjudicate the plethora of conflicts that arise, but its authority is needed to settle and certify them.

Descriptive nosology in diagnoses paired with a somatic, medicalized style of reaction, little as the two sides have to do with one another, provide a settlement mechanism that works without being called upon too strongly. Descriptive nosology provides a buffet for institutions to help themselves on, leading their clients to it as well; all psychiatry has to do is print the menu and provide the pills.

The Descriptive-Nosological Pivot

1980 is a pivotal year in the story of expansion and fluidity, though, at first, in the attempted limitation of it. 1980's third edition of the DSM (Diagnostic and Statistical Manual of the American Psychiatric Association), DSM-III, abandoned the previous orientation of the discipline to psychoanalysis in favor of a purely somatic-descriptive-nosological frame, and did so by committee. Psychoanalysis held that very different histories can show the same outward manifestations, and the same histories can show different ones. That was not just an obstacle to standardization in practice; it was also a quite mundane problem for insurance claims and reimbursements as well as a cold, economic problem of making it difficult for pharma companies' medical processes to test medications.

The tectonic shift of mainstream psychiatry from psychoanalysis to the descriptive-nosological model (Kirk & Kutchins, 1992) in use since 1980 must be understood on this background, as a quest to fulfill the needs of a language of fixity for file-keeping, accounting, and medication testing. This way, a narrative of "new fixity" in the sense of being an "objective" description of a physical reality comes into psychiatry. This is a descriptive-nosological fixity theater, a presentation of fixity for institutional audiences; in it, the messy "inner" conditions and relational tangles of psychiatric clients no longer matter as a basis for diagnoses (even though it remains as a treatment channel, especially for more wealthy clients); the theater of fixity is served by only taking into account external behavioral patterns that can be checkmarked on a clipboard. If a sufficient number of behaviors from the checkboxes on this clipboard are present, the person should be identifiable as a carrier of an illness. Each of these lists was linked to a "disorder" in an ever-growing corpus of psychiatric diagnoses, based on which psychiatry hoped to unify its notoriously unreliable diagnoses, which could not be cleanly reproduced by different psychiatrists, to make these diagnoses reproducible and to establish fixed courses of treatment, first and foremost to allow practitioners and insurance companies to deliver "objective" assessments. This has once again made psychiatry strongly nosological, a return to an old tradition of classification by genus description (Foucault, 1965; Kirk & Kutchins, 1992), offering checklists of "elements", imagined as "objective" that patient conduct, imagined as "objective", can be compared to. With a list of various symptomatic behavioral patterns, the typical pattern for "disorders" has since then become definitionally fixed and been applied to social reality. These define authoritatively and abstractly which behavioral patterns lie in a "healthy" and therefore tolerable range and which will be regarded as deviant. It is well documented that the lists that originate from the 1980 shift did not result from meticulous medical legwork, nor on the basis of extensive medical trial studies, but rather on the basis of applied individual cases and the arbitrary separation and merging of lists. Stuart Kirk and Herb Kutchins (1992, 1997), as well as Paula Caplan (1995) follow these lines when they demonstrate how the modern illness categories anchored in the DSM materialized in social and political conflicts (1992, 1997) and show, for example, how lobbying from Vietnam veterans led to the creation of Post-Traumatic Stress Disorder (p. 100 *f*.)—an inclusion which allowed their medical care to be considered a war-related injury. An example of an especially controversial and polarizing category which came under fierce attack can be seen in Masochistic Personality Disorder/Self-defeating Disorder (p. 126 *ff.*): controversy stemmed from the pathologizing of female roles and the transfer of the responsibility for abuse to women. Thus, the categories which can be found in the DSM (and in Europe in the ICD-10) as "objective illnesses", are clearly and unmistakably political categorizations which do not divide non-natural illness and natural health but rather stabilize roles, reinforce normality and set the boundaries for social rules.

But psychoanalysis was a social-relational-*causal* frame; in other words, it was not just for naming, but also for reacting. The descriptive-nosological frame is not: it is merely a naming scheme. To fill the void created on the other side of the tracks by this catalog shift, a second, completely unrelated stage of objectivity theater was added: To become more "medical", psychiatry has become increasingly somatic, adding a brain chemistry narrative that could never be proven, based on a reverse conclusion: if medication that changes brain chemistry changes the states of patients (an effect discovered by accident), then "imbalances" in brain chemistry must be the cause of the problem. Critical psychiatry has noted that this is akin to claiming that because caffeine relieves tiredness, tiredness must be a disease caused by a coffee imbalance. In recent years, the PR activity of pharmaceutical companies has focused on this side of the divide. These corporations, which fund the vast majority of studies on these category catalogs, are of course motivated by the goal of commercializing new psychotropic drugs.

Following the rules of front-stages facade presentation, this monumental change was not presented as a reaction to the low status of psychiatry in medicine, or as the requirements of insurance companies and pharma corporations, but as a necessary adjustment to make psychiatry more scientific. The scientific field cannot legitimately use any other front-stage justification, so the identification of this "purely scientific" narrative cannot be used as a charge any more than identifying that the police has interests and institutional structures behind "protecting public order", or the school behind "educating children" that cannot be named in public presentation. This is, by itself, no scandal; it is the normal course of institutional self-presentation.

This conglomeration of diagnostic cataloging to purely descriptive listings of human behavior on the one side and a medical-pharmaceutical paradigm on the other, held together by PR and duct tape, and the expansion of these categories has been a remarkable public success; so much that it has outgrown psychiatry. These categorizations have not only reached the status of an unquestioned matter-of-course truth and have been doggedly defended in everyday life—using the claim of working against the stigmatization of the mentally when the approach is questioned. Also, social work and the various education professions increasingly base their work on illness diagnoses, which deal with problem categories in cases of "non-conformist" behavior.

Descriptive Expansion?

The availability and success of psychiatric nosology in troubled persons industries in schools, universities, workplaces, social work, and so on coincide with a steady expansion of what psychiatry has declared itself responsible for. Beyond the simple story of attributing this growth to "better diagnostic tools" and the "recognition" of cases that always been present, the critical discourse, also within psychiatry, will attribute this expansion to the expansion of the catalog: The number of people showing "behavioral problems" requiring medical intervention has consistently expanded with each consecutive issue of the DSM. Originally only those few cases where interaction with others led to severe irritation received psychiatric attention, while today increasingly more cases of interaction irritation are assigned psychiatric responsibility. The fifth and newest edition, DSM 5, has been accompanied by an avalanche of criticism faulting it for expanding the realm of psychiatric responsibility, pathologizing interactions that had not been problematic before, all the while not delivering on its ever-present promise of increased scientific rigor (Caplan, 2013; Frances, 2013; Greenberg, 2013; Whitaker, 2010, 2011). The narrative that catalog expansion can be found at the heart of psychiatric success can be found in Frances' internal criticism of psychiatric classification (2013), but also in critical analyses of psychiatry like Bruce Cohen's *Psychiatric Hegemony* (2016), which shows how the classification catalog has not only continuously expanded, but also changed its wording to include more and more "everyday" words and references, such as the increase of the mention of "school" and "work", which Cohen finds to skyrocket from 4 and 5 in DSM-I in the 1950s to 257 and 288 in the newest editions (Cohen, 2016: 121). The catalog was expanded to be more and more compatible with everyday forms of talk, to be more easily adapted and appropriated by everyday conflicts.

It is the descriptive fixity of the descriptive-nosological model, then, is what enables its expansion of use: It has made psychiatry accessible to anyone with access to the list of elements, and has reformulated these elements to be easily applicable by laypeople as well, in self-tests as well as in institutional settings. While laypeople can hardly use psychoanalytic analysis from scratch, the descriptive-nosological model is a literal checklist that anyone can (be made to believe to) be able to fill out. At the same time, the elements remain vague and encompassing enough that it is hard not to fulfill at least a few of them, and in the model, a few is all it takes, as the lists are "3 out of 5" or "4 out of 7", even with an additional category that allows to assemble random checkable elements from other catalogs into a "miscellaneous" category, a psychiatric build-a-bear. This makeup makes it easy to spread them wide and far in media accounts and social media posts, brochures and handouts, institutional directions and afternoon seminars that can just "teach" lists of descriptors.

Fluidity and Fixity

It is easy to attribute psychiatry's success to these expansions and simplifications, noting that these changes have made psychiatry much more capable to fit divergent social situations. That narrative, however, runs into trouble, at least from within psychiatry's own self-narrative. The new-found "fixity" of psychiatric categories in the descriptive-nosological paradigm was an attempt to make psychiatry *less* malleable, or at least, so the story went: the fluidity of psychoanalysis was the core of the problem for pharmaceutical testing and insurance accounting, and descriptive nosology was supposed to replace it with fixed, "objective" labels.

Fluidity in a Theater of Fixity

That institutions often do badly at fulfilling their front-stage institutional raisons d'être is equally banal, at least for sociologists. This is no different for psychiatry as a whole; though for our purposes, the important element is that psychiatry's pivot has not fulfilled this particular front-stage narrative: The reproducibility of diagnoses has been a perennial struggle for psychiatry, and the fixity and reproducibility of diagnoses has been one of the main "problems" the 1980 redesign should fix. The evaluation of clients by psychiatric observers is still, probably necessarily, a highly interpretive matter as it (almost) exclusively focuses on the assessment of social behavior,[2] which must be read, interpreted, and compared in a social process that will forever remain unquantifiable, and relies on interpretation processes that many social actors are involved in, rather than them just being a one-sided determination by a medical "expert" (Jutel, 2011). The descriptive categorizations offer a seemingly highly differentiated categorical template which at its core requires a behavior evaluation that is legal in form, not medical (Dellwing, 2010): Like in law, it requires the interpretation of a set of rules in light of the interpretation of a set of behaviors, which are embedded in social contexts that must be deleted or translated to fit the rule's framework. The fluidity of the system is, thus, not only expungable from it through a descriptive-nosological model; it only imports the fixity facade the law has used for centuries to fix a complex, contextual, and fluid decision-making process with the facade of legal objectivity (Dellwing, 2015; Fish, 1989), now transferred into the medical process. Again, this—also—had reasons in insurance accounting, limiting the spread between diagnoses for the same person, increasing the reproducibility of assigned catalog codes.

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[2] Unlike within the rest of the medical establishment, there are no blood or urine tests which can support the existence of psychiatric categories. Although psychiatrists do conduct blood tests to identify signs of stress, excitement or alcohol use, this is not evidence of a disease but only an accounting of consequences of a behavior that is then interpreted as pathology.

The aim to rein in fluidity failed. Psychiatric categories are just as fluid and malleable contextual tools for social control as they were before—and then gained a use for more fluid expansion of these categories far beyond psychiatry.

Intersubjective Fluidity: A Pragmatist Approach

To attribute psychiatric crawl to the categories of psychiatry is simplistic: it assumes clean, categorical world orders that only very cerebral philosophy can believe. Those assumptions cut off of the complex, intertwined intersubjective processes of making official definitions and applying them, and they can only appear as the binary idea of recognition in them. The fixation by institutions on controlling and helping is therefore not a "mistake" of psychiatry which needs to be abandoned for them to act "correctly". If psychiatry were to no longer exercise this function, it would no longer be psychiatry: this fixation is at the core of their efforts. Psychiatry and its "user studies", primarily conducted within education and social work, is not seeking to understand illness as "assigned role" or itself as an illness-generating mechanism, but rather to help cement broken situations and utilize the potent illness vocabulary of "mental disorder" to reach solutions. In this sense, there is no alternative conceptualization for the profession, as it can only (even against the will of the individual) negotiate its way into an active position by formulating such diagnoses and applying them to descriptions of individual cases. Sociology, in contrast, examines how this functions, and utilizes the analytically potent—yet comparatively useless in concretely defining situations—vocabulary of "social construction". This vocabulary focuses on how things work in practice, in the words of John Dewey, "what happens if we believe it", or the Thomas theorem, in which things are "real in their effects". It seems to analyze processes of reality construction, without contributing to this fixation which would make such an analysis impossible.

Any explanation that looks *only* within the structure of psychiatry and its catalog is dubious from its inception. The social meaning of psychiatry, of its catalog of disorders, and of the criteria offered by psychiatry are not attributes of psychiatry; they are intersubjective interpretations that require an audience to read, interpret, transfer, and thereby appropriate not just the wording, but an entire history of development and use for a specific case (Dellwing, 2010, 2015). Any "use" of a rule is an interpretation of the rule, of the things and/or persons the rule is applied to, and the context in which that happens; as pragmatism holds, there is no determining structure, but a flexible and fluid intersubjective interplay.

There are at least two sides to this story; the most fluid catalog is useless, quite literally, if it is not used. The simple conclusion is that psychiatry has become useful for institutions the job of which it is to enforce social normality: schools, social work, prisons. Its theater of fixity, combined with relentless PR for decades that extends into schools, workplaces, and peer to peer communication online, has given it the status of a self-evident scientific truth enjoys today. The fluidity added through the widening of reception and utilization allows institutions of everyday life to use this veneer of objectivity to adjudicate its conflicts. That these categorizations which provide illness catalogs—political categorizations due to institutional motivations—not only reflect current ideas of social normality but often have a significant influence on their establishment, can thus be considered a sociological truism. In this light, these debates on illness categories are not simply matters of "knowledge" of "illness" that can be safely left to the institutions of psychiatry. In this light, these determinations are essential to our social coexistence and the question of who bears the power to make such determinations—and under which control they are conducted—is central.

Fluidity, then, is not an attribute of the diagnostic system, and neither is fixity. They are, if at all, attributes of reception, of interpretation: you can interpret it as fluid or fixed, and that is what gives it chance to be used. The success of psychiatric classification is not a consequence of that classification, but of the uses that are made of it: of utilization. Practical utilization is not oriented as much to some general and abstract system of categories as it is to situations and occasions in which certain uses have consequences, a context that critical perspectives on psychiatry have underemphasized: these categories are reinterpreted situationally, "made small" from a large system (Beck & Bonß, 1989: 9). Any situation, therefore, is an adaption of a category system; not merely "use", but a new production, a new creation of a result (Beck & Bonß, 1989: 11). Looking at utilization also means abandoning the focus on categories and catalogues, shifting from content analysis to the analysis of actual use, where "this translation changes what is translated and those who translate". (Czarniawska & Sevòn, 2005: 10). This points sociology toward finding out what these interpretations, the intersubjective complexities of use actually are; and this makes the field a ripe fruit for ethnography and other forms of interpretive social science. Empirical investigation must look at the practices of use, not at categories; at the way the use makes the category, not the other way around.

Utilization studies offer a connection between academic debate and practical consequence, and an ethnographically oriented sociology can ask how knowledge is made and remade in public without returning to questions of either whether these uses are *right* in a strict sense, or whether they conform to the structure of the system used, i.e. whether they are "right" in the eyes of that system. That system has no eyes and cannot decide; it has actors, but their determinations are not actively present unless they are called upon, and will often act as institutional allies when they are, taking their information from authority figures like teachers and parents, whose descriptions of teenagers' conduct will often become the basis for diagnosis.

Pragmatically, then, it is not the underlying, fundamental "philosophy" or diagnostic structure of psychiatry that created troubled persons industries as a corollary; while they make it easier, the intersubjective nature of meaning-making means that this alone does not work without this category also being utilized and received, entangled with a contextual and fluid everyday life in which the meaning of these categories is continually under negotiation. Psychiatric categorization is used to do a job; psychoanalysis has done this job, but while this path is very fluid and open, it is also labor-intensive and difficult to outsource outside the psychiatric profession. Somatic treatments of descriptive-nosological categories, on the other hand, can be utilized in everyday life much more easily; and their objective veneer fulfills the needs of other actors in the medical sphere. In addition, the somatic narrative provides a simple story that can be spread in institutions and told in families.

A critical sociology of psychiatry can, on the one hand, note that these theaters of fluidity and clarity provide social functionality; rather than just being "wrong", they adjudicate interpersonal conflicts and are used to stabilize social orders (Goffman, 1971). The critical element of this analysis must, however, note what order it is that these tools protect and repair: that psychiatry still underpins the authority of the family, that it supports the normality of wage work and an increasing expectation that people devote their lives to that wage work. Before that, psychiatry underpins the expectation that students devote themselves to schooling, and a kind of schooling that privileges reproduction, memorization, standardized testing, and obedience to institutional authority. Psychiatry is consistently used to support ideologies of the family, bourgeois normalities of family life and representation, and a solid facade of the loving family, to the detriment of those who resist, mangle, wrestle and suffer under these structures. By doing so, psychiatry has been and remains one of the main foundations of the late capitalist social order, medicalizing divergence and naturalizing institutional expectations. An expanding troubled persons industry refers to psychiatry to extend this medicalization and naturalization into the very institutions the existence and legitimacy of which are supported by this medicalization. In so doing, the expansion and pragmatic fluidity of psychiatry into schools, social work, prisons, work, care facilities, and families constitutes a power grab in which this medical authority to support hegemonic structures is used by these institutions themselves. In a situation in which the power structures that underpin them are more and more obvious, and global resistance against this institutional order grows stronger on many fronts, these institutions can now point to their duty of care and their "worry" for the populations under their control to mask their perpetuation of these expectations under the guise of medical treatment and "assistance". The pragmatic argument that psychiatry fulfils a function and would need to be invented if it did not exist (Goffman, 1971: 335) only works as long as the "functioning" of existing social structures is deemed desirable. If we drop this piece of not at all self-evident background, then many things appear not so mad, and the "solution" to them appears as a security operation. Disalignment with these expectations, including the persistent kind; disaffection, including the vocal kind as well as the sad kind; fear and loathing, whether stark or a constant undertone of "anxiety" in everyday life; physical resistance against the demand to concentrate on things authorities tell you to concentrate on; a focus on activities not deemed compatible with work and family life: all of these could, instead, be seen as understandable. Then, it would be the attempts to enforce the structures of "normal" normality that could seem, in contrast, quite mad, and legitimately maddening.

References

American Psychiatric Association. (1980a). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

American Psychiatric Association. (1980b). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

Basaglia, F. (1985). What is psychiatry? *International Journal of Mental Health, 14*(1–2), 42–51.

Beck, U., & Bonß, W. (1989). Verwissenschaftlichung ohne Aufklärung? Zum Strukturwandel von Sozialwissenschaft und Praxis. In U. Beck & W. Bonß (Eds.), *Weder Sozialtechnologie noch Aufklärung? Analysen zur Verwendung sozialwissenschaftlichen Wissens*. Suhrkamp Verlag.

Becker, H. (1967). *Whose side are we on? Social problems* (pp. 239–247). Oxford University Press.

Caplan, P. (1995). *They say you're crazy: How the world's most powerful psychiatrists decide*. Da Capo Press.

Caplan, P. (2013). Psychiatric diagnosis as the last bastion of unregulated, rampant harm to populace. In M. Dellwing & M. Harbusch (Hg.), *Krankheitskonstruktionen und Krankheitstreiberei. Die Renaissance der soziologischen Psychiatriekritik*. Springer

Castel, R. (1988). *The regulation of madness: Origins of incarceration in France: The origins of incarceration in France*. Polity Press.

Cohen, B. M. Z. (2016). *Psychiatric hegemony. A Marxist theory of mental illness*. Palgrave macmillan.

Conrad, P., & Scheider, J. W. (1980). *Deviance and medicalization: From badness to sickness*. Mosby.

Cooper, D. (1980). *The language of madness*. Penguin.

Czarniawska, B., & Guje, S. (Ed.). (2005). *Global ideas: How ideas, objects and practices travel in the global economy*. Liber and Copenhagen Business School Press.

Dellwing, M. (2010). "Wie wäre es, an psychische Krankheiten zu glauben?": Wege zu einer neuen soziologischen Betrachtung psychischer Störungen. *Österreichische Zeitschrift Für Soziologie, 35*, 40–55.

Dellwing, M. (2015). *Recht*. Springer.

Dellwing, M., & Tietz, A. (2019)**.** Pathologisierte Sozialität: „Spielsucht" als institutionelle Verteidigung. In M. Dellwing & M. Harbuschn (Hg.), *Pathologisierte Gesellschaft?* Juventa Verlag GmbH.

Fish, S. (1989). *Doing what comes naturally*. Duke University Press.

Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason*. Pantheon Books.

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, big pharma, and the medicalization of ordinary life*. HaperCollins Publishers.

Goffman, E. (1971). *Relations in public: Microstudies of the public order*. Basic Books.

Gomory, T., Cohen, D., & Kirk, S. A. (2013). Coercion: The only constant in psychiatric practice? In M. Dellwing & M. Harbusch (Hg.), *Krankheitskonstruktionen und Krankheitstreiberei. Die Renaissance der soziologischen Psychiatriekritik*. Springer.

Greenberg, G. (2013). *The book of woe: The DSM and the unmaking of psychiatry*. Scribe Publications.

Grusky, O., & Pollner, M. (1981). *The sociology of mental illness*. Basic Studies.

Hasinoff, A. A. (2015). *Sexting panic: Rethinking criminalization, privacy, and consent*. University of Illinois Press.

Jutel, A. (2011). *Putting a name to it*. Diagnosis in contemporary society.

Kirk, S. A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. Routledge.

Kirk, S. A., & Kutchins, H. (1997). *Making us crazy: The psychiatric bible and the creation of mental disorders*. Free Press.

Mechanic, D. (1969). *Mental health and social policy*. Prentice-Hall.

Morrison, L. (2009). *Talking back to psychiatry*. Routledge.

Pilgrim, D., & Rogers, A. (2005). *A sociology of mental health and illness* (3rd ed.). Open University Press.

Scheff, T. (1975). *Labeling madness*. Prentice-Hall.

Shachak, M., Canabas Diaz, E., Angeles Cohen, M., & Illouz, E. (2013). Psychiatry as culture. transforming childhood through ADHD. In M. Dellwing & M. Harbusch (Hg.), *Krankheitskonstruktionen und Krankheitstreiberei. Die Renaissance der soziologischen Psychiatriekritik*. Springer.

Whitaker, R. (2010). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Basic Books.

Whitaker, R. (2011). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. Crown Publisher.

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