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Psychiatrization of society

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Psychiatrization of society

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Editorial: Psychiatrization of society

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Editorial on the Research Topic
Psychiatrization of society

Worldwide, there have been consistently high or even rising incidences of people classified as mentally ill (Bloom et al., 2011; World Health Organization, 2019), paired with increasing mental healthcare service utilization over the last decades (Lipson et al., 2019; Olfson et al., 2019). While psychiatric institutions have been successively expanding, psychiatric knowledge has become increasingly dispersed and globalized, making psychiatric vocabularies and classificatory systems widely available, shaping increasing areas of life, creating powerful markets for therapeutic services of all kinds, and impacting how we understand ourselves and others. This process can be described as the psychiatrization of society (Beeker et al., 2021). Psychiatrization is highly complex, diverse, and global, although it takes different forms in different contexts, involves various actors with largely diverging motives, and is part of a wider assemblage of the psy-disciplines.

The effects of psychiatrization are vast and varied. Individuals or groups might well benefit from aspects of psychiatrization, as the growing mental healthcare system can also increase accessibility of services that are subjectively helpful (Lancet Global Mental Health Group et al., 2007; Thornicroft et al., 2017). In this context, psychiatric diagnosis may essentially determine which quality and quantity of support is available for people in distress. Yet psychiatrization can be potentially harmful to individuals and to public healthcare, e.g., through overdiagnosis and overtreatment (Moynihan et al., 2012), the psychological burden of being labeled (Livingston and Boyd, 2010), the epistemic injustice inherent in not valuing the knowledge of those with lived experience (Leblanc and Kinsella, 2016), and, in the Global North, exploding costs to meet the needs of the "worried well" (Wang et al., 2007). From a societal perspective, psychiatrization may further narrow down what is perceived as normal, diverse attention from the structural determinants of mental health and boost medical interventions which incite individual coping instead of encouraging long-term political solutions (Davies, 2017). In the Global South, where biomedical psychiatric practice is to a large degree exerted by trained non-specialists, psychiatrization could lead to excessive diagnosis and prescription of medication with little monitoring (Mills, 2014) while the expansion of westernized, colonially informed psychiatry risks undermining local support systems (Davar, 2014).

Given the rich body of research on medicalization (Zola, 1972; Illich, 1974; Conrad, 1992, 2005) with seminal publications going back to the 1970s, the question is legitimate why a whole Research Topic should be dedicated to psychiatrization, which might be perceived as just one special branch of medicalization among many others. It seems safe to say that there are more than enough medical specialties in which overdiagnosis and overtreatment are posing significant problems to patients, clinicians and public finance. So why should we speak of psychiatrization but not, for example, of an "urologization" of society to criticize the widespread overdiagnosis of prostate cancer (Vickers et al., 2023)?

The above listed effects of psychiatrization already indicate the reason: There might be much more at stake than harm through sub-optimal treatment decisions and the irresponsible use of taxpayers' money. As several contributions to this Research Topic compellingly show, psychiatry has the power to shape large parts of modern societies and is increasingly used to handle its discontents. By defining, for example, which kinds of human suffering should be understood as individual pathologies, psychiatric diagnosis ultimately becomes an important terrain of negotiation for fundamental questions such as how we expect ourselves and other people to be or in which kind of society we want to live. And in an ironic contrast to the scope of potential consequences of psychiatric diagnosis, there might be no other medical branch where it is so easy to invent new disease entities or to expand criteria for diagnosis, due to the notorious lack of objective correlates of psychiatric disorders, which pushes the doors wide open for the inflationary use of psychiatric concepts and treatments.

Apart from the more obvious large-scale impacts that are mentioned above, psychiatrization may become tangible in a multitude of more subtle phenomena, for instance in science publishing: when we set up this Research Topic, our aim was to motivate scientific contributions from a broad array of fields, following our understanding of psychiatrization as being an interdisciplinary phenomenon. Clearly, we wished for academic psychiatry to play a main role among the contributing disciplines. However, when we asked Frontiers in Psychiatry to co-host our Research Topic with Frontiers in Sociology, which is actually a very common design in the Frontiers' universe, our query was denied with the brief notice that "*psychiatrization of society*" as a topic was not of interest for the journal because it would not fit well with its aims. But when mainstream psychiatry fails to understand that debates on its role in society are relevant to its very nature, this seems to be a highly problematic self-conception. It also begs the question of how psychiatry as a practical and scientific discipline can possibly be trusted to responsibly manage its various and often controversial impacts on society, when it does not acknowledge its situatedness within the realm of the social. Adding to that, a scientific discourse that becomes hermetic toward the perspectives from other disciplines risks to lose the essential openness that characterizes every true scientific endeavor.

However, we were very happy to receive many valuable contributions. In their totality, they may help to shed a light on how psychiatrization can be conceptualized, how it manifests in different terrains, its effects on individuals and societies, and strategies to counter psychiatrization. Despite that, any kind of heuristics risks falling short of their variety and complexity, the articles are presented in chapters that reflect the *theoretical*, *practical*, and *political* dimensions of psychiatrization, with a special emphasis on the lively debate about the *psychiatrization of childhood* (Beeker et al., 2020).

Theorizing psychiatrization

In Beeker et al., the authors present a working definition of psychiatrization as a "complex process of interaction between individuals, society, and psychiatry through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole". As a starting point for further research, the authors suggest a basic model of psychiatrization. This model takes into account that psychiatrization is not exclusively caused in a top-down-way by organized psychiatrists or the pharmaceutical industry, but quite frequently co-produced by top-down and bottom-up-interactions. The latter may originate from a demand for support, recognition or explanations by patients, consumers and ordinary citizens without professional ties to the healthcare system.

In direct reply, Haslam et al. compare psychiatrization with their seminal idea of "concept creep" that was first described by Haslam in 2016 (Haslam, 2016). Concept creep refers to the gradual expansion of harm-related concepts such as addiction, prejudice, or bullying, that were semantically re-shaped over the last decades to include an increasingly wide range of phenomena. The authors show that their original conception of "vertical" vs. "horizontal creep" can be applied fittingly to diagnostic inflation in its twofold meaning of relaxation of diagnostic criteria respectively creation of new diagnostic entities. They suggest considering that psychiatrization may be embedded in the same cultural dynamics as concept creep, which is a growing sensitivity to harm with a tendency to its amplification. Thus, concept creep and psychiatrization may have similar ambivalent effects by drawing attention to neglected harms or illnesses but inflating also minor harms in a problematic way at the same time.

Demke provides a close critical reading of the influential vulnerability-stress-model, finding that while the model appears to integrate social dimensions of mental health, it also perpetuates a medicalised view of faulty individuals. The author questions the very idea of inherent vulnerability—with its potential to divert "attention from the gravity of actual wounds, which would have to be taken seriously in order to open up empowering avenues such as fighting for one's rights and against discrimination, victimization and other grievances that are known to make people unwell". She situates the model, as it emerged in the 1970s, during a period of fundamental critique of psychiatric theory and practice, showing how such critique can be integrated into psychiatry while "allowing for a continued reliance on core elements of the medical model such as the focus on the inherently deficient individual and mandatory pharmaceutical intervention".

Topor et al. describe how "recovery" evolved from a radical concept questioning the core of psychiatric practice and knowledge to an idea that has become increasingly psychiatrized itself.

Starting as a concept that emphasized the social character of mental health and promoting hope for individuals that the use of psychiatric services could be left behind once and for all, the concept of recovery underwent a transition during which it became gradually individualized and detached from the social. This streamlined notion of recovery finally became even integrated into the psychiatric services, where it did not mean much more than a never-ending personal journey. In contrast to such a shallow, de-socialized view, the authors advocate the reappropriation of the concept of recovery as a "deeply social, unique, and shared process in which our living conditions, material surroundings, social relations and sense of self evolve".

Russo shifts the focus of this volume by urging researchers concerned with the concept of psychiatrization to clearly define their position in relation to their field of study. She poses a critical question on how to prevent the (re)psychiatrization of our own research work. The author argues from a mad studies' perspective that psychiatrization is not something separate from us as researchers; rather, it is an integral part of the knowledge production on mental health and distress in which we are actively involved. The author encourages us to examine our perspectives, research ethics, and the manner in which we communicate our findings. Her text can be interpreted as both a manifesto and a call for a candid debate about the potential for enacting transformative research within the existing structures of knowledge production. When viewed as a personal issue, a political matter, and a strategy for de-psychiatrizing our own research, it delves into the epistemological and ethical foundations that underlie the social production of knowledge. Specifically, the author advocates for a radical shift toward de-psychiatrization in our work and invites us to actively participate in this crucial endeavor.

The psychiatrization of childhood

Witeska-Młynarczyk suggests examining the adoption practices in contemporary Poland as a part of larger processes of psychiatrization. She provides an ethnographic account of what she calls "the advancing psychiatrization of kinning". This phenomenon occurs at the intersection of family and social policies as the medicalization, and psychologization of familial relationships. Taking a diachronic perspective, the author offers a portrayal of the adoption network and its functioning. She perceives it as facilitating the "privatization of the social problem" and working toward individualizing the responsibility for its resolution. To describe the ways in which the network of public institutions, relying on psy-knowledge, assesses children and prospective parents for adoption, as well as educates future parents about the therapeutic role their future family should play, Witeska-Młynarczyk employs the concept of "biopolitical bureaucracy" (Nissen and Bech Risør, 2018). She also introduces the notion of "invisible disabilities" (Blum, 2015) to discuss the range of anxieties, self-doubts, and intense emotions generated within this context set in motion by the state. Once adoption is legalized, the new family is compelled to embark on a solitary "diagnostic journey", bearing the full financial and emotional responsibility while completely absolving the state of its role. This is coupled with a growing interest of psychiatry in mental health of adopted young people, as well as in adoptive family as such.

Batstra et al. argue that to avoid unnecessary psychiatrization, schools potentially need to be a primary target as teachers are often the first to instigate a psychiatric classification. However, reification is a pervasive problem. Reification refers to the process of presenting behavioral descriptions from the DSM, like ADHD, as disease entities. A major driver of reification is for instance the widely made "ecological fallacy" which means that very small average differences like slower brain maturation in groups with an ADHD classification are presented as if everyone with a classification displays such a pattern of brain growth. Reification is at odds with the goal of inclusive education, because the perception of unwanted behaviors as caused by medical entities entails the (psychiatric) adjustment of children to make them fit in. The authors contrast this with a more community-based view of disability that holds the position that it is not disabilities but barriers in society that cause exclusion. The authors argue that for such a community-based approach to be successful however, a small but pervasive perceptual shift might be necessary. Rather than singling out children as having special needs to be addressed, the focus can instead be placed on teachers who -as an inherent part of the professionalized socialization- will always need some degree of special needs to do their work. Hence, we should no longer be speaking about children with special needs but about teachers with special needs.

However, the many challenges that need to be faced when moving away from an individualized narrative become clear in the study by Honkasilta and Koutsoklenis. The authors debunk the feeble scientific basis of a classification like ADHD, for instance by looking at the ambiguous, overlapping, and rather arbitrary criteria, obviously informed by contemporary norms and societal values and changing from one version of the DSM to the next, without any real scientific rationale. However, despite the weak scientific base, the authors reveal how deeply engrained classifications like ADHD have become. They may serve as legal entities, deciding who gets additional services and goods but a classification may also provide a moral excuse for misbehavior and may even exempt from legal liability. Likewise, classifications can be instrumental for parents and children themselves as tools to evoke understanding and compassion. Some may feel empowered by classification such as ADHD in an attempt to embrace their alleged "differently wired brains". At the same, classifications can remove agency, helped by the DSM discourse suggesting children are "unable" rather than unwilling to perform certain behaviors. Eventually, the pseudo-scientific discourse surrounding classification seems to create a reality rather than describe it, and unfortunately a reality that might severely restrain ways of being normal or even ways of being in general.

Psychiatrization and medical practice

van Dijk et al. present a qualitative study on how general practitioners (GPs) in the Netherlands dealt with sadness complaints of young adults. Based on 13 interviews, a typology of GPs was developed. GPs who tended to a fast referral to specialist care were usually motivated by personal concern for their patients, by pragmatical reasons or by feelings of incompetence when confronted with seemingly psychiatric conditions. Sadness complaints, thus, were transferred quite easily into a medical condition. GPs who felt well prepared to recognize and treat psychiatric disorders themselves also tended to low-threshold diagnosis and pharmaceutical treatment in primary care. Only GPs who acknowledged that their responsibility may often transcend pure medical problems and, in consequence, saw themselves as partners to discuss the more or less existential questions of life, were inclined to non-psychiatrizing interventions such as watchful waiting. This result emphasizes that only those practitioners who are willing to set the biomedical framework aside in favor of true human encounter may be able to offer support in a non-psychiatrizing way.

In a similar vein, Beeker explores how psychiatrization may emerge from mental healthcare settings. The author focusses on the micro-level by analyzing two prototypical cases of patients coming to the emergency department of a general hospital to receive help in an initially undefined situation. The cases illustrate why decisions whether to label and treat a certain condition as a "mental disorder" or not, can be highly difficult for practitioners, especially in cases where the (health) concerns are rather moderate, and clearly associated with common life problems. However, psychiatrist's decisions may be largely biased in favor of psychiatrization by a wide array of top-down-drivers on the one hand, among which clinical routines, the vagueness of classificatory systems, the necessity of diagnosis for reimbursement of any kind of support and professionals' striving for the reduction of legal risks. On the other hand, also bottom-up mechanisms such as help-seekers' expectations and understandings of their own problems, that may be shaped by soft cultural factors or prior treatment-experiences of friends and family, may play a crucial role when negotiating the accurate interpretation of a situation of crisis.

Baumgardt and Weinmann forward the use of Crisis Theory as a less pathologizing and more normalizing approach to provide help in situations such as those witnessed by the emergency department. The authors discuss Crisis Theory against the background of the widely adopted but severely flawed medical nosology of the DSM and go on to discuss the stress-vulnerability model that was successively introduced to counter some of the limitations of the biomedical approach. Unfortunately, misapplication of the model again placed biological factors at the centerfold. Crisis Theory offers an alternative heuristic approach for understanding the nature and development of mental distress but is seldom explored to its full capacity. The authors discuss several misconceptions and problems that may hamper the adoption of Crisis Theory like it's supposed unsuitability to tackle more severe problems of people with an alleged biological disposition for mental illness–which psychiatry assumes to be different from those who experience a psychological, stress-related crisis. However, the authors clarify how, regardless of the alleged biological or stress-related nature of the problems, Crisis Theory can bring many improvements to the status quo, particularly by combining it with a system-oriented approach.

von Peter et al. explore if Open Dialogue (OD) has the potential to offer psychosocial support in a significantly less or even non-psychiatrizing way. OD was initially developed in Finland in the 1980 for patients with acute psychosis and from then on applied in more than 30 countries. Being essentially a kind of home-treatment with systemic background, it offers multi-professional, and needs-oriented support, nowadays also for users with various kinds of mental distress. As a core element, regular network meetings with the service users and their private or professional environments provide an opportunity to develop a shared understanding of the current crisis, and to make joint decisions for the further course of action. While previous research has shown that OD can limit the use of neuroleptics and decrease the use of psychiatric services, the authors explore the inner logic of OD for further potential for de-psychiatrization. They suggest that OD's tendency to encourage the use of everyday terms instead of the psychiatric idiom, together with a dialogical, polyphonic process of meaning making can be "breaking the interpretative sovereignty of psychiatric language" and concepts. In this polyphonic process, psychiatrists and other health professionals become only individual voices among many others. Instead of communicating psy-knowledge in a top-down way, their new role is to facilitate the dialogical quest for a mutual understanding and for adequate, by far not only medical help. In sum, OD could be a promising means to offer a different, less-psychiatrizing kind of support, shifting the emphasis from individualizing medical thinking toward a more social model of crisis and help.

Politics of psychiatrization

Logan and Karter analyze psychiatrization as a kind of "ontological politics", that imposes narrow interpretative limits on states of difference and distress and tends to exclude other possible meanings. By doing so, psychiatrization may function as a tool of disciplinary control of any kind of resistance against hegemonic norms and institutions of gendered or racialized oppression in domestic or international contexts. The authors exemplify their hypothesis with a close look on consumer/survivor/ex-patient and psychosocial disability movements in the Global South. They demonstrate how psychiatrization may thwart activists' original aims of transforming both the mental healthcare system and the political weight of mental distress, and advocate for understanding at least some mental suffering as a materialization of discontent with oppressive political or socioeconomic conditions.

In a thorough Marxist analysis of the mental health system, Moncrieff argues that the concept of mental illness (understood as an individual medical problem) plays a strategic role in contemporary societies. Specifically, it works to obscure the failings of the neoliberal economic system. The author takes the United Kingdom as a case study to explain how the public mental health system has evolved alongside capitalism, catering to the regulatory needs of the labor market. Adopting a synchronic approach, she unravels trends typical of the capitalist system in general, with a particular focus on the neoliberal system. In this context, large segments of the post-industrial population are marginalized and categorized as mental patients. Indicators of the changing structure of capitalism include the widespread consumption of antidepressants and the increasing psychiatric diagnoses. The author does not limit herself to a critical analysis but also emphasizes the need for political change based on a radical rejection of the medicalization of "so-called" mental health problems.

Schumann et al. discuss Psychiatry's relation to right-wing extremism which they view as an example of undue top-down psychiatrization. For instance, they criticize the superficial tendency to focus on psychological vulnerabilities and social risk factors such as bad peer influence leading up to right-wing extremism. The authors argue that this narrow focus may lead to a predominantly individualized psychiatric gaze on right wing beliefs that are often better understood as a response of more complex factors such as societal conflict, economic uncertainty and societal processes of individualization and anomie. Furthermore, due to this narrow focus other areas of interests may be overlooked. For example, more conceptual understanding of the complex interplay between individual and social factors is needed, as well as a more practical orientation on the challenges that patients and staff may face when working with patients with right-wing tendencies.

Conclusion: the way ahead

The heterogeneity of the papers included in this collection demonstrates once more the complexity of psychiatrization as a field of research and gives a glimpse into the many different ways that psychiatric knowledge and practices may be engrained into contemporary societies. Further studies following different epistemologies and using different methodologies still seem necessary to get a clearer view on the scope, the origins, the mechanisms and the various impacts of psychiatrization—including its influence on the researchers themselves. However, despite the magnitude of this endeavor, a dash of optimism appears legitimate: as this collection shows, a critical interdisciplinary analysis of psychiatrization seems to be possible and worthwhile, especially when research is conceptualized as dialogical and multi-perspective.

Nevertheless, research alone cannot be an end in itself. The negative effects of psychiatrization are ubiquitous and significant, as constantly voiced by the user-/survivor-movement and underlined by this collection. Many creative ideas will be needed to build up measures of psychosocial support that are not psychiatrizing, but provide effective and sustainable help in situations of crisis. The articles of this Research Topic may offer valuable inspirations for winding back some of the harms of psychiatrization and to start doing what will most likely be inevitable on the long run: to move away from the individualized, medical perspective with its narrow confines toward a broader view that dares to re-contextualize and re-politicize human suffering.

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References

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12, 645556. doi: 10.3389/fpsyt.2021.645556

Beeker, T., Witeska-Młynarczyk, A., te Meerman, S., and Mills, C. (2020). Psychiatrization of, with and by children: drawing a complex picture. *Glob Stud Child.* 10, 12–25. doi: 10.1177/2043610619890074

Bloom, D. E., Cafiero, E. T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., Fathima, S., et al. (2011). *The Global Economic Burden of Noncommunicable Diseases*. Geneva: World Economic Forum (2011). Available online at: http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf (accessed October 5, 2023).

Blum, L. (2015). *Raising Generation RX: Mothering Kids with Invisible Disabilities in an Age of Inequality*. New York, NY: New York University Press.

Conrad, P. (1992). Medicalization and social control. *Annu. Rev. Sociol.* 18, 209–232. doi: 10.1146/annurev.so.18.080192.001233

Conrad, P. (2005). The shifting engines of medicalization. *J. Health Soc. Behav.* 46, 3–14. doi: 10.1177/002214650504600102

Davar, B. V. (2014). Globalizing psychiatry and the case of "vanishing" alternatives in a neo-colonial state. *Disabil Global South.* 1, 266–84. Available online at: https://disabilityglobalsouth.files.wordpress.com/2012/06/dgs-01-02-04.pdf (accessed October 5, 2023).

Davies, J. (2017). "Political pills: psychopharmaceuticals and neoliberalism as mutually supporting," in *The Sedated Society*, ed. J. Davies. (Cham: Palgrave Macmillan), 189–225.

Haslam, N. (2016). Concept creep: psychology's expanding concepts of harm and pathology. *Psychol. Inq.* 27, 1–17. doi: 10.1080/1047840X.2016.1082418

Illich, I. (1974). *Medical Nemesis*. London: Calder & Boyars.

Lancet Global Mental Health Group, Chisholm, D., Flisher, A. J., Lund, C., Patel, V., Saxena, S., et al. (2007). Scale up services for mental disorders: a call for action. *Lancet* 370, 1241–1252. doi: 10.1016/S0140-6736(07)61242-2

Leblanc, S., and Kinsella, E. (2016). Toward epistemic justice: a critically reflexive examination of 'sanism' and implications for knowledge generation. *Stud. Soc. Just.* 10, 59–78. doi: 10.26522/ssj.v10i1.1324

Lipson, S. K., Lattie, E. G., and Eisenberg, D. (2019). Increased rates of mental health service utilization by U.S. college students: 10-year population-level trends (2007-2017). *Psychiatr. Serv.* 70, 60–63. doi: 10.1176/appi.ps.201800332

Livingston, J. D., and Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Soc. Sci. Med.* 71, 2150–2161. doi: 10.1016/j.socscimed.2010.09.030

Mills, C. (2014). *Decolonizing Global Mental Health: the Psychiatrization of the Majority World.* London/New York, NY: Routledge.

Moynihan, R., Doust, J., and Henry, D. (2012). Preventing overdiagnosis: how to stop harming the healthy. *BMJ*. 344, e3502. doi: 10.1136/bmj.e3502

Nissen, N., and Bech Risør, M. (2018). “Configurations of diagnostic processes and practices. an introduction,” in *Diagnostic Fluidity. Working with Uncertainty and Mutability*, eds N. Nissen, and M. Bech Risør (Terragona: Publications URV), 11–32.

Olfson, M., Wang, S., Wall, M., Marcus, S. C., and Blanco, C. (2019). Trends in serious psychological distress and outpatient mental health care of US adults. *JAMA Psychiat.* 76, 152–161. doi: 10.1001/jamapsychiatry.2018.3550

Thornicroft, G., Chatterji, S., Evans-Lacko, S., Gruber, M., Sampson, N., Aguilar-Gaxiola, S., et al. (2017). Undertreatment of people with major depressive disorder in 21 countries. *Br. J. Psychiat.* 210, 119–124. doi: 10.1192/bjp.bp.116.188078

Vickers, A., Brien, F., Montorsi, F., Galvin, D., Bratt, O., Carlsson, S., et al. (2023). Current policies on early detection of prostate cancer create overdiagnosis and inequity with minimal benefit. *BMJ*. 381, e071082 doi: 10.1136/bmj-2022-071082

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., et al. (2007). Worldwide use of mental health services for anxiety, mood and substance disorders: results from 17 countries in the WHO World Mental Health (WMH) Surveys. *Lancet* 370, 841–850. doi: 10.1016/S0140-6736(07)61414-7

World Health Organization (2019). *Fact Sheet Mental Disorders*. Available online at: http://www.who.int/mediacentre/factsheets/fs396/en/ (accessed October 5, 2023).

Zola, I. K. (1972). Medicine as an institution of social control. *Soc. Rev*. 4, 487–504. doi: 10.1111/j.1467-954X.1972.tb00220.x

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Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research

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Purpose: Worldwide, there have been consistently high or even rising incidences of diagnosed mental disorders and increasing mental healthcare service utilization over the last decades, causing a growing burden for healthcare systems and societies. While more individuals than ever are being diagnosed and treated as mentally ill, psychiatric knowledge, and practices affect the lives of a rising number of people, gain importance in society as a whole and shape more and more areas of life. This process can be described as the progressing psychiatrization of society.

Methods: This article is a conceptual paper, focusing on theoretical considerations and theory development. As a starting point for further research, we suggest a basic model of psychiatrization, taking into account its main sub-processes as well as its major top-down and bottom-up drivers.

Results: Psychiatrization is highly complex, diverse, and global. It involves various protagonists and its effects are potentially harmful to individuals, to societies and to public healthcare. To better understand, prevent or manage its negative aspects, there is a need for transdisciplinary research, that empirically assesses causes, mechanisms, and effects of psychiatrization.

Conclusion: Although psychiatrization has highly ambivalent effects, its relevance mainly derives from its risks: While individuals with minor disturbances of well-being might be subjected to overdiagnosis and overtreatment, psychiatrization could also result in undermining mental healthcare provision for the most severely ill by promoting the adaption of services to the needs and desires of the rather mild cases. On a societal level, psychiatrization might boost medical interventions which incite individual coping with social problems, instead of encouraging long-term political solutions.

Keywords: psychiatrization, transdisciplinary research, psychiatric epidemiology, medicalization, overdiagnosis, health system research, medical sociology, mental health

INTRODUCTION: SCOPE OF THE PROBLEM

According to the World Health Organization, nearly 10% of the world's population is affected by common mental disorders at any given time (1). Depression and anxiety disorders alone are estimated to cost the global economy more than one trillion dollars each year (2), while the burden on health-care systems and societies is allegedly still underestimated (3, 4) and projected to grow constantly (5). However, epidemiological field studies mostly suggest either consistently high prevalences since the introduction of DSM-III in the year 1980 or show rather small increases (6). In the USA, nearly a full half of the population is claimed to meet the criteria for a DSM-IV disorder over the course of their lives (7, 8), confirming previous data using DSM-III-R as diagnostic manual (9). A meta-analysis of mental health surveys across 63 countries identified an average 12-month prevalence of 17.6% for common mental disorders (10). At the same time, epidemiological research on child and adolescent mental health indicates that approximately one in five children and adolescents worldwide are affected by mental health problems (11, 12).

Despite epidemiological research pointing to high, but relatively stable incidences and prevalences of mental disorders, there is clear evidence that more and more people are using in- or outpatient mental health services, regularly resulting in the prescription of psychotropic medication. For instance, antidepressant drug consumption more than doubled between 2000 and 2015 in many OECD- countries (13). In Germany, there have been constant increases of psychiatric hospital beds and in-patient case-numbers from 2007 to 2016 (14). Also, disability pensions due to mental disorders have increased in many countries (15–17). In the USA, the number of outpatient mental health service users increased by nearly one-fifth within one decade, while an estimated 1 in 6 US-adults are on psychiatric drugs at some point per year (18, 19) Among American college students, the rates of past-year psychiatric or psychotherapeutic treatment nearly doubled from 2007 to 2017 (from 19 to 34%) (20). Epidemiological field studies concerning mental disorders in non-Western countries are rare and prevalence rates often rely on estimates (10, 21–23). Nevertheless, Western psychiatric concepts and mental healthcare are expanding to the Global South, which is supported by international organizations like the WHO and World Bank, advocating for "scaling up" access to mental health services (24).

Explanations for the consistently high prevalences, increase in diagnoses and rising mental healthcare service use are diverse. It has been recurrently argued that improved recognition and advancing destigmatization of mental disorders might be uncovering its real prevalence for the first time (25–27). Also, contemporary working and living conditions (28–32), conflict, poverty and inequality (33), inflated epidemiologic data (34, 35), and overdiagnosis (36, 37) are speculated to be contributing to what seems to be a significant increase in psychiatric morbidity. Although all of these factors appear to be relevant, the question remains whether there is a more general, higher-order process behind these developments, both connecting and explaining them. In this paper, this process is identified as a progressing psychiatrization of society.

This article aims to be a theoretical contribution to advance further studies. Its main purpose is the systematic development of a model of psychiatrization, which can serve as starting point for both empirical and conceptual research.

Methodology (Purpose)

There is a rich canon of literature in the social sciences, medical anthropology, and critical psychology which deals with various aspects of psychiatrization, but mostly using different terminology and against different theoretical backgrounds. Also, this literature usually targets a micro-level [e.g., ethnographic case studies on the effects of psychiatric diagnosis (38–40)] or is unspecific to the field of psychiatry (e.g., research on medicalization, pharmaceuticalization, see below). Yet, as discussed in the introduction, there is empirical research from the medical field that points at various developments within psychiatry (e.g., research on drug safety, prescription rates, overdiagnosis, and overtreatment), based on numerous sources and levels of data from different domains and disciplines. Both fields of discourse are rarely brought into productive contact with each other. This may result in conceptual research which tends to neglect empirical data of the criticized psychiatric discourse itself and then again in medical research which does not specifically aim at a theory-based interpretation of its own findings in the light of larger social, political, and cultural developments.

Methodologically, this article is a conceptual paper which focusses on theoretical considerations and theory development. Its intention is neither to prove empirically that psychiatrization exists nor to speculate in whichever ontological sense this could be true. In line with Grant & Booth's typology of reviews, it can be considered as "critical review" that "goes beyond mere description" to produce "a hypothesis or a model, not an answer," and which can serve as a "launch-pad" for further conceptual, but also empirical research [(41), p. 93]. Drawing on a diverse literature base on various aspects of psychiatrization, this article aims at mediating between the plurality of disciplines, concepts, and available data. It intends to contribute to a synthesis of the discourses within medical and social sciences, which are not only heterogeneous but stand in a tradition of being perceived as incommensurable.

Given that psychiatrization is a highly diverse, ambiguous and in itself transdisciplinary research object with fuzzy edges, a systematic literature review covering the multitude of disciplines involved was not feasible. Instead, literature was selected with regard to content and by focusing on the most influential authors and most quoted theoretical contributions surrounding psychiatrization over approximately the past 25 years. Drawing on this rich corpus of literature, an overarching, yet preliminary, model is proposed, which integrates the main actors, drivers and sub-processes of the field into a larger framework that eventually aims at setting the stage for further transdisciplinary research.

Given that the main body of research literature focusses on the Global North, the emphasis of this article will necessarily lie on how psychiatrization manifests in industrialized countries where established psychiatric services already exist. However, despite the limitations of our approach, psychiatrization in low and middle income countries will remain an equally important topic for any kind of further research.

CONCEPTUAL ANALYSIS

Related Concepts

The term "psychiatrization" is first mentioned in psychiatric literature in the year 1983 by Dušan Kecmanovic, who briefly discusses psychiatric labeling of social phenomena or of deviance from existing norms (42). Within the last years, a range of popular criticism about certain aspects of psychiatry's expansion has been mostly interested in the soaring use of psychotropic medication or the inflation of diagnostic categories in the context of DSM-5, which appeared in 2013 (36, 43–46). However, more ambitious empirical and theoretical scholarship with an explicit focus on psychiatrization as higher-order process, aiming at an overarching theory or presenting a comprehensive model is rare.

For instance, the sociologist Nikolas Rose examines reasons for and interpretations of the inflation of some psychiatric diagnoses and related treatments, but without using the term psychiatrization or attempting to systemize his findings under a different term. Instead, he concludes by advocating a more complex approach to understand the growth of these diagnoses in the broader context of Western societies and their cultural developments (47). The rich work of philosopher of science Ian Hacking puts an emphasis on how psychiatric classification interacts with society, but without focusing on the expansion of psychiatry as a whole, e.g., by considering quantitative data, or developing a more unified model. However, Hacking compellingly shows how psychiatric taxonomy can deeply change the identity of the targeted persons, who, in return, react to the provided description by various degrees of embracement or resistance, which then creatively re-shapes the classifications ("looping effect") (48, 49). Hacking also claims that classification has the power of literally "bringing into existence" the classified objects, thus "making up people" and creating "ecological niches" for new ways of existence as a certain kind of person (50, 51).

Furthermore, there is some ethnographic research detailing a few of psychiatrization's mechanisms at work in specific countries and groups worldwide (38–40, 52–54). Theoretical and experiential accounts of psychiatrization are also evident in psychiatric user and survivor scholarship, the burgeoning area of Mad Studies (55–57), and, of course, the classic anti-psychiatric literature of the 1960s and 70s (58–61). Recently, there have been several campaigns and publications addressing medical overdiagnosis and disease-mongering in general but lacking a special focus on psychiatry (62–66). Conceptually, psychiatrization unfolds as a co-production of various psy-disciplines (psychology, psychotherapy, psychoanalysis) from which mostly synergistic processes of dispersion of psy-knowledge, concepts, and vocabulary are derived (67). It shares many features with various current or preceding concepts and theories that are grounded in a plethora of disciplines:

(1) The conceptual framework of medicalization has been mainly coined by social scientists, among them Irving Zola, Peter Conrad, and Ivan Illich (68–74). Medicalization is understood as the process of defining and treating problems as medical that formerly had been perceived as non-medical, and thus expanding medical jurisdiction into new realms.

(2) Building on these ideas, the concept of biomedicalization (75) describes an intensification of medicalization driven by technological progress in the bio- and life-sciences, whose main vector of expansion is the conversion of health into a commodity and normality into something which has to be maintained or actively produced.

(3) A third line of argument uses the term pharmaceuticalization to point to a growing consumption of prescription- and lifestyle-drugs in many fields of medicine (76–78). More specific to psychiatry, medical anthropologist Janis Jenkins (79) explores how the cultural constitution of the self is influenced by widespread use of psychopharmaceuticals, while Nikolas Rose (80) has coined the expression of "neurochemical selves" for individuals who experience their own emotions as epiphenomena of their brain chemistry.

(4) A fourth theoretical tradition builds on the notion of psychologization (81, 82) or therapeutization (83), seeing psychology as a discipline that shares or better reproduces many of psychiatry's most fundamental assumptions. Yet, unlike psychiatry, psychology does not necessarily make claims about the biological base of mental illness or human behavior in general. Instead it supports the psychiatric epistemology by centering around individualist categories (e.g., individual capacities or deficiencies), and thereby tending to overlook or neglect political and social contexts. In a slightly different sense, psychologization is also used to refer to society's growing interest in individual emotions and psychological mechanisms in general over the last decades, preparing the breeding ground for what has been called a "therapy culture" (84). In a similar vein, it has been argued that many psychological concepts relating to harmful events and negative human experience have undergone semantic shifts within the last years in a way that they now include a broader range of phenomena or quantitatively less extreme examples of already known phenomena. This "concept creep" is hypothesized to mirror society's growing sensitivity toward harm and suffering, but on the other hand, criticized for contributing to further psychologizing and pathologizing normal experiences (85).

Psychiatrization: A Working Definition

Psychiatrization is notoriously hard to define, as psychiatry itself is diverse, comprising rivaling branches with very different views on what causes and defines mental disorders and how to treat them. Also, the boundaries between psychiatry and neighboring disciplines like clinical psychology are often fuzzy and difficult to determine. Synthesizing the aforementioned approaches and concepts, we suggest to define psychiatrization as a *complex process of interaction between individuals, society, and psychiatry* through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole. Psychiatrization is an ongoing process which is not monolithic. Like other complex social developments, such as individualization or modernization, it is in itself extremely heterogeneous and appears in multiple, steadily transforming sub-processes (86) (see **Figure 1**). It can include both material (e.g., growth of psychiatric infrastructures) as well as ideological aspects (e.g., defining a certain condition as disorder) and is rooted in numerous fields and disciplines (e.g., psychology, psychotherapy, etc.). As a whole, psychiatrization reciprocally both causes and reflects the seemingly high incidences of psychiatric disorders and growing mental healthcare utilization.

Although there is some criticism that psychiatric epidemiology might be over-inclusive and biased (87–89), high prevalences and incidences of mental disorders, and even more so, strong evidence for growing service-use based on psychiatric diagnosis indicate that an increasing number of people currently *are* or *are likely to* be affected by psychiatry either directly or indirectly. This demonstrates the core feature of psychiatrization: its strong drive toward quantitative expansion (47), which comes into being, for example, through changes in diagnostic practices [e.g., through diagnostic inflation (36, 73, 90)], the growth of the psychiatric healthcare system in many countries or the soaring use of psychotropic drugs worldwide (13, 19, 91). Changes at the institutional or scientific level often correspond with more subtle transformations, such as the infusion of psychiatric terminology into everyday language (e.g., trauma, paranoid) or the interpretation of life events and personal experiences through the lens of psychiatric concepts (e.g., burn-out, depression). Thus, psychiatrization also transforms the life worlds of people without any personal connection to psychiatry.

However, the general psychiatrization of society might also be contrasted with rare examples of de-psychiatrization, which demonstrate that psychiatrization is not a deterministic one-way road. Instead, it is actively negotiated and can sometimes even be openly resisted by professionals as well as by laypeople. The most prominent case of de-psychiatrization might be the de-pathologization of homosexuality and its removal from DSM-II in 1973, showcasing that changing attitudes in society can also result in the rejection of psychiatric labels and normalize behavior, which was previously deemed “sick” or “ill” (92). Also, competing psy-disciplines might sometimes, at least partially, challenge psychiatrization despite sharing some underlying logic, for example, when therapists oppose the pharmaceutical treatment of disorders thought to respond better to psychotherapy.

Approaching a Comprehensive Model

According to the literature mentioned above and the broad variety of factors for psychiatric expansion that it displays, it is important to keep in mind that the various manifestations of psychiatrization are not under central control or a common endeavor of certain key-players. Their power derives much more from public and scientific discourse or economic rationality than from deliberate actions of specific individuals. This also implies that explanations that mainly focus on the collaboration between psychiatry and the pharmaceutical industry run the risk of scientifically falling short (36, 44). However, in most cases, psychiatrization unfolds in multiple interactions with vectors going *top-down* as well as *bottom-up*. This dynamic can also implicate looping-effects in the very sense of Ian Hacking’s theory (48, 49).

As a heuristic approximation, relevant protagonists can be classified into agents on the top-level or on the bottom-level. Top-level agents are defined as being either mental healthcare professionals or in other ways professionally tied to the healthcare system, while the agents on the bottom level are “laypeople” from a medical point of view, who do not have a professional connection to (mental) healthcare. A comprehensive model of psychiatrization and any further analysis needs to incorporate these two main levels and the vectors of interaction in between (see, **Figure 1**). This structure may also serve as a scheme to help characterize single sub-processes of psychiatrization (93).

Top-Down Psychiatrization

Typical protagonists of top-down psychiatrization would be psychiatrists, psychotherapists, clinical, and non-clinical scientists with connections to psychiatry, politicians with an impact on healthcare on a structural level, health insurers, pension funds, the pharmaceutical industry, and medical engineering companies. Examples for top-down-initiated psychiatrization processes can be large scale restructuring of mental health services, lawmaking, publication of new treatment and diagnostic guidelines, the introduction of new diagnoses into ICD and DSM, diagnosis- or treatment-related financial incentives by insurers, the development of new and the approval of existing psychotropic drugs for certain conditions, compulsory mental health screening in schools and workplaces, and requirements for diagnoses to access educational support.

> In the texts that form the foundation for this conceptual mapping, various examples for analysis focusing on top-down-mechanisms are provided. For instance, Whitaker and Cosgrove detail how top-down psychiatrization in the USA evolved in close cooperation between the American Psychiatric Association, the pharmaceutical industry and academic psychiatry, resulting in the systematic popularization of overestimated benefits from SSRI-treatment and in official treatment guidelines comprising recommendations which contradict solid scientific evidence (44).
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> Conrad (72) describes the re-shaping of the DSM-III diagnosis “social phobia” into “social anxiety disorder” (SAD) in DSM-IV, which has been criticized elsewhere as “the medicalization of shyness” (94). Small changes in wording expanded the reach of this previously rather rare diagnosis considerably. This was embraced by the pharmaceutical company SmithKline Beecham’s as an opportunity to sell the SSRI-antidepressant Paxil, despite the market for depression having already reached saturation. Conrad highlights the crucial importance of *lawmaking*, as the loosening of legal requirements for direct-to-consumer (“DTC”) pharmaceutical advertising in the United States set the stage for a new marketing strategy with emphasis on television commercials. These turned out to play a key role in creating the “anxiety-market” by raising public awareness for SAD as a widespread and highly debilitating condition and, after Paxil’s FDA-approval for SAD

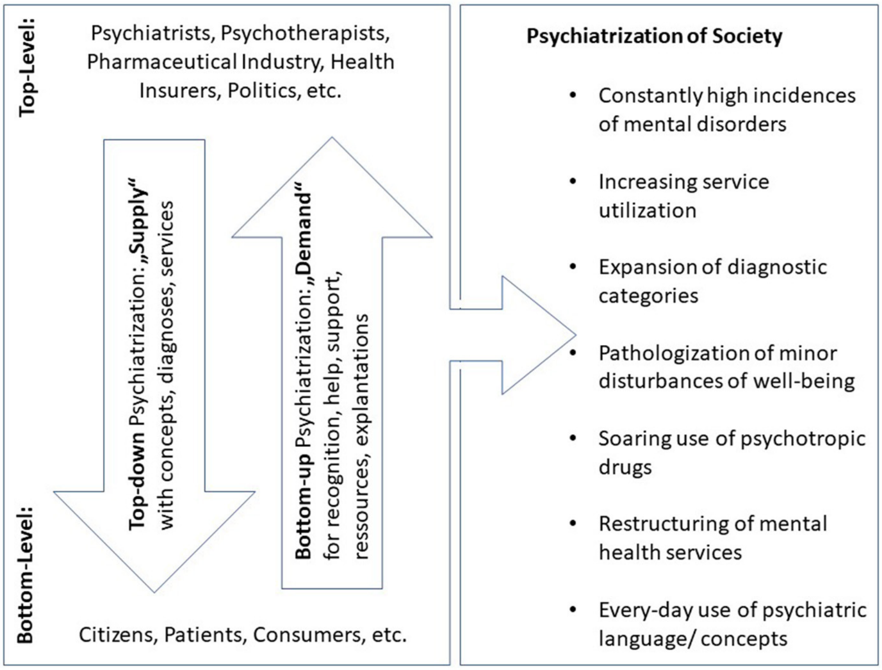

FIGURE 1 | Top-down and bottom-up psychiatrization (original figure). Main protagonists and vectors of psychiatrization consisting of heterogeneous sub-processes, of which the most important are listed on the right side of the figure.

in 1999, by promoting Paxil as the adequate remedy. In this case of top-down psychiatrization, changes to the DSM and federal lawmaking contributed heavily to the creation of a new epidemic of SAD with estimated point prevalences of up to 13,3% in the US-population on the one hand (72), and Paxil becoming one of the world's best-selling drugs of all time on the other hand (71).

A more recent example of top-down psychiatrization, which has been discussed extensively in both scientific and popular literature, is the suspension of the so called "bereavement-exclusion" from DSM-IV to DSM-5 (95–97). This alteration, which was performed in a top-down-way by the DSM-5 Task Force, is criticized for further inflating the psychiatric category of depression, thus blurring the line between mental illness and ordinary grief while making more individuals eligible for psychiatric treatment.

In the Global South, top-down psychiatrization may occur through turning culturally accepted ways of expressing distress into psychiatric conditions, e.g., through integration as culture-bound syndromes into DSM and through mental health legislation, such as the categorization of specific psychotropic drugs as "essential medicines" by the WHO or its encouragement of the use of the mhGAP-Intervention Guide as diagnostic and treatment algorithm in primary care (24, 98, 99). Also, the pharmaceutical industry's initiatives to open up new markets for psychotropic medication in non-Western countries can often be seen as mainly top-down driven cases of psychiatrization (100). Exporting specific medication may also entail the export of the very Western concepts of mental disorders which are the underlying rationales for its use, as has been discussed e.g., for the marketing of SSRI-antidepressants in Japan (101, 102).

Bottom-Up Psychiatrization

Most criticism about psychiatry's expansion highlights agents on the top-level and top-down processes. However, it seems to be a main characteristic of psychiatrization in modern and postmodern societies that it is advanced to a significant degree by laypeople without professional ties to psychiatry or the health-care system in general (see, **Figure 1**). This argument is in line with Michel Foucault's claim that psychiatrization might be "requested, rather than imposed" [(103), p. 296] and "does not come from above, or not only from above" [p. 295]. As opposed to top-down psychiatrization, where the supply of certain options (treatments, diagnosis, etc.) precedes and prompts the demand on the bottom-level, the concept of *bottom-up psychiatrization* underlines that the needs and desires of patients, proto-patients, and consumers can also induce changes on the top-level. This typically results in widening the range, changing the kind or facilitating the accessibility of the available options. Hence, the psychiatric permeation of individual life and collective spheres in capitalist Western societies is to a large part *demand-* and *consumer-driven*, which resonates with widespread claims about the gradual transformation of patients into consumers in medical sociology (70, 104, 105) and the commodification of individual health (75, 106).

Typical drivers of bottom-up psychiatrization might be people searching for recognition of subjective suffering or difference through clinical diagnosis (47), people with mild or unspecific "symptoms" using professional healthcare services without clear indication (107, 108), or the demand of parents or other caregivers for diagnoses and treatment of perceived learning and behavioral disorders (109, 110). Individual interests might also be organized in and articulated by advocacy groups trying to raise awareness for certain diseases and stimulate political action in favor of people with specific diagnoses (110, 111).

In the aforementioned literature and related publications, several examples for bottom-up psychiatrization can be found, although the traditional view of psychiatric expansion lays more emphasis on top-down processes. Conrad (71) and Scott (112) analyze the inclusion of Posttraumatic Stress Disorder (PTSD) into the DSM-III as a joined endeavor of returning Vietnam war veterans and some anti-war psychoanalysts and psychiatrists. The objectification of PTSD as psychiatric disorder hence was driven to a substantial degree by political motivations and private, not least financial interests of laypeople, namely ex-soldiers, whose psychological distress due to deeply disturbing war experiences had not been officially recognized as disorder before (113).

Conrad and Potter (48) describe how Attention Deficit Hyperactivity Disorder (ADHD) evolved from a condition which used to be limited to childhood into a lifespan disorder. This transformation was triggered by a wave of books and articles in lay media popularizing the idea that ADHD could persist beyond childhood and might account for many problems in adult life such as relationship issues or disorganization at the workplace. The ADHD support and advocacy group CHADD ("Children and Adults with Attention-Deficit/Hyperactivity Disorder") played a prominent role in the further promotion of the idea that ADHD should be seen as neurobiologically caused and consequently as a lifespan-disorder. Within this context, many adults who claimed to recognize themselves in ADHD-symptomatology were seeking official confirmation of their self-diagnosis from GPs and psychiatrists, often also asking to be treated with medication. In this case, bottom-up psychiatrization was mainly driven by ordinary individuals' demand for explanations, official recognition and medical treatment of their life-problems or suffering as psychiatric disorder, relating to what Nikolas Rose has described as the readiness for "the psychiatric reshaping of discontents" [48, p. 479]. It ultimately led to the inclusion of adult ADHD into DSM-IV and the FDA-approval of psychostimulants and other medication for its treatment, which from then on were routinely prescribed by physicians.

Similar constellations, in which primarily consumers and/or patients campaign for the official recognition of particular disease entities, can be found for many psychosomatic symptom clusters such as chronic fatigue or fibromyalgia syndrome (114, 115). However, because laypeople always need to mobilize agents of the top-level to achieve effective changes (e.g., of the DSM), in all of these examples medical expertise has to be incorporated at some levels. This expertise may consist of scholars with research interest in particular conditions, or in clinicians who also identify as activists for a certain kind of suffering and become "moral entrepreneurs" [48, p. 476]. Top-level agents may thus even actively encourage bottom-up psychiatrization (93). Also, as in the case of CHADD, financial support from the pharmaceutical industry might help to maximize reach and political leverage of self-advocacy (48, 116). Still, it seems justified to interpret the above cases as bottom-up psychiatrization, as the main initiative in all of them derives from ordinary people without professional ties to the healthcare-system.

In the Global South, bottom-up psychiatrization appears to happen more rarely or is at least less represented in scientific literature. Mental health advocacy, e.g., for scaling up psychiatric services or to reduce stigma, is usually led by professionals or by human rights activists, mostly originating from countries of the Global North (24). However, a key strategy of many NGOs is to train non-specialists in tasks (diagnostics, administering medication, etc.) which are usually carried out by mental health professionals. This re-distribution of professional work known as *task-sharing* explicitly aims at laypeople acting as proxies of psychiatric experts and thus could arguably be conceived as bottom-up psychiatrization (117). Still, bottom-up psychiatrization understood in the sense of demand- or desire-driven induction of changes on the top-level seems to take place rather in consumerist societies, where economies run on evoking desires and elaborate psychiatric infrastructures already exist.

DISCUSSION

Relevance and Consequences

Processes of psychiatrization are increasingly relevant in the light of a fundamental reorientation of mental healthcare provision in many countries worldwide (e.g., through digitalization, further deinstitutionalization, and the scaling up of community care), which may coincide with ongoing profound political and social changes (e.g., due to economic crisis, climate change, globalization) (86, 118–121). The extent, and dynamics of psychiatrization processes largely depend on the economic situation of a region or country, the structure of its healthcare system or cultural influences. Given the magnitude of these factors, which all include a historical dimension that adds further complexity, a full assessment of context and origins remains a challenge for future research. Also, the effects of psychiatrization are diverse, highly ambivalent, and significantly influenced by the aforementioned local factors. Individuals or groups might well-benefit from aspects of psychiatrization, as the growing mental healthcare system can also increase accessibility and provision of services that are subjectively helpful and medically clearly indicated. Thus, it can be complicated for research to distinguish legitimate attempts to meet real unmet-needs from building up infrastructures which create artificial need or promote pathologization and overtreatment of mental distress, especially in areas with little specialized care for mental disorders.

However, further research about the nuances of psychiatrization is necessary. Besides significant regional differences in its causes and mechanisms, the role of mental health professionals other than psychiatrists or psychotherapists may be a crucial, widely unexplored aspect. Given the trend to the multidisciplinary treatment of mental distress in the Global North, professions such as occupational therapists, social workers, mental health nurses, or rehabilitation counselors deserve a special focus. They may be agents who play an important role in mediating between the top- and the bottom-level of psychiatrization (see, **Figure 1**). On the one hand, although they do not exert the power of psychiatric diagnosis themselves, they might benefit from psychiatric expansion and their professional (group) interests might be a reinforcing factor. On the other hand, their work may also contribute to preventing psychiatrization or to mitigate its effects, e.g., by avoiding hospitalization or by empowering people in mental distress to overcome crisis without consulting a psychiatrist or psychotherapist. In this context, it will also be an important research question how the growing involvement of mental health service-users as counselors or lay-therapists in psychiatric institutions relates to psychiatrization.

Advancing research on psychiatrization may be important, in the light of its obvious risks on the individual, societal and public health-level: First, on the individual level, negative consequences of psychiatrization may relate to overdiagnosis and overtreatment, e.g. medication adverse effects and harms from long term use (43, 122–128), but may also be about the impacts of labeling and of coercive treatments (129–131). Through pathologization of minor disturbances of well-being, individual variation and numerous life issues, psychiatrization can also co-produce avoidable patient careers, create dependencies on mental health services, and ultimately promote disempowering changes to subjectivity and sense of self (80, 132–134).

Second, on the societal level, psychiatrization may risk to further narrow the range of what is perceived as "normal," encourage ineffective and short-term medical interventions, prompt individuals to cope with social problems and impede the finding of adequate long-term solutions (67, 134, 135). Such solutions would be situated rather in the realm of politics, where psychiatrization might otherwise be contributing to disguising failed policies.

Third, from a public health perspective, psychiatrization of society runs the risk of establishing widespread inverse care by increasingly neglecting the most severely and chronically ill, when mental health services are tailored to the needs of the mildly ill and borderline cases (18, 136, 137). Accordingly, the relative shortage of psychotherapists and long waiting times for out-patient services in some countries of the Global North may be a direct effect of structurally induced healthcare over-utilization by the "worried well" (138, 139).

Fourth, from a global perspective, psychiatrization could lead to excessive diagnosis and prescription of medication with little monitoring once people are medicated in countries with low and middle incomes, where psychiatrization is to a large degree exerted through task-sharing. In these countries this may also undermine local support systems and promote individualized interventions into poverty (67, 140). Worldwide, psychiatrization could contribute to challenging public health by misallocating scarce resources toward biomedical research and pharmacological treatment instead of strengthening psycho-social interventions (141, 142).

CONCLUSION AND PERSPECTIVES

Psychiatrization is a highly complex and diverse global process with various protagonists. Its effects are ambivalent but can be harmful in many ways to individuals, societies, and public healthcare systems. To better understand, and also to deal with negative consequences of psychiatrization, there is primarily a need for research, which might be accompanied by public debate and, ultimately, may help inform political decision-making.

On the scientific level, transdisciplinary research is necessary to empirically establish the existence of psychiatrization by assessing and, wherever possible, measuring its different causes, mechanisms and effects in relation to clearly defined areas, such as a region, a city or a nation. This kind of research should also include the different perspectives of a broad variety of professions involved in mental health care, among them, apart from psychiatrists and psychotherapists, social workers, occupational therapists, mental health nursing professionals, or rehabilitation counselors. To this end and due to the complex and multi-layered nature of the research topic, a mixed-methods approach seems most suitable (143): Quantitative methods can contribute to establishing a solid fact base about the growth of psychiatric infrastructures, local trends in prevalence, and healthcare utilization (144). Relevant data would comprise changes in treatment capacities and utilization of psychiatric hospitals and outpatient-departments, government and health insurance expenditure for mental health, trends in psychotropic drug prescription and self-reported usage, availability and utilization of psychological treatment, numbers of primary-care physician contacts for psychological problems and all kinds of available data sets about prevalence and incidences of mental disorders, e.g., as measured by national mental health surveys. Qualitative approaches such as expert interviews, in-depth group interviews or participant observation would be used to make visible the effects of psychiatrization in the everyday life of individuals, exploring subjective and collective meanings of different aspects of psychiatrization and identifying motives for engaging in psychiatrization processes or resisting them (145–147).

Both types of research will be necessary prerequisites for data-based theory development about psychiatrization, its causes, its mechanisms, and its effects on public health, individuals and society. As mentioned above, the extent and type of psychiatrization processes largely depend on the economic and political situation, culture and history of a region or country. This renders a complete assessment of context difficult to achieve. Nonetheless, a data-based theory, enriched with an in-depth description of contextual factors, seems to be a realistic goal which can also help inform public debate, stakeholders in healthcare and political decision-makers. Main overall research goals will be to better understand how changes on the level of mental healthcare provision or utilization (1) are shaped by individual action of both top- and bottom-level agents, (2) are affecting patients' and proto-patients' lives, e.g., through (over)diagnosis, changing self-definitions or inducement of patient-careers, (3) advance the dissemination of psychiatric concepts, knowledge and epistemologies in society, (4) induce or intensify the permeation of certain areas of private and public life, and (5) interact with or are determined by larger economic, social, and cultural developments.

As psychiatrization is transdisciplinary as a research-object, expertise from various fields other than psychiatry are required, such as health services research, epidemiology, and public health. To mediate between the discourses of the various sciences and disciplinary traditions, researchers with a background in ethnology, medical anthropology, sociology, and philosophy etc. should also be involved from the beginning. It will be equally important for all research to build up collaborative projects between professionals and service users that value user, survivor and Mad Studies knowledge, whose common point of reference are negative experiences with ideology and practice of clinical psychiatry and its impacts on personal well-being and biography. Thus, there is an intrinsically critical view on psychiatrization contained in the experiential knowledge of service users and the epistemologies derived from it (148).

Such transdisciplinary research as described could result in empirically proving that psychiatrization exists, developing valid indicators for its extent, showing hot spots and key-factors on a local scale, thickening theory and generating hypotheses and research goals for more complex, larger scale research programs. In the long run, as psychiatrization occurs globally, both local and global perspectives will be required, pointing out the many different ways that psychiatrization manifests, is embraced, appropriated, or resisted around the world.

AUTHOR CONTRIBUTIONS

TB, ST, and SP initiated research and were responsible for devising the article. TB developed the comprehensive model, wrote the initial draft, and coordinated the other authors' contributions. All authors contributed to literature search, interpretation of literature, helped draft the final version of the manuscript and revised the article critically for important content. All authors approve the final version to be published and agree to be accountable for all aspects of the work, its accuracy and integrity.

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REFERENCES

1. World Health Organization. *Fact Sheet Mental Disorders*. (2019). Available online at: http://www.who.int/mediacentre/factsheets/fs396/en/ (accessed May 12, 2020).
2. World Health Organization. *Out of the Shadow: Making Mental Health a Global Priority*. (2016). Available online at: https://www.who.int/mental_health/advocacy/wb_background_paper.pdf?ua=1 (accessed May 19, 2021).
3. Vigo D, Thornicroft G, Atun R. Estimating the true global burden of mental illness. *Lancet*. (2016) 3:171–8. doi: 10.1016/S2215-0366(15)00505-2
4. Takayanagi Y, Spira AP, Roth KB, Gallo JJ, Eaton WW, Mojtabai R. Accuracy of reports of lifetime mental and physical disorders: results from the baltimore epidemiological catchment area study. *JAMA Psychiatr*. (2014) 71:273–80. doi: 10.1001/jamapsychiatry.2013.3579
5. Bloom DE, Cafiero ET, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. *The Global Economic Burden of Noncommunicable Diseases*. Geneva: World Economic Forum (2011). Available online at: http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf (accessed May 4, 2020).
6. Richter D, Wall A, Bruen A, Whittington R. Is the global prevalence rate of adult mental illness increasing? Systematic review and meta-analysis. *Acta Psychiatr Scand*. (2019 140:393–407. doi: 10.1111/acps.13083
7. Kessler RC, Berglund P, Demler O, Jin R, Merikangas KR, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Arch Gen Psychiatry*. (2005) 62:593–603. doi: 10.1001/archpsyc.62.6.593
8. National Institute of Mental Health. *Statistics mental illness*. (2019). Available online at: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (accessed May 16, 2020).
9. Kessler RC, McGonagle KA, Zhao S, Nelson CB, Hughes M, Eshleman S, et al. Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the united states: results from the national comorbidity survey. *Arch Gen Psychiatry*. (1994) 51:8–19. doi: 10.1001/archpsyc.1994.03950010008002
10. Steel Z, Marnane C, Iranpour C, Chey T, Jackson JW, Patel V, et al. The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. *Int J Epidemiol*. (2014) 43:476–93. doi: 10.1093/ije/dyu038
11. Kieling C, Baker-Henningham H, Belfer M, Conti G, Ertem I, Omigbodun O, et al. Child and adolescent mental health worldwide: evidence for action. *Lancet*. (2011) 378:1515–25. doi: 10.1016/S0140-6736(11)60827-1
12. Collishaw S. Annual research review: secular trends in child and adolescent mental health. *J Child Psychol Psychiatr*. (2015) 56:370–93. doi: 10.1111/jcpp.12372
13. Organisation for Economic Co-Operation and Development (2020) *Statistics Health Status*. Available online at: https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed May 16, 2020).
14. Thom J, Bretschneider J, Kraus N, Handerer J, Jacobi F, et al. Versorgungsepidemiologie psychischer Störungen. *Bundesgesundheitsbl*. (2019) 62:128–39. doi: 10.1007/s00103-018-2867-z
15. Viola S, Moncrieff J. Claims for sickness and disability benefits owing to mental disorders in the UK: trends from 1995 to 2014. *BJPsych Open*. (2016) 2:18–24. doi: 10.1192/bjpo.bp.115.002246
16. Schofield TP, Kiely KM, Mykletun A, Harvey SB, Butterworth P. Using longitudinal survey data to estimate mental health related transitions to a disability pension. *J Occup Environ Med*. (2018) 60:166–72. doi: 10.1097/JOM.0000000000001269
17. Portal für psychische Gesundheit am Arbeitsplatz. *Daten und Fakten*. (2019). Available online at: https://www.psyga.info/psychische-gesundheit/daten-fakten/ (accessed 13 May, 2020).
18. Olfson M, Wang S, Wall M, Marcus SC, Blanco C. Trends in serious psychological distress and outpatient mental health care of US adults. *JAMA Psychiatr*. (2019) 76:152–61. doi: 10.1001/jamapsychiatry.2018.3550

19. Moore TJ, Mattison DR. Adult utilization of psychiatric drugs and difference by sex, age and race. *JAMA Intern Med*. (2017) 177:274–5. doi: 10.1001/jamainternmed.2016.7507
20. Lipson SK, Lattie EG, Eisenberg D. Increased rates of mental health service utilization by U.S. College students: 10-year population-level trends (2007-2017). *Psychiatr Serv*. (2019) 70:60–3. doi: 10.1176/appi.ps.201800332
21. Baxter A, Scott K, Vos T, Whiteford H. Global prevalence of anxiety disorders: a systematic review and meta-regression. *Psychol Med*. (2013) 43:897–910. doi: 10.1017/S003329171200147X
22. Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. *Lancet*. (2013) 382:1575–86. doi: 10.1016/S0140-6736(13)61611-6
23. Ferrari A, Somerville A, Baxter A, Pacella RE, Patten S, Vos T, et al. Global variation in the prevalence and incidence of major depressive disorder: a systematic review of the epidemiological literature. *Psychol Med*. (2013) 43:471–81. doi: 10.1017/S0033291712001511
24. Mills C. Decolonizing global mental health: the psychiatrization of the majority world. London /New York, NY: Routledge (2014). doi: 10.4324/9780203796757
25. Richter D, Berger K. Are mental disorders increasing? Update of a systematic review on repeated cross-sectional studies. *Psychiat Prax*. (2013) 40:176–82. doi: 10.1055/s-0032-1333060
26. Mars B, Heron J, Kessler D, Davies NM, Martin RM, Thomas KH, et al. Influences on antidepressant prescribing trends in the UK: 1995–2011. *Soc Psychiatry Psychiatr Epidemiol*. (2017) 52:193–200. doi: 10.1007/s00127-016-1306-4
27. Mojtabai R. Mental illness stigma and willingness to seek mental health care in the European Union. *Soc Psychiatry Psychiatr Epidemiol*. (2010) 44:705–12. doi: 10.1007/s00127-009-0109-2
28. Dittmar H, Bond R, Hurst M, Kasser T. The relationship between materialism and personal well-being: a meta-analysis. *J Pers Soc Psychol*. (2014) 107:879–924. doi: 10.1037/a0037409
29. Eckersley R. Is modern Western culture a health hazard? *Int J Epidemiol*. (2005) 35:252–8. doi: 10.1093/ije/dyi235
30. Rosa H. *Social Acceleration. A New Theory of Modernity*. New York, NY: Columbia University Press (2015).
31. Cvetkovich A. Depression. *A Public Feeling*. Durham/London, Duke University Press (2012). doi: 10.1215/9780822391852
32. Ehrenberg A. *The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age*. Montreal, McGill-Queen's University Press (1998).
33. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. (2018) 392:1553–98. doi: 10.1016/S0140-6736(18)31612-X
34. Horwitz AC, Wakefield JC. The epidemic in mental illness: clinical fact or survey artefact. *Contexts*. (2006) 5:19–23. doi: 10.1525/ctx.2006.5.1.19
35. Brhlikova P, Pollock AM, Manners R. Global burden of disease estimates of depression-how reliable is the epidemiological evidence? *J R Soc Med*. (2011) 104:25–34. doi: 10.1258/jrsm.2010.100080
36. Frances A. Saving normal: an insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary Life. New York, NY: William Morrow (2013).
37. Moynihan R, Doust J, Henry D. Preventing overdiagnosis: how to stop harming the healthy. *BMJ*. (2012) 344:e3502. doi: 10.1136/bmj.e3502
38. Jain S, Orr DM. Ethnographic perspectives on global mental health. *Transcult Psychiatr*. (2016) 53:685–95. doi: 10.1177/1363461516679322
39. Behrouzan O. *Prozak Diaries: Psychiatry and Generational Memory in Iran*. Bloomington, Stanford University Press (2016). doi: 10.1515/9780804799591
40. LeFrançois BA. The psychiatrization of our children, or, an autoethnographic narrative of perpetuating First Nations genocide through 'benevolent' institutions. *Decolon Indigen Educ Soc*. (2013) 2:108–23. Available online at: https://jps.library.utoronto.ca/index.php/des/article/view/18687/16239 (accessed May 19, 2021).
41. Grant MJ, Booth A. A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Inform Libraries J*. (2009) 26:91–108. doi: 10.1111/j.1471-1842.2009.00848.x
42. Kecmanović D. Psychiatrization: a general view. *Int J Soc Psych*. (1983) 29:308–12. doi: 10.1177/002076408302900411
43. Whitaker R. *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York, NY: Broadway Books (2010).
44. Cosgrove L, Whitaker R. *Psychiatry Under the Influence. Institutional Corruption, Social Injury, and Prescriptions for Reform*. New York, NY: Palgrave Macmillan (2015).
45. Paris J. *Overdiagnosis in Psychiatry. How Modern Psychiatry Lost Its Way While Creating a Diagnosis for Almost All of Life's Misfortunes*. New York, NY: Oxford University Press (2015). doi: 10.1093/med/9780199350643.001.0001
46. Kirsch I. *The emperor's New Drugs. Exploding the Antidepressant Myth*. London, Random House (2009).
47. Rose N. Disorders without borders? The expanding scope of psychiatric practice. *BioSocieties*. (2006) 1:465–84. doi: 10.1017/S1745855206004078
48. Hacking I. *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. New Jersey, NJ: Princeton University Press (1995). doi: 10.1515/9781400821686
49. Hacking I. *The Social Construction of What?* Cambridge, Harvard University Press (1999).
50. Hacking I. *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*. Charlottesville: University of Virginia Press (1998).
51. Hacking I. Making Up People. In: Heller TL, Sosna M, Wellbery DE, editors. *Reconstructing Individualism*. Stanford, CA: Stanford University Press (1985). p. 222–36.
52. Lakoff A. *Pharmaceutical Reason: Knowledge and Value in Global Psychiatry*. Cambridge, Cambridge University Press (2006). doi: 10.1017/CBO9780511489150
53. Mills C. The Psychiatrization of poverty: rethinking the mental health-poverty nexus. *Soc Personal Psychol Compass*. (2015) 9:213–22. doi: 10.1111/spc3.12168
54. Cohen BM. Passive-aggressive: Māori resistance and the continuance of colonial psychiatry in Aotearoa New Zealand. *Disabil Global South*. (2014) 1:319–39. Available online at: https://disabilityglobalsouth.files.wordpress.com/2012/06/dgs-01-02-06.pdf (accessed May 19, 2021).
55. Burstow B, LeFrançois BA, Diamond S. *Psychiatry Disrupted: Theorizing Resistance and Crafting the (R)evolution*. Montreal: McGill-Queen's University Press (2014).
56. LeFrançois BA, Menzies R, Reaume G, editor. *Mad Matters: A critical reader in Canadian Mad Studies*. Toronto, ON: Canadian Scholars Press Inc, (2013).
57. Russo J, Sweeney A. *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*. Monmouth: PCCS Books (2017).
58. Goffman E. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York, NY: Anchor Books (1961).
59. Foucault M. *Madness and Civilization. A History of Insanity in the Age of Reason*. New York, NY: Random House (1965).
60. Szasz TS. *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York, NY: Harper & Row (1974).
61. Cooper D. *Psychiatry and Anti-Psychiatry*. London, Tavistock/Paladin (1967).
62. *Preventing Overdiagnosis: Winding Back the Harms of too Much Medicine*. Available online at: https://www.preventingoverdiagnosis.net/ (accessed May 19, 2021).
63. ABIM-Foundation Our Mission. Available online at: http://www.choosingwisely.org/about-us/ (accessed at: May 16, 2020).
64. BMJ's Too Much Medicine Initiative. Available online at: http://www.bmj.com/too-much-medicine (accessed at: May 16, 2020).
65. Moynihan R, Heath I, Henry D. Selling sickness: the pharmaceutical industry and disease mongering. *BMJ*. (2002) 324:886–91. doi: 10.1136/bmj.324.7342.886
66. Moynihan R, Cassels A. Selling sickness. New York, NY: Nation Books (2005). doi: 10.1037/e514562004-001
67. Klein E, Mills C. Psy-expertise, therapeutic culture and the politics of the personal in development. *Third World Quart*. (2017) 38:1990–2008. doi: 10.1080/01436597.2017.1319277
68. Zola IK. Medicine as an institution of social control. *Soc Rev*. (1972) 4:487–504. doi: 10.1111/j.1467-954X.1972.tb00220.x
69. Conrad P. Medicalization and social control. *Annu Rev Sociol*. (1992) 18:209–32. doi: 10.1146/annurev.so.18.080192.001233

70. Conrad P. The shifting engines of medicalization. *J Health Soc Behav*. (2005) 46:3–14. doi: 10.1177/002214650504600102
71. Conrad P. The medicalization of society. *On the Transformation of Human Conditions into Treatable Disorders*. Baltimore, John Hopkins University Press (2007).
72. Conrad P. The medicalization of mental disorder. In: Aneshensel CS, et al., editors. *Handbook of the Sociology of Mental Health*, *2nd Edn*. Springer, Dordrecht (2013). p. 61–73 doi: 10.1007/978-94-007-4276-5_4
73. Conrad P, Potter D. From hyperactive children to ADHD adults: Observations on the expansion of medical categories. *Soc Probl.* (2000) 47:59–82. doi: 10.2307/3097135
74. Illich I. *Medical Nemesis*. London: Calder & Boyars (1974). doi: 10.1016/S0140-6736(74)90361-4
75. Clarke A, Shim J, Mamo L, Fosket J, Fishman J. Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. *Am Soc Rev*. (2003) 68:161–94. doi: 10.2307/1519765
76. Fox NJ, Ward KJ. Pharma in the bedroom…and the kitchen….The pharmaceuticalisation of daily life. *Sociol Health Illn*. (2008) 30:856–68. doi: 10.1111/j.1467-9566.2008.01114.x
77. Abraham J. Pharmaceuticalization of society in context: theoretical, empirical and health dimensions. *Sociology*. (2010) 44:603–22. doi: 10.1177/0038038510369368
78. Healy D. Pharmageddon. Berkerley, LA: University of Virginia Press (2012). doi: 10.1525/9780520951815
79. Jenkins JH, editor. *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology*. Santa Fe: SAR Press (2011).
80. Rose N. Neurochemical selves. *Society*. (2003) 6:46–59. doi: 10.1007/BF02688204
81. Gordo Lopez A, De Vos J. Psychologism, psychologising and de-psychologisation. *Ann Rev Crit Psychol*. (2010) 8:3–7. Available online at: https://thediscourseunit.files.wordpress.com/2016/05/arcp8full.pdf (accessed May 19, 2021).
82. De Vos J. From Milgram to Zimbardo: the double birth of postwar psychology/psychologization. *Hist Hum Sci*. (2010) 23:156–75. doi: 10.1177/0952695110384774
83. Sommers CH, Satel S. *One Nation Under Therapy: How the Helping Culture is Eroding Self-Reliance*, New York, NY: St Martin's Press (2005).
84. Furedi F. *Therapy Culture: Cultivating Vulnerability in an Uncertain age*. London, Routledge (2004).
85. Haslam N. Concept creep: psychology's expanding concepts of harm and pathology. *Psychol Inq*. (2016) 27:1–17. doi: 10.1080/1047840X.2016.1082418
86. Bauman Z. *Liquid Modernity*. Cambridge: Polity Press (2000).
87. Jorm AF. National surveys of mental disorders: Are they researching scientific facts or constructing useful myths? *Aust N Z J Psychiatr*. (2006) 40:830–4. doi: 10.1080/j.1440-1614.2006.01901.x
88. Wakefield JC, Schmitz MF. The challenge of measurement of mental disorder in community surveys. In: Pilgrim D, Rogers A, Pescosolido B, editors. *The Sage Handbook of Mental Health and Illness*. New York, NY: Sage (2011). p. 26–48. doi: 10.4135/9781446200988.n2
89. Wakefield JC. DSM-5, psychiatric epidemiology and the false positives problem. *Epidemiol Psychiatr Sci*. (2015) 24:188–96. doi: 10.1017/S2045796015000116
90. Batstra L, Frances A. DSM-V further inflates attention deficit hyperactivity disorder. *J Nerv Ment Dis*. (2012) 200:486–8. doi: 10.1097/NMD.0b013e318257c4b6
91. Pratt LA, Brody DJ, Gu Q. *Antidepressant Use Among Persons Aged 12 and Over: United States, 2011–2014*. NCHS Date Brief No. 283 (2017). Available online at: https://www.cdc.gov/nchs/data/databriefs/db283_table.pdf#4 (accessed May 16, 2020).
92. Drescher J. Out of DSM: depathologizing homosexuality. *Behav Sci*. (2015) 5:565–75. doi: 10.3390/bs5040565
93. Beeker T, Witeska-Młynarczyk A, te Meerman S, Mills C. Psychiatrization of, with and by children: drawing a complex picture. *Glob Stud Child*. (2020) 10:12–25. doi: 10.1177/2043610619890074
94. Scott S. The medicalisation of shyness: from social misfits to social fitness. *Sociol Health Illn*. (2006) 28:133–53. doi: 10.1111/j.1467-9566.2006.00485.x
95. Wakefield JC. The DSM-5 debate over the bereavement exclusion: psychiatric diagnosis and the future of empirically supported treatment. *Clin Psychol Rev*. (2013) 33:825–45. doi: 10.1016/j.cpr.2013.03.007
96. Bandini J. The medicalization of bereavement: (Ab)normal Grief in the DSM-5. *Death Stud*. (2015) 39:347–52. doi: 10.1080/07481187.2014.951498
97. Horwitz AV. The DSM-5 and the continuing transformation of normal sadness into depressive disorder. *Emot Rev*. (2015) 7:209–15. doi: 10.1177/1754073915575401
98. World Health Organization. *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings*. (2010). Available online at: https://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/ (accessed at: May 8, 2020).
99. Dua T, Sharma A, Patel A, Hanna F, Chowdhary N, Saxena S. Integrated care for mental, neurological and substance use disorders in non-specialized health settings: rising to the challenge. *World Psychiatr*. (2017) 16:216–7. doi: 10.1002/wps.20430
100. Watters E. *Crazy Like Us: The Globalization of the American Psyche*. New York, NY: Free Press (2011).
101. Kirmayer LJ. Psychopharmacology in a globalizing world: the use of antidepressants in Japan. *Transcult Psychiatr*. (2002) 39:295–322. doi: 10.1177/136346150203900302
102. Applbaum K. Educating for Global Mental Health. The Adoption of SSRIs in Japan. In: Petryna A, Lakoff A, Kleinman A, editors. *Global Pharmaceuticals. Ethics, Markets, Practices*. Durham; London: Duke University Press (2006). p 85–110. doi: 10.1215/9780822387916-004
103. Foucault M. *Abnormal: Lectures at the Collège de France*, *1974–1975*. New York, NY: Picador (2003).
104. Miller P, Rose N. Mobilizing the consumer: assembling the subject of consumption. *Theory Cult Soc*. (1997) 4:1–36. doi: 10.1177/026327697014001001
105. Applbaum K. Pharmaceutical marketing and the invention of the medical consumer. *PLoS Med*. (2006) 3:445–7. doi: 10.1371/journal.pmed.0030189
106. Ignaas D, van Hoyweghen I. A new era of medical consumption: medicalisation revisited. *Aporia*. (2011) 3:16–21. Available online at: http://hdl.handle.net/1854/LU-1852744 (accessed May 19, 2021).
107. Barsky AJ, Borus JF. Somatization and medicalization in the era of managed care. *JAMA*. (1995) 274:1931–4. doi: 10.1001/jama.1995.03530240041038
108. Emanuel EJ, Fuchs VR. The perfect storm of overutilization. *JAMA*. (2008) 299:2789–91. doi: 10.1001/jama.299.23.2789
109. Singh I. Doing their jobs: mothering with Ritalin in a culture of mother-blame. *Soc Sci Med*. (2004) 59:1193–205. doi: 10.1016/j.socscimed.2004.01.011
110. Hande MJ, Taylor S, Zorn E. Operation ASD: philanthrocapitalism, spectrumization, and the role of the parent. In: Burstow B, editor. *Psychiatry Interrogated*. Cham: Springer International Publishing (2016). p. 81–101. doi: 10.1007/978-3-319-41174-3_5
111. Epstein SG. Patient groups and health movements. In: Hackett EJ, Amsterdamska O, Lynch M, Wajcman J, editors. *The Handbook of Science and Technology Studies*, *3rd Edn*, Cambridge, MIT Press (2008). p. 499–539.
112. Scott WJ. PTSD in DSM-III: a case in the politics of diagnosis and disease. *Soc Probl*. (1990) 37:294–10. doi: 10.2307/800744
113. Young A. *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder*. Princeton NJ, Princeton University Press (1995). doi: 10.1515/9781400821938
114. Barker K. Self-Help literature and the making of an illness identity: the case of fibromyalgia syndrome (FMS). *Soc Probl*. (2002) 49:279–300. doi: 10.1525/sp.2002.49.3.279
115. Barrett D. Illness movements and the medical classification of pain and fatigue. In: Packard RM, Brown PJ, Berkelman RL, Frumkin H, editors. *Emerging Illnesses and Society: Negotiating the Public Health*. Baltimore, MD, Johns Hopkins University Press (2004). p 139–70.
116. Rose SL. Patient advocacy organizations: institutional conflicts of interest, trust, and trustworthiness. *J Law Med Ethics*. (2013) 41:680–7. doi: 10.1111/jlme.12078
117. Patel V. *Where There is no Psychiatrist. A Mental Health Care Manual. Royal College of Psychiatrists*, Glasgow: Bell and Bain (2003).
118. Bauman Z. *Globalization. The Human Consequences*. Cambridge: Polity Press (1998).

119. Crouch C. *Post-Democracy*. Cambridge: Polity Press (2004). doi: 10.1093/0199259402.003.0007
120. Piketty T. *Capital in the Twenty-First Century*. Cambridge MA: Harvard University Press (2014). doi: 10.4159/9780674369542
121. Klein N. *This Changes Everything. Capitalism vs. the Climate*. New York, NY: Simon & Schuster (2014).
122. Castner SA, Williams GV, Goldman Rakic PS. Reversal of antipsychotic-induced working memory deficits by short-term dopamineD1 Receptor stimulation. *Science*. (2000) 287:2020–2. doi: 10.1126/science.287.5460.2020
123. Reilly JL, Harris MSH, Keshavan MS, Sweeney JA. Adverse effects of risperidone on spatial working memory in first-episode schizophrenia. *Arch Gen Psychiatr.* (2006) 63:1189–97. doi: 10.1001/archpsyc.63.11.1189
124. Faber G, Smid HGOM, van Gool AR, Wiersma D, Van Den Bosch RJ. The effects of guided discontinuation of antipsychotics on neurocognition in first onset psychosis. *Eur Psychiatr.* (2012) 27:275–80. doi: 10.1016/j.eurpsy.2011.02.003
125. Kirsch I, Deacon BJ, Huedo-Medina TB, Scoboria A, Moore TJ, Johnson BT. Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS Med.* (2008) 5:e45. doi: 10.1371/journal.pmed.0050045
126. Turner EH, Matthews AM, Linardatos E, Tell RA, Rosenthal R. Selective publication of antidepressant trials and its influence on apparent efficacy. *N Engl J Med*. (2008) 358:252–60. doi: 10.1056/NEJMsa065779
127. Read J, Cartwright C, Gibson K. Adverse emotional and interpersonal effects reported by 1829 New Zealanders while taking antidepressants. *Psychiatry Res*. (2014) 216:67–73. doi: 10.1016/j.psychres.2014.01.042
128. Fava GA, Gatti A, Belaise C. Withdrawal symptoms after selective serotonin reuptake inhibitor discontinuation: a systematic review. *Psychother Psychosom*. (2015) 84:72–81. doi: 10.1159/000370338
129. Livingston JD, Boyd JE. Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Soc Sci Med*. (2010) 71:2150–61. doi: 10.1016/j.socscimed.2010.09.030
130. Chang CR, Bassman R. Psychiatric diagnosis and the power of names. *J Humanist Psychol.* (2019) 59:1–23. doi: 10.1177/0022167819852786
131. Georgieva I, Mulder CL, Whittington R. Evaluation of behavioral changes and subjective distress after exposure to coercive inpatient interventions. *BMC Psychiatr.* (2012) 12:54. doi: 10.1186/1471-244X-12-54
132. Von Peter S. 'Chronic' identities in mental illness. *Anthropol Med*. (2013) 20:48–58. doi: 10.1080/13648470.2013.772493
133. Haslam N, Kvaale EP. Biogenetic explanations of mental disorder: the mixed-blessings model. *Curr Dir Psychol Sci*. (2015) 24:399–404. doi: 10.1177/0963721415588082
134. Brinkmann S. *Diagnostic Cultures: A Cultural Approach to Pathologization of Modern Life*. New York, NY: Routledge (2016). doi: 10.4324/9781315576930
135. Davies J. Political Pills: Psychopharmaceuticals neoliberalism as mutually supporting. In: Davies J, editors. *The Sedated Society*. Cham: Palgrave Macmillan (2017). p. 189–225. doi: 10.1007/978-3-319-44911-1_8
136. Hart JT. The Inverse care law, *Lancet*. (1971) 297:405–12. doi: 10.1016/S0140-6736(71)92410-X
137. Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Worldwide use of mental health services for anxiety, mood and substance disorders: Results from 17 countries in the WHO World Mental Health (WMH) Surveys. *Lancet*. (2007) 370:841–50. doi: 10.1016/S0140-6736(07)61414-7
138. Miller D, Acton TM, Hedge B. The worried well: their identification and management. *J R Coll Physicians Lond.* (1988) 22:158–65.
139. British Medical Association. Available online at: https://www.bma.org.uk/news/media-centre/press-releases/2018/february/new-bma-research-unveils-blindspot-in-mental-healthcare (accessd at: April 05, 2020).
140. Davar BV. Globalizing psychiatry and the case of 'vanishing' alternatives in a neo-colonial state. *Disabil Global South*. (2014) 1:266–84. Available online at: https://disabilityglobalsouth.files.wordpress.com/2012/06/dgs-01-02-04.pdf (accessed May 19, 2021).
141. Dorsey ER, de Roulet J, Thompson JP. Funding of US biomedical research, 2003-2008. *JAMA*. (2010) 303:137–43. doi: 10.1001/jama.2009.1987
142. Dorsey ER, Vitticore P, De Roulet J. Financial anatomy of neuroscience research. *Ann Neurol*. (2006) 60:652–9. doi: 10.1002/ana.21047
143. Teddlie C, Tashakkori A. *Foundations of Mixed Methods Research: Integrating Quantitative and Qualitative Approaches in the Social and Behavioral Sciences*. LA: SAGE Publications (2009).
144. Little TD, editor. *The Oxford Handbook of Quantitative Methods*. Oxford; New York, NY: Oxford University Press (2013). doi: 10.1093/oxfordhb/9780199934898.001.0001
145. Krueger RA. Focus Groups. *A Practical Guide for Applied Research*. London: Sage Publications (2015).
146. Spradley JP. *Participant Observation.* Wadsworth, Belmont (1980).
147. Denzin NK, Lincoln YS, editor. *The SAGE Handbook of Qualitative Research, 5th Edn*. Thousand Oaks, CA: Sage Publications (2018).
148. Cargo M, Mercer S. The value and challenges of participatory research: strengthening its practice. *Annu Rev Public Health.* (2008) 29:325–50. doi: 10.1146/annurev.publhealth.29.091307.083824

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Concept Creep and Psychiatrization

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Some aspects of psychiatrization can be understood as forms of concept creep, the progressive expansion of concepts of harm. This article compares the two concepts and explores how concept creep sheds light on psychiatrization. We argue that although psychiatrization is in some respects a broader concept than concept creep, addressing institutional and societal dimensions of the expanding reach of psychiatry in addition to conceptual change, concept creep is broader in other respects, viewing the expansion of psychiatric concepts as examples of the broadening of a more extensive range of harm-related concepts. A concept creep perspective on psychiatrization clarifies the different forms of expansion it involves, the centrality of harm to it, its benefits as well as its costs, its variations across individuals and groups, and the drivers of psychiatrization in the general public and in fields beyond psychiatry.

Keywords: concept creep, diagnosis, harm, psychiatric classification, over-diagnosis

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INTRODUCTION

The concept of psychiatrization identifies a pattern of correlated societal and cultural changes that have been underway for several decades but now seem especially urgent to address. Beeker et al. s (2021) review of the field points to rising rates of mental illness, increasing mental health service utilization, and evidence of over-diagnosis, over-treatment, and over-prescription (Paris, 2020). Coupled with these changes is an expansion in the number and inclusiveness of psychiatric diagnoses that has led critics to lead campaigns to save normality from the relentless encroachment of diagnosable pathology (Frances, 2013). Beyond changes such as these in the field of mental health, expanded understandings of mental disorder have spread in the culture at large, accompanied by popular adoption of a psychiatric idiom to make sense of everyday experiences of deviance and distress. Psychiatrization is a multi-faceted phenomenon and drawing its aspects together under the term provides researchers and theorists with an opportunity to join forces to understand it better.

In that spirit, we argue that "concept creep" offers a useful vantage-point for understanding some aspects of psychiatrization. Although that notion emerges from a different intellectual context–a psychological frame of references and an emphasis on conceptual change and its cultural dimensions–concept creep has a strong alignment with psychiatrization. Both refer to the expansion of a set of concepts and practices that has taken place over a period of decades. Both emphasize how these expansions have broad but ambivalent ramifications throughout society. In addition, some work on concept creep has explored psychiatric concepts such as mental illness and trauma.

In this article we offer an overview of theory and research on concept creep and examine how it might illuminate psychiatrization. We make no attempt to reduce one concept to the other but explore their intersections and speculate on how concept creep might deepen or challenge our understanding of some elements of psychiatrization. We conclude the article with a few specific points where the concept creep perspective might advance the study of psychiatrization.

CONCEPT CREEP

First described by Haslam (2016), concept creep refers to the gradual expansion of the meaning of harm-related concepts. Haslam argued that several prominent psychological concepts had undergone a process of semantic inflation whereby they had come to refer to an increasingly wide range of phenomena. That broadening occurs in two directions, he argued. Concepts creep horizontally by coming to refer to qualitatively new phenomena, and vertically by coming to refer to quantitatively less extreme phenomena.

In the original paper, for example, Haslam (2016) presented case studies of six creeping concepts: abuse, addiction, bullying, mental disorder, prejudice, and trauma. The concept of bullying, for example, was initially used in the 1970s to refer to aggressive behavior among children that was intentional, repeated, and perpetrated downward in a power hierarchy. Over time, bullying expanded horizontally to include the behavior of adults in workplaces, exclusionary rather than intimidating behavior (e.g., shunning), and intimidation carried out online rather than only in person ("cyber-bullying"). Bullying also expanded vertically to include less extreme behavior such as acts that were unintentional, unrepeated, and directed at people of equal or higher power than the perpetrator.

Haslam (2016) presented similar evidence of the outward and downward spread of the other creeping concepts. He also speculated on concept creep's causes and effects. He argued that broadened concepts of harm might result from a rising cultural preoccupation with vulnerability and risk, as proposed by Furedi (2004), and with what Pinker (2011) referred to as the "civilizing offensive" of the 1960s rights revolutions. Expansive concepts of harm problematize previously tolerated behavior and reflect a growing sensitivity to suffering and injustice. Haslam also raised the possibility that the objective decline in rates of violence and adversity in the West, also noted by Pinker, may have contributed to less severe threats being encompassed within existing concepts of harm that had previously applied only to more extreme phenomena. As levels of violent bigotry declined, for example, concepts of racism began to include subtler forms of "modern", "aversive", and "implicit" prejudice. In view of the centrality of harm concepts to morality, especially for social progressives, and the generally progressive thrust of most examples of concept creep, Haslam argued that it reflected in part a liberal moral agenda.

Haslam (2016) argued that the consequences of concept creep were likely to be ambivalent. On the one hand, broadened concepts of harm recognize forms of suffering and maltreatment that had previously gone unrecognized, thereby identifying them as requiring remedy and giving moral legitimacy to condemnations of harmful behavior. Defining nonviolent but negligent parenting as abuse recognizes it as a problem, just as defining significant gambling problems as addictions acknowledges their seriousness and enables new kinds of intervention. On the other hand, it can be argued that broadened concepts of harm may engender over-sensitivity to minor harms, trivialization of more severe harms, constraints on expression, and, following the theory of moral typecasting (Gray and Wegner, 2009), a polarized view of a world populated by victims and villains. Concept creep might serve some progressive political and social goals but also undermine others.

RESEARCH ON CONCEPT CREEP

Since the initial description of concept creep, a body of empirical research on the subject has emerged (see Haslam et al., 2020, for a review). Some of this work has explored its historical dimensions whereas other studies have examined the breadth of harm-related concepts as a cross-sectional analogue of concept creep. The historical research has examined several large text corpora for evidence of shifts in the prominence and meaning of harm-related concepts or presented detailed conceptual analyses of specific concepts. For example, Wheeler et al (2019) examined moral language in the Google Books corpus from 1900 to 2007 and found that harm-related morality was unique among five moral foundations (Graham et al., 2011) in demonstrating a steep rise in prominence from around 1980, consistent with a cultural account of the drivers of concept creep in recent decades.

Related work has documented the rising prominence and expanding meanings of harm-related concepts in academic discourse. Examining a corpus of about 800,000 psychology article abstracts from 1970 to 2018, Vylomova, et al. (2019) found a rise in the relative frequency of 'addiction', 'bullying', 'harassment', 'prejudice', and 'trauma' over the study period. Using computational linguistic methods for determining concept breadth they revealed broadening of some concepts across decades and documented specific semantic shifts (e.g., the declining association of 'addiction' with substances and its rising association with behaviors such as gaming). Vylomova and Haslam, (2021) extended this work by evaluating both prominence and semantic breadth of an overlapping set of creeping concepts ('addiction', 'bullying', 'empathy', 'racism', and 'trauma') in a general text corpus, and by exploring causal relationships between salience and breadth and between corpora. In addition to these quantitative studies, historical studies of the broadening of 'hate' (Haslam and Murphy, 2020) and 'trauma' (Haslam and McGrath, 2020) have also appeared.

Studies of individual differences in the breadth of harm-related concepts do not address concept creep directly, as they examine psychological rather than temporal variability. Nevertheless, they provide clues to the factors that might influence and be influenced by concept creep as a historical phenomenon. McGrath et al. (2019) and McGrath and Haslam (2020) demonstrated that these individual differences generalize across multiple concepts, such that people who hold relatively inclusive definitions of bullying also tended to have inclusive definitions of trauma and prejudice, for example. This finding accords with Haslam. (2016) claim that harm is the common ingredient in concept creep. These studies also pointed to a variety of demographic, personality, and ideological factors that correlate with 'harm concept breadth'. Holding broad harm concepts is associated with being female, politically liberal, empathic, concerned about injustice toward others (but not preoccupied with injustice towards the self), likely to endorse harm-based morality, and high Neuroticism, a trait involving vulnerability to negative emotional states. Contrary to the narrative of hypersensitivity among young people, age was not associated with concept breadth. Beyond these correlates, concept breadth has been shown to predict some social judgments. In particular, people holding broader concepts of sexism and sexual harassment were more likely to judge the female victim of workplace sexism as harmed by it and deserving of compensation, and to judge the male perpetrators as more deliberate and more deserving of punishment (Chan and Haslam, 2019).

Most concept creep research has taken a wide-angle perspective on the domain of harm concepts rather than focused on the psychiatric domain. However, studies of shifts in the expansiveness of mental illness-related concepts have demonstrated the same inflationary pattern as other harm concepts. Corpus linguistic studies have revealed rises in the relative frequency (salience) and semantic breadth of trauma and addiction both in academic discourse (Vylomova et al., 2019; Vylomova and Haslam., 2021) and, somewhat less strikingly, in a general American text corpus (Haslam et al., 2016). The one notable exception to these trends for psychiatric concepts to amplify and broaden was a study not of word meanings but of shifts in the official diagnostic criteria for specific mental disorders from DSM-III to DSM-5 (Fabiano and Haslam, 2020). Contrary to expectations of a wholesale tendency for criteria to loosen, resulting in more people meeting diagnostic thresholds in more recent DSM editions, this meta-analysis of studies in which the same people were diagnosed using successive editions found no generalized pattern of diagnostic inflation. Although this finding contrasted with earlier analyses of DSM criterion sets (Boysen, 2011; Boysen and Ebersole, 2014), and with popular critiques of runaway pathologizing (Frances, 2013), it did establish strong evidence that specific disorders have inflated over time. Attention deficit hyperactivity disorder, autism, and some eating and substance use disorders exemplified this expansion.

Studies of individual differences in the breadth of mental illness concepts have also mirrored findings on individual differences in other, superficially unrelated concepts. McGrath and Haslam (2020) work revealed that people who hold more inclusive concepts of mental disorder than their peers also tend to hold more inclusive understandings of bullying and prejudice, for example, a correlation that cannot be explained by a tendency to hold more inclusive concepts of all concepts. By implication, the breadth of laypeople's concepts of mental illness is shaped in part by their sensitivity to harm, rather than being uniquely tuned to the psychiatric domain.

Recent work by Tse and Haslam (2021) indicates that the breadth of these lay concepts has implications for mental health help-seeking. They showed that people who held more inclusive concepts of mental illness, categorizing a wider variety of experiences and actions as disordered, had more favorable help-seeking attitudes. Asian American study participants tended to hold narrower disorder concepts than White Americans, and that difference partially accounted for their less favorable attitudes, a well-established finding in cultural psychiatry. More inclusive concepts of mental illness encourage and enable people to identify an experience or behavior as a problem requiring professional attention, whereas individuals and groups with narrower concepts may be more likely to regard help-seeking as unusual and unwarranted. Whether holding more favorable views of help-seeking is interpreted positively as overcoming barriers to care or negatively as encouraging overdiagnosis and overtreatment is moot.

CONCEPT CREEP AND PSYCHIATRIZATION

Concept creep theory proposes a broad historical shift in the inclusiveness of harm-related concepts that is connected to incompletely understood cultural, societal, and political changes and likely to have an array of social and psychological implications. As we have shown, empirical research is beginning to document and explore some of these processes. Psychiatrization also represents an expansionary historical trend that is likely to have complex causes and consequences. How might these two concepts be aligned? We suggest that concept creep is both narrower and broader than psychiatrization and offers a productive way to think through some of its aspects. Some of the main contrasts between the two concepts are summarized in **Table 1**.

Psychiatrization is broader than concept creep in several respects. First, according to Beeker and others' (2021) framework, psychiatrization involves not only the expansion of diagnostic categories and the broader process of pathologization–the central preoccupations of concept creep as it applies to psychiatric concepts–but also increases in the prevalence of psychiatric conditions and levels of service utilization. These increases might be understood as downstream consequences of category inflation from the standpoint of concept creep, but they are fundamental aspects of psychiatrization rather than merely effects of a more basic cause.

In addition, work on psychiatrization presents a more explicit account of the societal and institutional factors that drive the process, including the professions, the pharmaceutical and insurance industries, consumer organizations, and political forces. Writings on psychiatrization emphasize how these macro-level influences bear on the concrete realities of clinical practice and diagnostic revision. It is the combination of institutional, practice-related and conceptual shifts that is their primary focus, in accordance with psychiatrization's disciplinary home being in medical sociology. In contrast, explorations of concept creep emphasize the history of ideas and the psychological dimensions of conceptual change, as these are reflected in academic and public discourse and in individual minds, consistent with its origins within psychology. The theory of concept creep recognizes that shifting concepts of mental illness and mental health are closely linked to ambient macro-level cultural and societal changes but focuses its attention to the former. Ultimately, concept creep's focus is on the dynamics of

TABLE 1 | Selected contrasts been the concepts of psychiatrization and concept creep.

	Psychiatrization	Concept creep
Primary focus	Expanding reach of psychiatric institutions, practices and concepts	Semantic inflation of harm-related concepts
Disciplinary home	Medical sociology	Psychology
Explanatory emphasis	Institutional influences	Cultural influences
Domain of relevance	Psychiatry and mental illness	Concepts of harm, including psychiatric concepts

word meanings as effects of deeper cultural and societal shifts and as contributors to cultural, political, and psychological changes. In essence, concept creep is one account of the shifting understandings of distress and abnormality that underpin the broad, socially manifested phenomenon of psychiatrization.

If psychiatrization is a broader notion than concept creep in exploring the societal and institutional dimensions of the rise of psychiatric discourse, it is a narrower one in another way. Concept creep treats the expansion of psychiatric concepts as simply one example of a wider array of inflating concepts of harm. According to the theory of concept creep, concepts in the psychiatric domain such as 'mental disorder', 'trauma', and specific diagnostic entities have broadened their meanings over time, but so have 'abuse', 'bullying', 'empathy', 'harassment', 'hate', 'prejudice', 'violence' and many other harm-related concepts whose main field of relevance is outside or at most adjacent to that domain. Within psychology, for example, many of these concepts–which tend to involve interpersonal maltreatment rather than forms of suffering or of being harmed–are associated with developmental or social psychology rather than clinical psychology. In this respect, the semantic inflation of psychiatric concepts is one among several key domains in which concept creep takes place rather than its primary focus.

IMPLICATIONS OF CONCEPT CREEP FOR PSYCHIATRIZATION

We have argued that concept creep and psychiatrization are closely aligned notions whose distinctive emphases and levels of analysis are complementary. We firmly believe that the two emerging traditions of research and theory will be mutually informative. In that spirit, we propose six implications or clarifications that our work on concept creep might offer the study of psychiatrization.

Horizontal and Vertical Creep

The theory of concept creep distinguishes two forms of semantic expansion. Concepts may extend downward (vertical creep) to encompass less severe phenomena, and outward (horizontal creep) to include different kinds of phenomena. In the psychiatric domain, vertical creep corresponds to the relaxation of diagnostic criteria or the creation of new diagnostic entities that represent milder variants of already recognized conditions. Horizontal creep, in contrast, corresponds to the creation of qualitatively new entities, generally by colonizing new pathological territory (e.g., the addition of disorders of sleep, eating, or childhood during DSM's evolution).

These two kinds of expansion both pathologize new forms of behavior and experience, but they have not been distinguished consistently in previous research on psychiatrization or diagnostic inflation. There is some evidence that they may have occurred to differing degrees and have different implications. For example, Fabiano and Haslam (2020) meta-analysis found no general trend for vertical creep to occur between DSM-III in 1980 and DSM-5 in 2013, despite the frequency and intensity of critiques of diagnostic expansion in this period. Although some diagnoses have unquestionably crept vertically, the horizontal expansion of psychiatry's diagnostic reach, such as the ongoing invention of entirely new kinds of disorder, may have been more critical. Differentiating these two kinds of expansion, and their potentially different drivers and implications, could refine our understanding of psychiatrization.

The distinction between vertical and horizontal concept creep can also help to align explorations of psychiatrization with prior work on medicalization and over-diagnosis. Important work by Hofmann (2016) disentangles these frequently confused concepts, proposing that medicalization involves the extension of the medical domain into previously non-medical phenomena, whereas over-diagnosis extends existing biomedical conditions by diagnosing them when they are unlikely to cause significant suffering or impairment. On this account, medicalization is akin to horizontal concept creep whereas over-diagnosis is an example of vertical creep. Framing medicalization and over-diagnosis in this way allows them to be seen as instances of more general processes of conceptual change, analogous to shifts documented in other harm-related concepts such as prejudice and bullying (Haslam, 2016). Psychiatrization clearly involves both medicalization and over-diagnosis, and these may represent distinct dimensions of expansion in many conceptual domains.

The Role of Harm

From the standpoint of concept creep theory, the expansion of psychiatric concepts such as mental illness and trauma is simply an instance of a generalized expansion of harm-related concepts. Research lends support to this claim, finding that disparate harm-related concepts all show the same inflationary trend, and that holding inclusive concepts of mental illness correlates with holding other inclusive harm-related concepts. The finding that the prominence of harm discourse has risen steeply–in absolute terms and relative to other moral discourses–in concert with the historical expansion of these concepts also gives credence to the centrality of harm to concept creep.

It may be instructive for those who study psychiatrization to consider it as a trend that runs in parallel to the inflation of other harm-related concepts, and that may have some shared causes and consequences. To what extent, for example, does the expansion of psychiatric concepts and categories reflect the same dynamic that drives the expansion of concepts of prejudice, abuse, bullying, and so on? Might the broadening of the psychiatric domain be linked to the rising cultural preoccupation with and sensitivity to harm that concept creep theory proposes? Does the growing interest in mental health and illness consider it primarily in terms of suffering and impairment that demands care, harm's counterpart? Diagnostic expansion, for example, can be traced to professional bodies, lobby groups, and industrial interests, but might it also be associated with a more general cultural shift toward the acknowledgment and amplification of harm? Such an investigation might contribute to a fuller understanding of psychiatrization.

That investigation might also help to resolve a puzzling inconsistency in the political alignment of concept creep. Harm-based morality is endorsed more by people on the political left and American liberals hold relatively broader harm concepts (McGrath and Haslam, 2020). Typically, liberals are also more positively disposed than conservatives to the expansion of such harm concepts as prejudice, bullying, abuse, hate, and violence (Graham et al., 2011). Breaking this pattern, however, much of the critique of diagnostic expansion and psychiatrization or medicalization has come from the Left, who represent it as a malignant trend promoted by Big Pharma or oppressive political forces. An analysis of psychiatrization that understands it in part as a rising recognition of harm, and a corresponding expansion of certain forms of care, might complicate the views of some left-leaning critics of psychiatrization by revealing another, more progressive dynamic at play.

Benefits of Psychiatrization

The general tone of much research on psychiatrization is critical. Undoubtedly the risks of over-diagnosis, over-treatment, and resource misallocation are serious, and there are cultural costs associated with the adoption of a psychiatric idiom to understand everyday unhappiness. However, psychiatrization is also sure to have benefits. Concept creep theory has consistently maintained that shifting concepts of harm are likely to have mixed blessings: it draws attention to neglected harms but also inflates minor harms in problematic ways. Concept creep research (e.g., McGrath et al., 2019) has shown that holding broad concepts of harm, such as expansive definitions of mental illness, is associated with a mix of desirable and undesirable attributes and outcomes. Without making the naïve assumption that the benefits and costs of psychiatrization are equal, viewing it through the lens of concept creep may clarify its ambivalent character. Beeker et al. (2021) recognize this ambivalence in their overview of the topic, and concept creep provides a way to think through its benefits and costs.

The work of Tse and Haslam (2021) is a case in point, providing a detailed account of how concept creep might have specific benefits. They demonstrated that holding favorable attitudes to mental health help-seeking is associated with more inclusive concepts of mental disorder, and that cultural differences in the inclusiveness of these concepts are associated with differences in help-seeking. This research implies that in under-served populations, promoting broadened concepts of psychiatry's domain might have positive effects. Other work inspired by concept creep presents an equally detailed analysis of the costs of psychiatrization. Jones and McNally, (2021) found that people experimentally induced to hold a more expansive concept of trauma were more likely to experience lasting psychological effects after being exposed to a disturbing video. This work illustrates how the dissemination of broadened psychiatric concepts may foster vulnerability in the general public. The concept creep framework, which views any broadening of harm-related concepts as a potential acknowledgement of previously neglected harm and an opportunity for beneficial care, also recognizes it as a potential source of vulnerability, fragility, and unwarranted intervention.

Variation

Although a large proportion of concept creep research has examined it as a historical phenomenon, another significant focus has been on variability among individuals and groups in the adoption of broad concepts of harm. Our studies have shown that people who tend to have broader concepts–and might therefore be viewed as at the vanguard of harm inflation–tend to be politically liberal, female, high in empathy and sensitive to injustice, likely to endorse an individualist harm-based morality, and, in some cases young and liable to a sense of personal vulnerability. This work has not systematically examined variability in the breadth of psychiatric concepts–although these were included among others–but such an investigation might be pertinent to the study of psychiatrization. Although psychiatrization is primarily understood as a historical trend, it is unlikely to have unfolded in uniform ways by different groups or to have been universally accepted or rejected by them. It may be instructive to learn which groups of people–based on nationality, culture, race, gender, ideology, personality, age, and so on–are most likely to embrace or resist the rise of psychiatric discourse and the expansion of diagnostic categories. These differences, the pursuit of which has been central to concept creep research, may have implications for the future of psychiatrization.

Professional Versus Lay Concepts

The theory of concept creep proposes that broadened concepts of harm often originate in the academy and the professions, and then diffuse through the culture at large. In the psychiatric domain, for example, expansive concepts of mental illness may originate in psychiatry's diagnostic manuals and then disseminate into the wider public through education, the media, and encounters with professionals. Psychiatrization is understood to involve professionals and specialist interests as well as the citizenry, and to include the institutional practices of mental health professionals and their associated institutions as well as the everyday language use of laypeople, so the nature of the relationship between these 'top level' and 'bottom level' actors (Beeker et al., 2021) is important for understanding it. By recognizing a combination of top-down and bottom-up processes that jointly produce psychiatrization, Beeker and others acknowledge that the links between these levels are important to grasp.

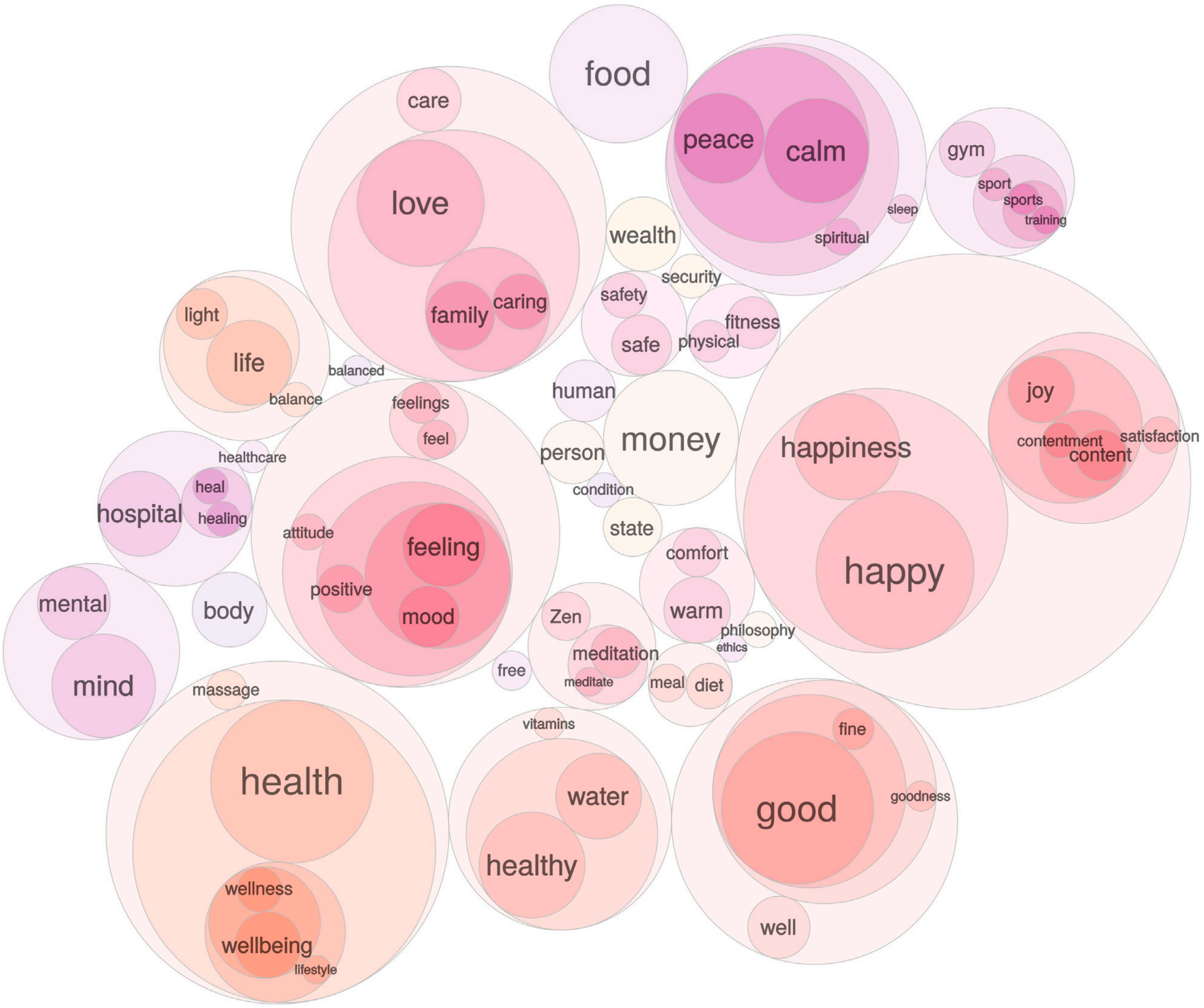

FIGURE 1 | Word association egograph for "well-being". Colors indicate distinct clusters of meaning extracted using walktrap clustering. Cluster size indicates the prevalence of association responses measured as response in-strength (i.e., the sum of weighted incoming edges).

One lesson from concept creep is that such links are likely to be complex and a simple dissemination process cannot account for it. (Haslam et al., 2016) examined changes in the relative frequency and semantic breadth of a collection of harm-related psychological concepts such as 'trauma' over the past 40 years in two text corpora, one professional (the abstracts of close to 800,000 psychology articles) and the other representing general cultural content (e.g., magazine and news articles, transcripts of TV programs, fiction). If the popularity or semantic inflation of the concepts disseminated from professional discourse into the wider culture, then lagged relationships should be evident in the frequency and breadth of the concepts between the two corpora, with shifts in the psychology corpus predating shifts in the general corpus. Such relationships were very scarce. Instead, it appeared that the popularity and breadth of the concepts varied within the two corpora in ways that were weakly couple, if at all. Understanding how top-down psychiatrization processes operate should be a priority for future research, but our work suggests these processes may be subtle.

A related observation we would make is that some of the discourse that may be driving psychiatrization, and the concept creep of 'mental illness' that underpins it, may not emanate from psychiatry at all but from adjacent studies of well-being within psychology and cognate fields. We have observed a growing tendency in these disciplines to conflate 'well-being' with 'mental health' that is likely to produce a tendency to pathologize what Freud called "common unhappiness". Whereas once 'mental health' was understood primarily as the absence of mental illness and 'well-being' as the presence of desirable emotional states and satisfaction with life, when the two concepts are conflated 'mental health' is increasingly represented as a positive state of health beyond the absence of symptoms. However, if 'mental health' becomes a salutary

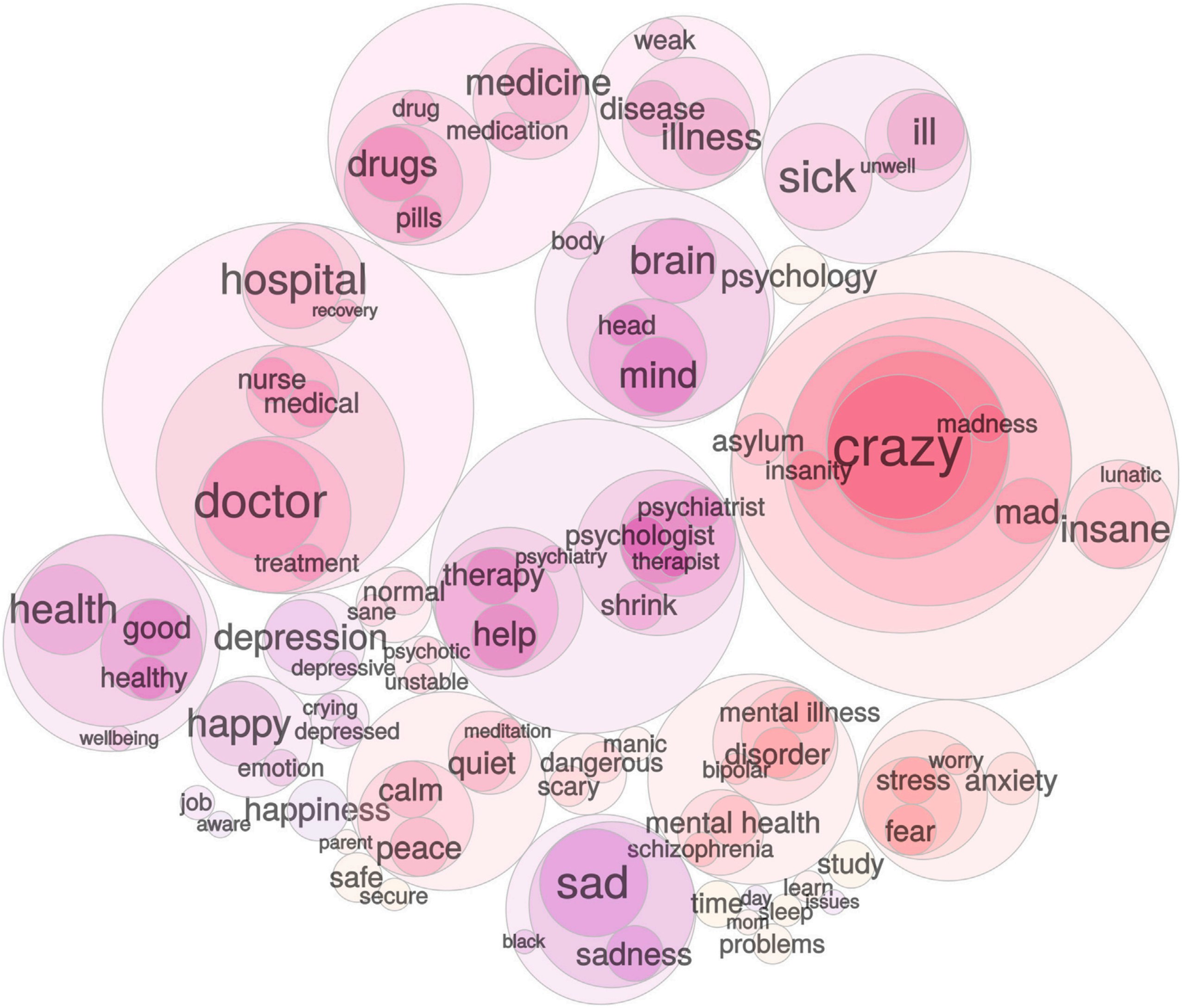

FIGURE 2 | Word association egograph for the word "mental health". Colors indicate distinct clusters of meaning extracted using walktrap clustering. Cluster size indicates the prevalence of association responses measured as response in-strength (i.e., the sum of weighted incoming edges).

state that is close to synonymous with 'well-being', then states of low well-being risk being seen as mental illness.

Systematic research on word associations supports the view that in the general public 'mental health' has a dual aspect, representing a positive state of well-being but also retaining strong associations with pathology. Using (De Deyne et al., 2019) massive 'small word of words' database, which contains associations for more than 15,000 words made by over 100,000 people, we have examined the mental associations of 'well-being' and 'mental health'. For each concept, directed weighted ego-graphs were extracted based on: 1) forward associations (e.g., responses to 'well-being' or 'mental health'), 2) backward associations (cue words that elicited 'well-being' or 'mental health' as a response), and 3) all edges between words in the ego-graph. For simplicity, infrequent responses (i.e., associative strength <0.04 on a scale from 0 to 1) were removed. To visualize the relation between words, hierarchal walktrap clustering was applied using the R igraph package (Csardi and Nepusz, 2006).

Figures 1, **2** present visualizations of the two terms' associations. 'Well-being' (**Figure 1**) is associated with a range of desirable states and their causes. However, 'mental health' (**Figure 2**), though ostensibly a positive concept and a near-synonym of 'well-being', is primarily associated with words referring to mental illness and its treatment, as well as diagnostic labels, stigmatizing terms, and unpleasant emotional states. 'Mental health' carries with it the shadow of pathology, and as it is increasingly employed as a substitute for or fellow traveller with 'well-being' it is likely to extend psychiatrization into the domain of suboptimal well-being. By implication, psychiatrization must be studied as a top-down process that emanates from a wider range of sources than psychiatry and the mental health industry narrowly conceived.

CONCLUSION

The concept of psychiatrization is a powerful one that has the potential to integrate several lines of theory and research on the causes and effects of the rising prominence of psychiatric concepts and practices. We applaud its integrative possibilities and the openness of its proponents to transdisciplinary research efforts. Research and theory on concept creep have a role to play in enhancing our understanding of psychiatrization and in framing new approaches to studying it.

AUTHOR CONTRIBUTIONS

NH wrote the manuscript. JT edited the manuscript and contributed to developing its argument. SD carried out the analysis of the word associations and created the Figures.

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REFERENCES

Beeker, T., Mills, C., Bhugra, D., Te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research. *Front. Psychiatry* 12, 645556. doi:10.3389/fpsyt.2021.645556

Boysen, G. A. (2011). Revision of the DSM and Conceptual Expansion of Mental Illness: An Exploratory Analysis of Diagnostic Criteria. *J. Mind Behav.* 32 (4), 295–315.

Boysen, G. A., and Ebersole, A. (2014). Expansion of the Concept of Mental Disorder in the DSM-5. *J. Mind Behav.* 35, 225–243.

Chan, J., and Haslam, N. (2019). Broad Concepts of Sexism Predict Polarized Moral Judgments of Victims and Perpetrators. *Personal. Individual Differences* 150, 109488. doi:10.1016/j.paid.2019.06.031

Csardi, G., and Nepusz, T. (2006). The Igraph Software Package for Complex Network Research. *InterJournal, Complex Syst.* 1695 (5), 1–9.

De Deyne, S., Navarro, D. J., Perfors, A., Brysbaert, M., and Storms, G. (2019). The "Small World of Words" English Word Association Norms for over 12,000 Cue Words. *Behav. Res. Methods* 51, 987–1006. doi:10.3758/s13428-018-1115-7

Fabiano, F., and Haslam, N. (2020). Diagnostic Inflation in the DSM: A Meta-Analysis of Changes in the Stringency of Psychiatric Diagnosis from DSM-III to DSM-5. *Clin. Psychol. Rev.* 80, 101889. doi:10.1016/j.cpr.2020.101889

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*. William Morrow.

Furedi, F. (2004). *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. London: Routledge.

Graham, J., Nosek, B. A., Haidt, J., Iyer, R., Koleva, S., and Ditto, P. H. (2011). Mapping the Moral Domain. *J. Pers Soc. Psychol.* 101 (2), 366–385. doi:10.1037/a0021847

Gray, K., and Wegner, D. M. (2009). Moral Typecasting: Divergent Perceptions of Moral Agents and Moral Patients. *J. Pers Soc. Psychol.* 96 (3), 505–520. doi:10.1037/a0013748

Haslam, N. (2016). Concept Creep: Psychology's Expanding Concepts of Harm and Pathology. *Psychol. Inq.* 27, 1–17. doi:10.1080/1047840x.2016.1082418

Haslam, N., Dakin, B. C., Fabiano, F., McGrath, M. J., Rhee, J., Vylomova, E., et al. (2020). Harm Inflation: Making Sense of Concept Creep. *Eur. Rev. Soc. Psychol.* 31 (1), 254–286. doi:10.1080/10463283.2020.1796080

Haslam, N., and McGrath, M. (2020). The Concept Creep of Trauma. *Soc. Res.* 87, 509–531.

Haslam, N., and Murphy, S. C. (2020). "Hate, Dehumanization, and "hate"," in *Perspectives on Hate: How it Originates, Develops, Manifests, and Spreads*. Editor R. J. Sternberg (Washington, DC: American Psychological Association), 27–41. doi:10.1037/0000180-002

Haslam, N., Vylomova, E., Zyphur, M., and Kashima, Y. (2016). The Cultural Dynamics of Concept Creep. *Am. Psychol.* 4 (2), 199–211. doi:10.1177/092137409100400207

Hofmann, B. (2016). Medicalization and Overdiagnosis: Different but Alike. *Med. Health Care Philos.* 19 (2), 253–264. doi:10.1007/s11019-016-9693-6

Jones, P. J., and McNally, R. J. (2021). Does Broadening One's Concept of Trauma Undermine Resilience. *Psychol. Trauma Theor. Res. Pract. Pol.* doi:10.1037/tra0001063

McGrath, M. J., and Haslam, N. (2020). Development and Validation of the Harm Concept Breadth Scale: Assessing Individual Differences in Harm Inflation. *PloS one* 15 (8), e0237732.

McGrath, M. J., Randall-Dzerdz, K., Wheeler, M. A., Murphy, S., and Haslam, N. (2019). Concept Creepers: Individual Differences in Harm-Related Concepts and Their Correlates. *Personal. Individual Differences* 147, 79–84. doi:10.1016/j.paid.2019.04.015

Paris, J. (2020). *Overdiagnosis in Psychiatry: How Modern Psychiatry Lost its Way while Creating a Diagnosis for Almost All of Life's Misfortunes*. Oxford University Press.

Pinker, S. (2011). *The Better Angels of Our Nature: Why Violence Has Declined*. Viking.

Tse, J. S. Y., and Haslam, N. (2021). Inclusiveness of the Concept of Mental Disorder and Differences in Help-Seeking between Asian and White Americans. *Front. Psychol.* 12, 3221. doi:10.3389/fpsyg.2021.699750

Vylomova, E., and Haslam, N. (2021). "Semantic Changes in Harm-Related Concepts in English," in *Computational Approaches to Semantic Change*. Editors N. Tahmasebi, L. Borin, A. Jatowt, Y. Xu, and S. Hengchen (Berlin: Language Science Press), 93–121.

Vylomova, E., Murphy, S., and Haslam, N. (2019). "Evaluation of Semantic Change of Harm-Related Concepts in Psychology," in *Proceedings of the 1st International Workshop on Computational Approaches to Historical Language Change* (Stroudsburg, PA: Association for Computational Linguistics), 29–34. doi:10.18653/v1/w19-4704

Wheeler, M. A., McGrath, M. J., and Haslam, N. (2019). Twentieth century Morality: The Rise and Fall of Moral Concepts from 1900 to 2007. *PLoS ONE* 14 (2), e0212267. doi:10.1371/journal.pone.0212267

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The Vulnerability-Stress-Model—Holding Up the Construct of the Faulty Individual in the Light of Challenges to the Medical Model of Mental Distress

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In the late 1970s, the course seemed to be set for a reconciliation of the controversy around the somatic vs. the social nature of mental distress. The biopsychosocial model and the vulnerability-stress-model were influential agents in this move, but a medicalized somatic view on mental distress persisted nonetheless. The reasons for this persistence are complex, and naturally include questions of structural power. However, the adherence to a certain fundamental framing of a problem may continue to be transmitted not only out of conviction, but also unwittingly. The vulnerability-stress-model allowed those who used it to effectively stick to the implications of a medicalized somatic view of the faulty individual who falls ill, while also allowing them to believe they integrated the social dimensions of the problem. A close reading and hermeneutical interpretation of the text by Zubin and Spring (1977) and an analysis of its use in psychoeducation serve as a case study in this respect. The vulnerability-stress-model (simply called "vulnerability model" by Zubin and Spring; more often "stress-vulnerability model" by English speaking recipients, and "vulnerability-stress-model" by German authors) seems to have been a success story: since its publication by Zubin and Spring (1977), it has been the point of reference for numerous scholarly and popular ("psychoeducational") adaptations. It was soon extended from the diagnosis of schizophrenia to various psychiatric diagnoses, understanding mental distress as the result of a trait/state-interaction in the shape of "deviant coping patterns" (Zubin and Spring, p. 112). Recipients appraised the integration of environmental and dispositional factors, some of them opposing the supposed originally integrative intention of the VSM to reduced applications of it (Schmidt, 2012). However, it can be argued that this integration is a matter of rhetorics rather than argumentative essence. Their argument which significantly depends on the use of metaphors, as well as their referencing amounts to a confirmation of a medicalized view on mental distress and a dismissal of the role played by societal factors. Applied to psychoeducation, this paradoxical combination reinforced a view of the persons in question as individually vulnerable, rather than socially wounded. The consequences in terms of what appears as remedy are significant and contribute to turning individual difference into disability.

Keywords: psychiatrization, vulnerability-stress-model, psychoeducation, movement of (ex-)users and survivors of psychiatry, medical model

INTRODUCTION

J. Zubin and B. Spring were both psychologists, the former being a senior researcher specializing in questions of biometrics, pharmaceutical issues and the diagnostics of schizophrenia, and the latter his doctoral student.

The central argument of their vmodel (Zubin and Spring, 1977) runs along the lines of state-and-trait-interaction: People with an enduring disposition (trait), called vulnerability, are more strongly affected by events that elicit stress (state). The higher the vulnerability the lower the level of stress, resulting in episodes characterized as illness, which in close succession may present themselves as a seemingly permanent condition that is then called schizophrenia.

The authors put forward this concept of vulnerability under the title of a "new view on schizophrenia" in a contribution to the "Journal of abnormal psychology." The very name of the journal, the talk by the authors of "faulty reaction to life's exigencies" (Zubin and Spring, 1977, p. 112), as well as of "deviant coping patterns" (ibid.), strike today's reader as witnesses to an era in which derogatory turns of phrase applied to those judged to divert from psychosocial norms were the accepted scholarly norm [In fact, only recently, the editors announced that the journal will be renamed, citing that "the terms abnormal and abnormality now are pejorative tropes" (MacDonald and Watson, 2021, p. 1)]. Historically seen, it is not the pejorative labeling which appears to be new, but rather the societal rules banning its prominent use.

Zubin and Spring's (1977) work has been one of the foundations for a framing of mental distress which has been most influential since: the proclaimed integration of biological and societal aspects, in this instance understood as the interaction of vulnerability and stress, hence vulnerability-stress-model (VSM) or diathesis-stress-model. The VSM has been considered an "extremely useful model" (e.g. Goh and Agius, 2010) for decades, even by proponents of alternatives to traditional psychiatric care. For instance, Luc Ciompi, one of the founding figures of the soteria—which focuses on interpersonal and authentic (rather than professionally trained) ways of encounter as the road to recovery—considered his own work to be building upon the VSM (http://www.ciompi.com/de/schizophrenie.html, last accessed: 5/02/2022).

The VSM has been a popular point of reference in the various research contexts in which it has been theoretically modified and elaborated (e.g. Nuechterlein and Dawson, 1984; Nuechterlein et al., 1994; Hankin and Abela, 2005; Ferriter, 2019), in the training of medical students (e.g. Broerman, 2017), and in particular, in the medico-paedagogical contexts of German Psychoedukation (psychoeducation) for patients and their relatives (e.g. Bäuml, 2005; Bäuml and Pitschl-Walz, 2007). Thus, this article which appears merely historical on one hand, and of lasting influence on the other, is worth a closer look: Which contemporary debates do the authors take up? What is their specific line of argument, and what sources or evidence do they rely on? And what was the wider socio-political context in which it was published?

The VSM is related to a long-standing debate in both the philosophical and medical traditions: the question of the explanatory power of "nature vs. nurture," given that vulnerability (or diathesis) is understood as mainly inborn, and stress as the effect of later occurrences. The model thus promises to solve a historical conundrum with respect to what was considered as mental illness, specifically to do with the diagnosis of schizophrenia. Concerning so-called severe mental illness, and despite national differences in intensity and exclusiveness (Bernet, 2013), psychiatry had had a long trajectory of stressing the "nature" aspect from the late 19th century onwards. In opposition to it, there stands a centuries-old common senses—as put succinctly, for example, by the German classicist dramatist G. E. Lessing in the 18th century: "Whoever doesn't lose his mind over certain things has no mind to lose" (in the play Emilia Galotti, IV.7). It has been frequently reformulated since, in particular by psychiatric survivors throughout the 20th century, who insist that suffering is caused by "broken hearts, not broken brains" (Sen, 2017), thus emphasizing the "nurture" (i.e. the environmental) side of the problem. Without naming it in these abstract terms, the VSM takes a stance on this fundamental conflict.

Modeling experiences diagnosed as schizophrenia as an outcome of the interaction of disposition and environmental factors was not new in 1977. Zubin and Spring themselves refer to Meehl (1962) as a predecessor arguing along similar lines, and so did Bleuler (1963). The term "vulnerability" had also been used in the context of describing psychopathology before (Beck, 1967). This puts additional stress on the question: why have Zubin and Spring (1977) become such a popular point of reference, in particular in psychoeducation? What is the socio-historical significance of their formulation of the VMS in the mid-1970s?

REVISITING THE ORIGINAL PUBLICATION OF THE VSM

A Close Reading

Structure and Rhetoric

In order to tackle these questions, the article by Zubin and Spring (1977) will be considered not just as a set of arguments but as a text, the meaning of which is constituted through specific textual features such as the use of rhetorical means and metaphors as well as its intertextuality. These aspects will be analyzed in the vein of a close reading as suggested by literary scholars (Basseler, 2013). Zubin and Spring (1977) start with an overview of the "descriptive psychopathology" and "etiology" of the diagnosis of schizophrenia in just five pages. They move on from passing remarks on Ancient Ayurvedic teachings (ibid, p. 103) and pre-historic times to Kraepelin and recent research, such as the WHO's 1973 pilot study on schizophrenia (ibid., p. 104), paraphrasing these references in ways that imply that what contemporary medicine diagnoses as schizophrenia is in essence a transcultural and transhistorical phenomenon. At the same time, they do not enter into a scholarly debate on this contentious assumption, nor do they reflect upon the fact that, for example, the WHO study was widely read as a challenge to—rather than a confirmation of—Western psychiatric practices.

Their discussion of etiology rests on an earlier scheme of 6 ways of modeling the origins of the experiences diagnosed as schizophrenia (Zubin, 1972), and concentrates on two of these in order to contrast the "ecological" and "genetic" models; however, other models mentioned (developmental psychological, learning psychological et.al.) would have fallen into the same nature/nurture divide. The concentration on "ecological" vs. "genetic," together with a narrow understanding of the "ecological," allows the authors to leave out large strands of etiology that question the medical model—of particular interest being the consequences of poverty, abuse and other social hardships. At the same time, they present the conclusion of these passages as if the chosen models were representative combatants in the argument of nature vs. nurture: "Corresponding to the two types of etiological models—the biological and the field theory—there are two major components of vulnerability, the inborn and the acquired." (ibid., p. 109).

This brief yet biased overview of psychopathology and etiology sets the stage for the VSM with rhetorical fanfare. Stating that "we are abysmally ignorant of the causes" (ibid., p. 105), and that a "formidable impasse" (ibid, p. 108) had been reached, the authors identify "parochialism" (ibid.) as the culprit and thus present the VSM as both a virtuous and historically necessary solution, avoiding "parochialism" and moving on from an alleged impasse.

Debate and Intertextuality: Citations and Omissions

While the journal article is obviously a piece of scholarly work, its way of referencing remarkably diverts from the conventions of the genre. On the matter of the conflict of "nature vs. nurture," the authors treat friends, bystanders and enemies distinctly differently. They never state this openly or explicitly, but their preference for geneticist views is clear. Thus, when contrasting the two chosen models of "ecological" vs. "geneticist" research, they deal with the former by referring to just one metatheoretical study and talking about unresolved methodological challenges. In contrast, geneticist research is represented by five studies, the arguments and findings of which they judge to be "exciting and striking" (ibid. 106).

When actually addressing questions of environmental factors contributing to "mental illness" in other passages (in the broad sense of including social hardships), Zubin and Spring more often than not omit the names of authors. Thus, they mention the problem of stigma, arguing that the VSM might in fact redress this problem, but they do not mention any piece of research. Dedicating space to Ayurvedic texts but not naming contemporary research—most notably, in the case of stigma, the research by their contemporary (Goffman, 1963/1990)—is a remarkable procedure. In effect, it operates as term-dropping—giving the impression that concepts shaped by a critique of the medical model, such as stigma, are dealt with, without seriously engaging with them in actuality. In this way, the authors give the appearance of working broadly and inclusively, while in fact not doing so—the omission of names seems to be systematic. Zubin and Spring conclude their discussion of psychopathology by asking: "Where does this leave the allegation that schizophrenia is a myth?" (ibid., p. 104)—an obvious allusion to Thomas Szasz' well-known book (Szasz, 1961/1974) that, again, omits naming him. Replacing citation and referencing with allusion is unusual in scholarly texts. By doing so, Zubin and Spring present the undesirable author as one not worth naming. Such a strategy turns into an instance of writing-out-of-history when a text becomes canonical. In this way, provocative knowledge can be removed from the realm of acceptable scholarly discourse.

While not naming him, Zubin and Spring come up with two arguments in reply to the Szasz's criticism, according to which mental illness is an invalid construct (or a "myth"): Based on the consideration that medical diagnoses are indeed constructs, Zubin and Spring claim that as long as there is consensus between experts on the identification of "schizophrenia," and as long as it is considered beneficial for choosing therapies and interpreting research, the construct should be used. Strangely, they neither use the scholarly term for this consensus (reliability) at this point, nor do they mention the fact that the low reliability of "schizophrenia" had been widely discussed—not least in the context of the WHO study of 1973 which they refer to. Even more irritatingly, they combine the psychometric criterion of reliability with a vague criterion of "being beneficial" (for whom?) as bases to defend the use of the construct of schizophrenia, while validity, of course, remains the foremost criterion (and what Szasz gets at is the validity of the construct of "mental illness"), without which the quality of other criteria becomes irrelevant. To put it bluntly: a myth may produce "reliability"—experts may highly agree in recognizing a certain myth and find this myth useful—but this does not stop it from being a myth. Zubin and Spring, as trained psychologists, naturally would have known about the significance of psychometric criteria, which leaves the reader wondering about their motivation for arguing in this way.

When it comes to psychological research traditions which do not immediately address mental distress but have the potential to contribute to overcoming a narrow medical understanding of it, Zubin and Spring mention famous authors and concepts in ways that strip them of their significance for the topic in question. For instance, they refer to Piaget and his terminological differentiating of assimilation vs. accommodation, which is based on his concept of cognitive schemata in learning (Piaget and

Inhelder, 1958). When thinking about the "nature vs. nurture" discussion, this belongs to the realm of "nurture," and the concept of cognitive schemata could help in understanding why some situations pose much greater and more fundamental challenges to some people than they do to others, rather than thinking about persons possessing greater or smaller capabilities in handling them. However, Zubin and Spring use Piaget's terminology in a biologized way. Thus, they describe coping as the intensity of effort that leads to either assimilation or accommodation, and argue that assimilation consists of changing the environment, whereas accommodation refers to the adaptation of the inner state of the organism to the environment.

This irritating use of terminologies in contradiction to and without discussion of the research contexts they stem from is merged with political statements. Thus, Zubin and Spring use their reading of assimilation vs. accommodation to argue that segregating mental patients in asylums had resulted in a useful reduction of stress through assimilation (ibid., p. 114). This argument can be interpreted as an indirect attack at contemporaneous scholars such as Goffman and his work on the dehumanizing effects of institutionalization, as well as on the movement of psychiatric survivors that shed light on the violent character of mental institutions (Goffman, 1961/1990).

A closer look at the references made by Zubin and Spring in conceptualizing the term "stress" confirms this analysis: They do name authorities from cognitive psychology, but rely on biological concepts. For instance, they mention the name of the cognitive psychologist Lazarus, whose work on the role of appraisal in stress had begun to be published in the 1960s (Lazarus and Alfert, 1964; Lazarus et al., 1965), appearing as a theoretical interface of environmental factors and experiences of stress, thus holding the potential to explain the differing effects of environmental impacts on persons without resorting to concepts of inherent otherness. However, when actually setting forth their understanding of stress, Zubin and Spring rely entirely on the biologist concept of stress proposed by Hans Selye, which in turn has been considered a facilitator for the medicalization of stress (Burrows, 2015). Its underlying stimulus-response-schematism leads to a quantitative modeling of the connection of event and resulting stress in the VSM, which relocate the problem in the deficient individual and her limited capacity for processing stress.

Foundation of Arguments: Metaphors and More

Zubin and Spring claim that the VSM is based on a "logical factor analysis" (ibid., p. 109) through which they establish a "second order model" based on finding the "common denominator" of all existing models. However, a factor analysis is used in order to study latent non-observable constructs based on observable phenomena. Treating various existing research models as if they were the observable phenomena from which to draw conclusions about the latent construct of schizophrenia is a surprising mixing up of incompatible levels of observation. Furthermore, formally speaking, it is not a logical conclusion to say that if C does not follow from either A or B alone, it must follow from a combination of A and B. And lastly, even such premises are not given anyway: after all, the discussion of the methodological problems in measuring environmental factors does not justify the conclusion that these factors do not account for distress diagnosed as mental illness.

Zubin and Spring use several metaphors to put forward their understanding of vulnerability: they compare it to the strength of a rope which has to hold a weight and might burst (the weight being the metaphor for stress) (ibid, p. 110); to the heart of a person who has suffered a heart attack and then runs a marathon (ibid., p. 112); to the cracks in the surface of the earth of a volcanic field which make an eruption more likely (ibid, p. 117); and they refer to sickle cell anemia in order to argue that environmental triggers may lead to the outbreak of an illness which is, in essence, genetic (ibid, p. 122). These analogies underline their understanding of stress and vulnerability as similar to natural events or somatic conditions. Coping abilities in turn are understood as effort plus competence, conceived in rather mechanical terms in their comparison to the voltage plus equipment of a machine. Accordingly, their suggestions for interventions are: vulnerability cannot be altered by psychological means, but only through psychopharmacology, while strengthening abilities in coping with stress may prevent the actual "breakdown" (ibid., p. 122) of the vulnerable person. Although additionally making provisions at first for a psychological component in vulnerability—talking of "traumas, specific diseases, perinatal complications ... that enhance or inhibit the development of subsequent disorder" (ibid., p. 109)—this aspect does not bear on the further development of their argument. The mechanical metaphors may appear intriguing in particular for the educational usages of the model, but they transmit a rather blunt idea of the faulty individual whose inherent makeup needs pharmacological remedy and whose abilities need improvement. At the same time the rhetorics of Zubin and Spring allow educators to believe they are taking trauma and other psychological causes of vulnerability into account. This makes it even harder for the person seeking support to voice their experience: dimensions of being wounded are not conceptualized in this elaboration of vulnerability and stress interaction, and are thus easily overlooked.

Socio-Historical Context: The Medical Model Under Challenge

The close reading has shown that Zubin and Spring (1977) have a preference for geneticist research, rely on biologist rather than psychological conceptions of stress and emphasize the necessity of a pharmaceutical response to what they see as a largely unchangeable vulnerability. Far from appreciating the impact of social adversity on human well-being, the model reduces adversity to situations that turn a person's assumed inherent and acquired deficiencies into illness. Against this background, the question arises as to why Zubin and Spring (1977) has been so widely accepted and popularized as an integration of genetic and environmental aspects.

Addressing this question with respect to social actors and power structures, and tracing networks and alliances, is beyond the scope of this article. However, looking at it in terms of discourse, understanding the latter as the "rules of the sayable"

(Landwehr, 2002) allows a hypothetical answer, considering what Zubin and Spring (1977) contributed to the Specter of accepted narratives on psychiatric care and mental illness. At the time their article was published, the medical model and psychiatric authority relying on it had been massively questioned for more than a decade. Fundamental criticisms had been put forward by a number of social groups: survivors, media, researchers. Researchers refuting the medical model in psychiatry came from outside as well as from within the profession. Two of the most illustrious names of sociology and philosophy of the 20th century—Goffman (1961/1990, 1963/1990) and Foucault (1969/1961, 2008/2003)—stand for the theorizing of the oppressive social function of psychiatric diagnostics and care, and the academic dissemination and international reception of the works was at their height in the years preceding the publication of the VSM. Around the same time, works of psychiatrists that questioned the theoretical foundation and ethical adequacy of their profession enjoyed high popularity, most famously Szasz (1961/1974) on the lacking validity of the construct of mental illness, and British anti-psychiatrists on social conflict leading to people being diagnosed (Cooper, 1971; Laing, 1971). Media—both journalism and fiction—scandalized dehumanizing aspects of psychiatric care, with the iconic example of this trend, the movie "One flew over a cuckoo's nest," being released in 1975. Strands of social science translated theoretical critique into experimental research (e.g. Rosenhan, 1973). Last but not least, in the early 1970s, the psychiatric survivor movement emerged, first in North America, England and Scotland. Being part of the new social movements, activists not only fought social injustice and discrimination, but argued that the medical model contradicted their demand for self-determination (Alvelo, 2011; Gallagher, 2017).

It is hard to imagine a more fundamental and massive questioning of a medical profession and institution than that of psychiatry during the 1960s and 1970s. If mental distress and the attribution of diagnoses were to be seen as social processes and psychiatric care had proven of little benefit to those speaking out about their experience receiving it—how could medical authority on psychological distress be upheld? Narratives framing the latter as including social and environmental aspects were needed to invalidate those criticisms. After all, "The view of mental disorders as non-biological psychosocial problems [had become] the source of anti-psychiatric arguments." (Rzesnitzek, 2013, p. 4).

Zubin and Spring were aware of this contemporary challenge. As has been shown, they avoided naming critics and entering into a discussion, making allusions instead. However, in one instance, they addressed historical circumstances explicitly: "In recent years there has been great concern with the civil rights of patients suffering from mental disorders … there is growing suspicion that the consequences of being labeled and stigmatized as mentally ill may be far reaching, dehumanizing, and injurious to civil rights. In the final analysis, attacks have often focused on the so-called medical model…" (Zubin and Spring, 1977, p. 121). They argued pragmatically, downplaying criticisms and suggesting that the construct of vulnerability might serve as a more acceptable label: "The vulnerability label is perhaps easier to accept and live with, since it presages a timelimited episode from which the patient will … recover" (ibid., p. 121).

Given the rhetorical focus of the article, and the mix of biologist preferences and integrative claims by the authors, it appears plausible that the VSM was successful as just this: a label easier to accept—and to apply—offering practitioners, users and even the wider society a narrative of a psychiatry which had taken into account the role of social adversity in understanding and dealing with mental distress, while not changing much in essence. After all, the medicalized view on mental distress persisted (Read et al., 2009).

Application and Consequences: Psychoeducation

Medico-pedagogical publications, proliferating in Germany under the name of "Psychoedukation," follow rather traditional didactic underpinnings, focusing on the dissemination of preconceived knowledge, rather than embracing an understanding of competence which emphasizes multiperspectivity and the transparency of controversial and constructionist dimensions of knowledge (Reusser, 2014). In "Psychoedukation," expertise is allocated one-sidedly to the medical professional, and a broader view on scholarly and societal approaches to mental distress is not integrated. Not making the addressee aware of the fact that academic knowledge is often controversial is a deliberate choice: "The publication of professional pieces of advice and opinions that are partly contradicting each other is very confusing and irritating for the service user" (Bäuml and Pitschl-Walz, 2007, p. 41). The realm of decision making for service users thus is limited to discussing matters of modifying the doses of medication (Bäuml and Pitschl-Walz, 2007).

In a dissertation dedicated to the critical analysis of psychoeducational approaches in Germany, Schmidt (2012, p. 37) identified the development of a "functional concept of the disease" as one of major goals of "Psychoedukation." Such an aim precludes the option that the addressee reaches a non-medical definition of her distress as a possibly functional concept based on her mature decision. Declaring "Psychoedukation" as aiming to involve "patients" as "mature partners" (Bäuml and Pitschl-Walz, 2007) in decision making and treatment is a modification in wording that can be observed—but method and content prove the contrary (see Bäuml and Pitschl-Walz, 2007, cf. Bäuml and Pitschel-Walz (2005)). Thus, the expertise of the person to be "psychoeducated" is reduced to applying the authoritative model to one's specificities, i.e. to identify stressors and coping mechanisms, rather than to judge the usefulness of the model for one's own life, taking into account its social and political implications.

These problematic and disempowering aspects of the VSM have been attributed to the fact that it has been stripped of "its original integrative character," leading to a one-sided focus on "somatic explanation," as well as "a superficial conception of stress" (Schmidt and Körtner, 2014, p. 241). However, as the close reading of Zubin and Spring (1977) has shown, the reductionism of a simplified understanding of stress and a focus on somatic etiology are not so much a distortion, but genuine characteristics of the original publication.

In psychoeducation these characteristics are transformed into immediate advice. While trusting medical expertise and taking medication as prescribed may appear as the usual goal of a desirable doctor-patient-relationship, there is something different at stake in the context of mental distress. The concept of a given "vulnerability," deduced from a questionable "logical factor analysis," concerns the framing of a one's own personality and biography. Should one, for example, struggle to address experiences of abuse, poverty or discrimination, get angry at the social injustices leading to such adversities, and perhaps even engage in activism to fight them? Or should stress be avoided, since it may lead to "illness"?

This is not a rhetorical question or one of politically instrumentalizing mental distress. Rather, it arises from observing a repeated feature in testimonials by psychiatric survivors: Embracing the stress that comes along with addressing trauma and adversity becomes part of the personal road to well-being, and these roads have to be discovered or even fought for against professional advice, as long as said professionals follow the implications of the VSM (e.g. Boevink, 2017; Brosnan, 2017).

A simplified understanding of stress is disseminated through illustrations, diagrams and textual explanation. Illustrations resort to metaphors, often that of buckets that are meant to symbolize the capacity of the person to tolerate stress and which overflow when more water enters than can be contained (e.g. Mediclin, 2018; Wirtz, 2021; Woodward, 2021; Patientenbroschüre, n.d.). The use of cross-section drawings underlines not only the technical character of the illustrations but acts as a way of looking inside, of seeing the otherwise invisible—the differing volume of buckets which look the same from outside. The need for an expert's gaze to recognize the internal condition of the bucket—as well as the notion that insufficiency may come unexpectedly—are additional elements of this iconography. It is also framed by its closeness to depictions of brains: photos alluding to neuroimaging (Mediclin, 2018) or drawings of a cortex (Patientenbroschüre, n.d.).

The message is clear: some people can take in less stress than others and the explanation for this difference lies with those experts who can look into structures invisible to the layperson. This impairment is to be tackled by taking neuroleptics, as set out already by Zubin and Spring (1977) and reinforced by subsequent psychoeducation.

However, the focus on pharmaceutical compliance is not only a consequence of the VSM and its modeling of vulnerability as a defect that can best be addressed by medication, but it is also an expression of the direct influence of pharmaceutical companies that sponsor publications (e.g. Bäuml and Pitschl-Walz, 2007, p. 4) or training for those offering psychoeducation (e.g. http://spi-paderborn.de/2018/03/psychoedukationsworkshop-des-spi-mit-prof-dr-baeuml/, accessed: 10/11/2021). However, the influence of pharmaceutical companies has been made more visible in recent years at least. As an example, a psychoeducational website sponsored by a pharmaceutical company, and produced in collaboration with the renowned Hamburg university hospital, changed its URL from www.psychose-wissen.de (last accessed: 5/6/2018; the title of the URL translates "knowledge on psychosis") to www.janssenwithme.de (last accessed: 10/11/2021). But boundaries between "Psychoedukation" and pharmaceutical advertisement remain blurred: the pharmaceutical company Janssen runs the website "Schizophrenie 24 x 7," and advertises it as a "useful offer for first information on this mental illness" [https://www.presseportal.de/pm/16998/3834936]—in fact offering mainly "education" on the inevitable necessity of taking neuroleptics.

Having concluded from the analysis so far that the adoption of mechanical metaphors that is characteristic of the VSM in psychoeducation contributed to the furthering of a medicalized understanding of mental distress in medico-pedagogical publications in Germany, it is worth taking a look at examples from recent psychoeducation in the UK, which bears witness to a stronger research tradition on the role of social adversity, and a more inclusive approach to (ex-)user knowledge (e.g. Longden and Read, 2016). Here, psychoeducational publications can be found which fundamentally divert from a narrow focus on compliance with psychopharmaceutical intervention and encourage users of psychiatry to find individual ways of coping, including an appreciative approach to voice-hearing (e.g. Woodward, 2021). However, the metaphor of the "stress bucket" persists. In these contexts, it is used to illustrate the need to monitor one's intake of stress and to think about ways of "releasing" it, while being formulated with a clear focus on social adversity such as exposure to bullying and bereavement. Examples from online self-help show the metaphor being removed from contexts of marking individual differences altogether by serving as an illustration to reflect on the components of any human experience of stress—leaving out allusions to "buckets" of different qualities in containment, and hinting at the fact that the experience of stress (rather than the containing qualities of "buckets") is individually unique (Liggins, 2021).

However, with respect to extreme mental distress and the suffering it involves, it might be useful to avoid mechanical metaphors altogether. After all, mechanics can hardly help in conceptualizing the paradoxical, which is characteristic of human experience—including the experience of suffering. Thus, to persons who have experienced extreme adversity such as abuse on a regular basis, exposure to a peaceful and caring environment may result in massive stress. Potential helpers—even those willing to consider social factors causing distress—run the risk of failing people, of being unable to understand the kind of support that is needed, and of staying unaware of the nature of the challenges when holding mechanical metaphors of stress in their minds, and looking for the quantifiable universal stressors psychoeducation tends to model.

DISCUSSION

The model proposed by Zubin and Spring (1977) represents less an integrative approach and more a defense of the medical model and its reliance on the construct of the deficient individual. This finding is in contrast to the rhetorical claims made by the authors and to the reputation the text enjoys. In psycho-education, in particular in its German version of "Psychoedukation," this mix of integrative rhetorics and biologist essence supports narratives which are dis-abling for the individual seeking support: The assumption of inherent vulnerability diverts the attention from the gravity of actual wounds, which would have to be taken seriously in order to open up empowering avenues such as fighting for one's rights and against discrimination, victimization and other grievances that are known to make people unwell. Mechanical images about a person's ability to take in "less" stress additionally promote this disempowering and finally disabling approach.

Seen socio-historically, it appears plausible that—published in the late 1970s—a narrative that separated the concern with (psycho-)social grievances from the realm of fundamental criticisms of psychiatric pathologization would have been successful. After all, it suggested that social grievances had been integrated into psychiatric theorizing and practice while allowing for a continued reliance on core elements of the medical model such as the focus on the inherently deficient individual and mandatory pharmaceutical intervention. However, in order to fully understand the genealogy of this persistence and the role of the VSM in it, further research is needed: It would be worthwhile to compare the reception of texts such as Engel (1977) and Zubin and Spring (1977) and also reconstruct the role of networks and power structures in the emerging popularity of the so-called "bio-psycho-social" approach while relating it to a critical appraisal of the seriousness dedicated to "psycho-social" aspects in its application. After all, the question needs to be answered: Why a period of such fundamental critique of psychiatric theory and practice as the one seen in the 1960s and 1970s failed to prevent further psychiatrization of Western societies.

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The author confirms being the sole contributor of this work and has approved it for publication.

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REFERENCES

Alvelo, P. J. (2011). *Politics of Madness: The Mental Patients' Liberation Movement in the 1970s*. Charleston: Proquest.

Basseler, M. (2013). "Close reading," in *Über die Praxis des kulturwissenschaftlichen Arbeitens. Ein Handwörterbuch* eds U. Frietsch and J. Rogge (Bielefeld: Transcript-Verlag), 84–89.

Bäuml, J. (2005). P*sychoedukative Verfahren. Behandlungsleitlinie: Psychosoziale Therapien.* Darmstadt: Steinkopff. 71–89.

Bäuml, J., and Pitschel-Walz, G. (2005). "Allgemeine Einführung zur Psychoedukation bei schizophrenen Erkrankungen," in Arbeitsbuch Psychoedukation bei Schizophrenie (APES), eds J. Bäuml and G. Pitschel-Walz (Stuttgart: Schattauer), 7–16.

Bäuml, J., and Pitschl-Walz, G. (eds.). (2007). *Psychoedukation bei schizophrenen Erkrankungen. Konsensuspapier der Arbeitsgruppe Psychoedukation bei schizophrenen Erkrankungen*. Zürich: Schattauer.

Beck, A. T. (1967). Depression: Clinical, Experimental, and Theoretical Aspects. New York, NY: Harper & Row.

Bernet, B. (2013). *Schizophrenie: Entstehung und Entwicklung eines psychiatrischen Krankheitsbilds um 1900*. Zürich: Chronos-Verlag.

Bleuler, M. (1963). Conception of schizophrenia within the last fifty years and today. *Proc. R. Soc. Med.* 56, 945–952.

Boevink, W. (2017). "Recovery Heißt discovery," in *Psychose als Selbst-Findung. Bald 100 Stimmen zu Dorothea Bucks 100. Geburtstag. Eine Fest- und Feierschrift*, eds E. Demke and M. Olostiak-Brahms (Bochum: BPE e.V.), 33.

Broerman, R. (2017). "Diathesis-stress model," in *Encyclopedia of Personality and Individual Differences*, eds V. Zeigler-Hill and T. K. Shackelford (Cham: Springer International Publishing), 1–3. doi: 10.1007/978-3-319-28099-8_891-1

Brosnan, L. (2017). "Escape from psychiatric capture," in *Psychose als Selbst-Findung. Bald 100 Stimmen zu Dorothea Bucks 100. Geburtstag. Eine Fest- und Feierschrift*, eds E. Demke and M. Olostiak-Brahms (Bochum: BPE e.V.), 24.

Burrows, V. (2015). *The Medicalization of Stress: Hans Selye and the Transformation of the Postwar Medical Marketplace*. Available online at: https://academicworks.cuny.edu/gc_etds/877 (accessed November 30, 2021).

Cooper, D. (1971). *The Death of the Family*. London: Penguin Books.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science* 196, 129–136. doi: 10.1126/science.847460

Ferriter, M. (2019). *Vulnerability-Stress-Models of Schizophrenia. Schizophrenia and Parenting.* Abingdon-on-Thames: Routledge. 95–102. doi: 10.4324/9780429436710-9

Foucault, M. (1969/1961). *Wahnsinn und Gesellschaft. Eine Geschichte des Wahns im Zeitalter der Vernunft*. Frankfurt: Suhrkamp.

Foucault, M. (2008/2003). *Psychiatric Power: Lectures at the Collège de France, 1973-74*. London: Picador.

Gallagher, M. (2017). *From mental patient to service user: deinstitutionalisation and the emergence of the Mental Health Service User Movement in Scotland, 1971-2006* (PhD thesis). University of Glasgow, Glasgow, Scotland. Available online at: https://theses.gla.ac.uk/8078/ (accessed January 31, 2022).

Goffman, E. (1961/1990). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York, NY: Anchor Books.

Goffman, E. (1963/1990). *Stigma: Notes on the Management of Spoiled Identity*. New York, NY: Simon & Schuster.

Goh, C., and Agius, M. (2010). The stress-vulnerability model how does stress impact on mental illness at the level of the brain and what are the consequences? *Psychiatr. Danub.* 22, 198–202.

Hankin, B., and Abela, J. (eds.). (2005). *Development of Psychopathology: A Vulnerability-Stress Perspective*. Thousand Oaks, CA: Sage Publications. doi: 10.4135/9781452231655

Laing, R. D. (1971). The politics of the family and other essays. New York, NY: Pantheon Books.

Landwehr, A. (2002). "Einführung in die Historische Diskursanalyse," in Geschichte des Sagbaren (Tübingen: edition diskord).

Lazarus, R., and Alfert, E. (1964). The short-circuiting of threat by experimentally altering cognitive appraisal. *J. Abnorm. Soc. Psychol.* 69, 195–205. doi: 10.1037/h0044635

Lazarus, R., Opton, E., Nomikos, M., and Rankin, N. (1965). The principle of short-circuiting of threat: further evidence. *J. Pers.* 33, 622–635. doi: 10.1111/j.1467-6494.1965.tb01408.x

Liggins, O. (2021). *The Stress Bucket*. Available online at: https://studentlife.lincoln.ac.uk/2021/01/21/the-stress-bucket-managing-your-stress/ (accessed November 30, 2021).

Longden, E., and Read, J. (2016). Childhood adversity and psychosis: generalised or specific effects? *Epidemiol. Psychiatr. Sci.* 25, 349–59. doi: 10.1017/S204579601500044X

MacDonald, A. W. III, Goodman, S. H., and Watson, D. (2021). The journal of psychopathology and clinical science is the future of the journal of abnormal psychology: an editorial. *J. Abnorm. Psychol.* 130, 1–2. doi: 10.1037/abn0000665

Mediclin (2018). Available online at: https://www.mediclin.de/medizin-gesundheit/ratgeber-gesundheit/artikel/psyche-koerper/stress-burnout/vulnerabilitaets-stress-modell/ (accessed November 30, 2021).

Meehl, P. E. (1962). Schizotaxia, schizotypy, schizophrenia. *Am. Psychol.* 17, 827–838.

Nuechterlein, K. H., and Dawson, M. E. (1984). a heuristic vulnerability/stress model of schizophrenic episodes. *Schizophr. Bull.* 10, 300–312. doi: 10.1093/schbul/10.2.300

Nuechterlein, K. H., Dawson, M. E., Ventura, J., Gitlin, M., Subotnik, K. L., Snyder, K. S., et al. (1994). The vulnerability/stress model of schizophrenic relapse: a longitudinal study. *Acta Psychiatr. Scand.* 89, 58–64. doi: 10.1111/j.1600-0447.1994.tb05867.x

Patientenbroschüre. (n.d.). Schizophrenie. Available online at: https://www.lundbeck.com/content/dam/lundbeck-com/europe/germany/06-downloads/patietenbrosch%C3%BCren/Patientenbrosch%C3%BCre_Schizo_deutsch.pdf.coredownload.pdf (accessed November 30, 2021).

Piaget, J., and Inhelder, B. (1958). *The Growth of Logical Thinking From Childhood to Adolescence*. New York, NY: Basic Books.

Read, J., Bentall, R., and Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiol. Psychiatr. Sci.* 18, 299–310. doi: 10.1017/S1121189X00000257

Reusser, K. (2014). Kompetenzorientierung als Leitbegriff der Didaktik. *Beiträge zur Lehrerinnen- und Lehrerbildung* 32, 325–339. doi: 10.25656/01:13873

Rosenhan, D. L. (1973). On being sane in insane places. *Science* 179, 250–258. doi: 10.1126/science.179.4070.250

Rzesnitzek, L. (2013). "Early Psychosis" as a mirror of biologist controversies in post-war German, Anglo-Saxon, and Soviet Psychiatry. *Front. Psychol.* 4, 481. doi: 10.3389/fpsyg.2013.00481

Schmidt, F. (2012). *Nutzen und Risiken psychoedukativer Interventionen für die Krankheitsbewältigung bei schizophrenen Erkrankungen*. Köln: Psychiatrie Verlag.

Schmidt, F., and Körtner, K. (2014). "Biografische Krankheitsverarbeitung in der Psychoedukation." in *Sinnsuche und Genesung. Erfahrungen und Forschungen zum subjektiven Sinn von Psychosen,* eds T. Bock, K. Klappheck, and F. Ruppelt (Köln: Psychiatrieverlag), 239–44.

Sen, D. (2017). "Broken hearts not broken brains," in *Psychose Als Selbst-Findung. Bald 100 Stimmen zu Dorothea Bucks 100. Geburtstag. Eine Fest- und Feierschrift*, ed E. Demke and M. Olostiak-Brahms (Bochum: BPE e.V.), 82.

Szasz, T. S. (1961/1974). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York, NY: Harper & Row.

Wirtz, A. (2021). *Vulnerabilitäts-Stress-Modell, in Dorsch Lexikon der Psychologie*. Available online at: https://dorsch.hogrefe.com/stichwort/vulnerabilitaets-stress-modell. (accessed November 30, 2021).

Woodward, S. (2021). *Manchester Early Intervention Team - Understanding Psychosis*. Available online at: https://gmwrag.files.wordpress.com/2018/02/presentation-on-26-01-18.pdf (accessed November 30, 2021).

Zubin, J. (1972). Scientific models for psychopathology in the 1970's. *Semin. Psychiatry* 4, 283–96.

Zubin, J., and Spring, B. (1977). Vulnerability: a new view of schizophrenia. *J. Abnorm. Psychol.* 86, 103–126. doi: 10.1037/0021-843X.86.2.103

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The Lost Social Context of Recovery Psychiatrization of a Social Process

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From being a concept questioning the core of psychiatric knowledge and practice, recovery has been adopted as a guiding vison for mental health policy and practice by different local, national, and international organizations. The aim of this article is to contextualize the different understandings of recovery and its psychiatrization through the emergence of an individualizing and de-contextualized definition which have gained a dominant position. It ends with an attempt to formulate a new definition of recovery which integrates people in their social context. Research results from various follow-up studies showing the possibility of recovery from severe mental distress have stressed the importance of societal, social and relational factors as well of the person's own agency when facing their distress and reactions from their environment. These researches were published in the 1970s and 80s; a period of struggle for liberation from colonialism, of struggle by women and black people for their civil rights, and a time of de-institutionalization of services directed toward the poor, elderly, handicapped, prisoners, and people with mental health problems. Recovery research pointed at the central role of individuals in their recovery journey and it was understood as a personal process in a social context. However, with neo-liberal political agenda, the personal role of individuals and their own responsibility for their well-being was stressed, and contextual understandings and the role of social, material and cultural changes to promote recovery faded away. Thus, during recent decades recovery has been mostly defined as an individualistic journey of changing the persons and their perception of their situation, but not of changing this situation. Contextual aspects are almost absent. The most quoted definition accepts the limits posed by an illness-based model. This kind of definition might be a reason for the wide acceptance of a phenomenon that was initially experienced as a break with the bio-medical paradigm. Recently, this dominant individualized understanding of recovery has been criticized by service users, clinicians and researchers, making possible a redefinition of recovery as a social process in material and cultural contexts.

Keywords: recovery, mental, individual, social, cultural, relationships, societal, psychiatrization

> . . . ideologies can be liberating while they are still in formation and oppressive once they become institutionalized (Scheper-Hugues and Lowell, 1986, p. 162).

THE SOCIAL CHARACTER OF MENTAL HEALTH

The topic of this article could be seen as paradoxical. How could recovery be part of the psychiatrization of society? From the beginning recovery was perceived as a process of leaving mental health problems and services behind and to be ≪recovered≫ thanks to changes in one's social and material conditions. It was about de-psychiatrization of one's life. However, recovery became psychiatrized and professionalized and transformed in a never-ending process of being ≪in recovery≫. People with mental health problems were again defined as suffering from diseases and as in need of psychiatric interventions mostly in "recovery-oriented" services.

Recently the most common understandings and definitions of recovery (Anthony, 1993; Leamy et al., 2011) have been criticized for their individualistic and normative aspects (Harper and Speed, 2014; Karadzhov, 2021; https://recoveryinthebin.org), as they do not mention the importance of social living conditions such as financial resources, housing and general living conditions (Harper et al., 2015). The critics have highlighted the social character of mental health problems and recovery, but also of the mental health field itself (Topor et al., 2011; Tew et al., 2012; Rose, 2018; Rose and Kalathil, 2019; Karadzhov, 2021). Materialities (Larsen et al., 2021), places (Duff, 2012; Doroud et al., 2018), and social relations (Topor et al., 2016a; Price-Robertson et al., 2017) have also been stressed as missing in recovery research. Finally, the narrative/biographical character of dominant recovery research putting recovery into the formula of a personal, chronological, order, at the cost of social aspects, has been questioned (Bøe et al., 2021).

Thus, it seems that people in recovery studies are floating in a social vacuum where their possibilities and capacities to live a satisfying life mostly depend on themselves and their own efforts. People in many recovery studies are not connected to their living conditions in a time of growing inequalities, social welfare cutbacks, and deteriorating conditions on the labor market. The lived life and thereby the basis for people's sense of self are excluded from our knowledge about recovery.

AIM AND METHODOLOGICAL CONSIDERATIONS

In this article we aim to place the development of medicalized, psychologized, and individualistic definitions of recovery in their contemporary historical contexts. Here we might see a special case of psychiatrization (Beeker et al., 2021). Not only that social, material and cultural conditions for people's life behind mental distresses are rendered invisible, but also the same conditions' central role for improvements and positive changes regarding these distresses. Finally, we propose the starting point for a contextual definition of recovery. As Ramon (2018) writes "... it is important to include reflections of recovery journeys alongside formal research" (p. 2).

Beeker et al. (2021) point out that psychiatrization is hard to define because of the diversity found in psychiatry itself. However, they suggest the following working definition:

> "[P]sychiatrization [is] a complex process of interaction between individuals, society, and psychiatry through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole" (p. 3).

In this paper we explore the emergence of recovery in light of these aspects, but in a period of de-institutionalization and de-psychiatrization. We also explore recovery's later transformation to a psychiatric and psychiatrizing concept and the context of this radical change. Finally, we point at discontents with the psychiatrization of society and of recovery and suggest a de-psychiatrizing definition of recovery.

Methodological Considerations—Some Words About Words

Goffman (1976/1979) made once a methodological statement:

> The particular matters I want to consider raise three distinct and general methodological questions that should not be confused: discovery, presentation, and proof. Only the first two will here be at issue... (24).

We adhere to Goffman's distinction and hope the reader will bear it in mind when reading this article.

The reader should also keep in mind that when writing about psychiatric diagnosis and recovery one is confronted with important questions regarding both language and technical issues (Boyle, 2015; Topor et al., 2018). The definition of a central diagnosis like schizophrenia varies with time and place. Boyle (2002) argues convincingly that the dementia praecox of Kraepelin might have been a completely different illness than the schizophrenia psychiatrists diagnose today (Hegarty et al., 1994). Recovery has also been analyzed and defined in many ways (clinical, total, social, personal, relational, etc.), based on a range of criteria (Davidson and Roe, 2007; Slade, 2009). Where possible, we have presented short *ad hoc* definitions. Throughout the paper, we do not use "illness," but rather "problems" and "distress."

Last but not least, who are we talking primarily about? All the terms in use, such as *patient, client, consumer, user, citizen,* and *survivor* are imbued with different ideological and scientific positionings. Therefore, we will refer to persons in inpatient settings as "patients" and outside these settings as "persons" or "people," "person with a diagnosis of severe mental problems" or "service users."

Follow-up studies have been criticized because of unclear definitions of central concepts and because of technical problems often inherent to this kind of study (biased population, drop-outs, different outcome measures...). The studies we present have also faced such criticism; however, they have been published in peer-review journals and the interested readers are kindly asked to maintain a critical stance toward both the referred literature and how this article's authors have used it for their own purposes.

THE (DE-)CONSTRUCTION OF CHRONIC MENTAL ILLNESSES

A re-occurring paradox in psychiatry is the simultaneous claims about discoveries of constantly more efficient treatment interventions on the one hand and the definition of most diagnosis/illnesses as "chronic," or "long-term" on the other (Warner, 2004; Priebe et al., 2013).

Specifically, schizophrenia is referred to as a progressive destruction of what constitutes a human being (Kraepelin, 1919/1971; Frith and Johnstone, 2003). Ey (1977), a major French psychiatrist summarized the different definitions of schizophrenia as:

> The loss of entity, that constitutes the individual, regression into delusions, detachment from reality, disturbance in communication are all various aspects of the emergence of a person without person and of a world without world, which is the very essence of schizophrenia (p. 64).

Therefore, recovery from schizophrenia has seldom been mentioned in literature as a consequence of a specific intervention, if it ever occurred. Kraepelin routinely considered patients improving as misdiagnosed (Harding et al., 1987c). Bleuler (1911/1950) stated: *"As yet I have never released a schizophrenic in whom I could not still see distinct signs of the disease…"* (p. 256, italics in the original). The history of schizophrenia is paved with attempts to maintain the chronic character of the diagnosis, so to explain the occurrence of recoveries Langfeldt (1937) created a special diagnosis "schizophreniform psychosis," a disease like schizophrenia in every aspect, except that the person recovered. However, remission, a time-limited recovery, could be accepted as a possible stage in the "natural course" of the general decline of the person.

The depressive character of psychiatric thought might, at least partly, have been a consequence of "the clinician illusion" (Cohen and Cohen, 1984), as many psychiatrists developing classifications were working in total institutions. There, they met persons with a diagnosis of severe mental problems when they were ill. Discharged patients who did not "relapse" disappeared from their sight, thus creating a biased experience-based body of knowledge about mental health problems as chronic illnesses (See also Bleuler, 1978).

Over the years different interventions were developed and presented as successful, such as ETC, psychosurgery, therapeutic community, the first and second-generation neuroleptics and the atypical one etc. Nevertheless, recovery from schizophrenia was not on the agenda. In the fourth edition of DSM (American Psychiatric Association, 2000) it was stated that: "Complete remission (i.e., a return to full premorbid functioning) is probably not common in this disorder." (p 282)

This definition constitutes an established but odd way to measure an improvement, as if recovery was about a kind of return journey in one's history. As if a person who had experienced the distress of severe mental illness and the challenges connected to stigma and to mental health care could or would return to a premorbid state (the state that might have triggered the problems). This reflects a central psychiatrizing pattern where the illness exists separate from and independently of life events and experiences; a figure we will come back to.

Recovery as a Probable Outcome

The publication around 1980 of several follow-up studies of persons diagnosed with schizophrenia constituted a challenge to the dominant medical understanding of severe mental illnesses. Living conditions and life-events, often connected to these conditions, played a central part in peoples mental health. This knowledge became part of a process of de-psychiatrization in western societies connected to the radical de-institutionalizing movement and focusing not only on psychiatric total institutions, but also on psychiatry's and psychiatrists' power-based knowledges and practices (Foucault, 1980; Scheper-Hugues and Lowell, 1986).

Thus, when the WHO (1979) started to publish the results from its international follow-up study they were met with skepticism and rejection. A first article on the US results was sent back to its authors, the reviewers arguing that they had to reconsider their statistics (John Strauss, personal communication). The proportion of persons in recovery was far too high to be plausible.

The WHO study was not critical to traditional psychiatric knowledge only because of the high percentage of recovered persons it showed. An even more unacceptable result was that the proportion of recovered persons was higher in low-income countries, with a limited presence of medical mental health resources, compared to high-income countries (Hopper et al., 2007; Mills, 2014).

However, the WHO study was followed by other studies presenting results showing that recovery from schizophrenia was not only a possibility, but that (in most studies) about one-fifth to one-third of the persons diagnosed with schizophrenia showed complete recovery (Bleuler, 1978; Ciompi, 1980; Harding et al., 1987a,b; Warner, 2004). This meant that they did not present any symptoms of the illness and were living independently in the community. Around the same number were classified as socially recovered as they could show mild but not invalidating symptoms and lived in the community, although with some support.

Harding et al. (1987a,b) published a follow-up study of patients from a mental hospital that were not able to be discharged when the first-generation neuroleptics had been administered to all the patients in the actual institution. At follow-up, 30 years later, 68% did not display any sign of schizophrenia, and 50% were not using neuroleptics.

Warner (2004) published a compilation of recovery studies conducted through the twentieth century. His review showed a total recovery rate fluctuating between 10 and 20 percent and a social recovery rate between 30 and 40 percent over the century.

He also found that the general use of first-generation neuroleptics in the 1950s did not improve recovery rates.

Bleuler (1978), the son of Eugen Bleuler who coined the term "schizophrenia," published the results of a follow-up study that had lasted over 30 years. Unlike his father he stayed in touch for decades with patients even after they were released from hospital, and included them in his study. His results showed that 23% were fully recovered and a further 43% were socially recovered. Father and son's different appreciations of the possibility of recovery might be seen a dramatic illustration of the "clinician's' illusion" thesis.

Recovery's Social Context

Besides showing that recovery was not rare, these studies showed that recovery could not be connected to specific treatment interventions. The consequences of the "psychopharmacological revolution" could not be detected in these studies. Recovery occurred at about the same rate at different times when different interventions were the golden rule of the day.

Different hypotheses were formulated to explain these results. Warner (2004) made statistical calculations to study possible reasons for the greatly reduced probability for recovery during a period between 1921 and 1940. His conclusion pointed at the increased un-employment rates during the Great Depression before World War 2 as the most probable explanation.

Regarding Harding et al.'s results (Harding et al., 1987a,b), we know that the patients remaining in the mental hospital after all in-patients had received first-generation neuroleptic treatment were offered a long-term rehabilitation program. Thereafter, patients began to leave the hospital after only a few months. Coming out, they were offered a range of residence alternatives and on-going rehabilitative support in the community. Analyzing these data, DeSisto et al. (1995) stressed the importance of hope, relational continuity, and collaboration between users and professionals for sustained recovery.

Different hypotheses regarding the difference between high- and low-income countries recovery rates (WHO, 1979) were formulated (Warner, 2004; Mills, 2014). Some were about the permeability of the work market in the latter, making it easier for people to find a workload appropriate to their actual condition, and about the presence of extended families in low-income countries spreading the family burden among several members, thus easing it for each of them. Another hypothesis was about the local systems of beliefs about the causes of madness. Religious or spiritual explanations were considered as more frequent in low-income countries and were supposed to have less severe consequences for the people and their networks' readiness to deal with problems. In contrast to medical expertise-based interventions, spiritual understandings could leave a greater possibility for people to act against the problems and thus to keep a hopeful mood (Waxler, 1979). Finally, a provocative hypothesis is that the higher recovery rate in low-income countries could be caused by the scarcity of bio-medical interventions and hospitalization possibilities. People in crisis would get Western medical treatment and be medicated, but as soon as the crisis was over, they would return to their villages far from the places offering medical interventions. As an unattended consequence, they would avoid long-term medication and its problems (see also Moncrieff, 2009; Harrow et al., 2012; Mills, 2014). However, one should not negate the existence of ill-treatment of persons with severe mental health problems in low-income countries.

It is noteworthy that these explanations were all basically social/societal and became part of a global questioning of the medical, psychiatric, framework. Thus, they put new questions on the research agenda about the conditions for favorable recovery journeys (Mezzina et al., 2006).

DE-INSTITUTIONALIZATION

In fact, these early follow-up studies results were threatening the vision of mental illnesses as illnesses and helpful interventions as medical interventions. They could be seen as a part in a spirit of this time of de-psychiatrizing mental health. If recovery could not be connected to specific medical interventions and if social, cultural, and societal factors were determinant for a recovery process, then mental illnesses were not illnesses. The knowledge collected about recovery and its conditions and practices ["Le savoir des gens" – "Peoples' knowledge," as Foucault (1980) mentioned] became part of the de-psychiatrization of society.

It seems probable that the de-institutionalization of psychiatry had its roots in a global liberation struggle. The publication of the above-mentioned studies coincides and interacts with societal circumstances. The post-World War 2 period was characterized by a wide range of liberation movements and struggles for applied citizenship. People from colonized countries participated in World War 2 on the side of their colonial powers and this fueled their struggle to be recognized as independent countries. These struggles influenced both the people fighting for their independence and people in the colonial powers and other high-income countries. Struggles for dignity and liberation in Europe and North America came to include basic civil rights, both for women and ethnic minorities (Davidson et al., 2010), but also for homosexuals (Kirk and Kutchins, 1992). Beeker et al. (2021) mentioned "…the de-pathologization of homosexuality and its removal from DSM-II in 1973" as "the most prominent case of de-psychiatrization" (p. 3). But one should not forget that both women and racialized people have been and still are psychiatrized and that their liberation struggle is at least partly about the psychiatrized boundaries of normality (Read and Beavan, 2013; Read et al., 2013).

Another struggle front was about developing welfare states and guaranteeing coverage of basic needs in the case of unemployment, sickness, and poverty. Finally, a process of de-institutionalization was initiated regarding the elderly, the handicapped, prisoners and mental health patients. These groups often lacked basic civil rights and the above-mentioned struggles have to be understood in the light of the cold war, where Western Europe and the US criticized the Soviet Union for the lack of democratic rights.

Already in the 1940s, long before the first-generation neuroleptics came into use, the number of in-patients in some states in the US diminished (Scull, 1984). After World War 2 this became the dominant trend in many high-income countries' psychiatric care. The closing of mental hospitals has been associated with the use of the first-generation neuroleptic drugs. However, as we mentioned, it started long before neuroleptics came in use, but in countries such as Sweden and Italy, the downsizing of mental hospitals waited until the end of the 60s, long after the use of these drugs had become generalized (Markström et al., 2004; Carta et al., 2020). De-institutionalization has sometimes been reduced to de-hospitalization; a mere closing of inpatient institutions. These situations resulted in homelessness and abandonment, leading to extensive tragedies (Scheper-Hugues and Lowell, 1986; Dear and Wolch, 1987).

De-institutionalization was not only to be understood as the closing of the total institutions, but also as the construction of alternatives in the community to facilitate the inclusion of the former segregated groups in society and the challenging of medicalized knowledge and practices about madness (Scheper-Hugues and Lowell, 1986; Rotelli, 1994; Carta et al., 2020).

This move from a specialized and segregated field open only for experts by profession to the public agenda including societal and political discussions about madness, mental health treatments and service organizations could be both illustrated and pushed forward by the publication in the 1960's first 2 years of Foucault's Histoire de la folie á l'age classique (1961), Goffman's Asylums - Essays on the social situation of mental patients and other inmates (1961), Szasz's The myth of mental illness (Szasz, 1961) and Liang's The divided self (Laing, 1960). From different perspectives they all considered psychiatry as a social field and mental illness as a medical construction that could and should be de-constructed.

De-institutionalization, de-psychiatrization and psychiatrization are complex concepts and their practice should not be reduced to simple processes. Already in Castel (1976), Castel pointed in "The psychiatric order" at modern psychiatry's new challenge. When the number of diagnosed persons was limited, the maintenance of order in society could be organized through the exclusion of the deviant in total institutions. When the number of deviants grew, exclusion threatened the very base of society; the production of goods. In this context the mission of psychiatry changed, from taking care of "lunatics" to taking care of the population. Psychiatry had to find solutions to maintain "people at risk" in the society and first of all as work force. Castel argues that the deployment of psychiatric structures in the society opened for constant monitoring and for the use of new techniques like behavioral therapy, but also of "constant performance evaluation and assessment from birth to death" (p. 290. See also "The advanced psychiatric society—the American model"; Castel et al., 1979).

However, another result of the closing of mental hospitals was the presence in the community of a growing number of persons with their own experience of mental distress and of psychiatric care, persons whose words and experiences could now be heard publicly without being immediately interpreted by mental health professionals as symptoms of their illnesses (Chamberlin, 1978; Deegan, 1988; Romme et al., 2009).

The De-Psychiatrization of the "Patient"—The Discovery of the Patient as a Person

De-psychiatrization of society also touched our notion of the mad person. Once the possibility of recovery from "illnesses" previously considered as "life-long" was established, studies focused on what benefits a recovery journey? What might hinder it?

At that time, the voices and experiences of service users had gained a certain credibility. Earlier narratives from users were mostly silenced or interpreted through the lenses of the experts by profession (Freud, 1905/1997). This increased credibility might be considered as one of the major contributions of the growing independent service users' movements and of recovery research; the transformation of the patients diagnosed as out of their mind and of reality, reduced to their symptoms, "a person without a person" into an expert with experience-based knowledge. The "discovery" of the patient as a person separated and not reduced to a diagnosis was reflected in titles of publications at that time, such as "The patient with schizophrenia as a person" (Strauss, 1994) and "From the mental patient to the person" (Barham and Hayward, 1991).

A central part of these narratives was the discovery of the importance for treatment results of professionals' confirmation of the patient as a person (Denhov and Topor, 2012; Topor and Denhov, 2015). Re-occurring concepts in the studies concern seeing "the service user as an individual, not just a patient" (Farrelly and Lester, 2014); as more than just a "…number, diagnosis, or set of diagnoses…" (Shattell et al., 2007). The basic aspect of it is the confirming of the user's "share humanity" (Sandhu et al., 2015) and as a "whole human being" (Grim et al., 2019) and "a fellow human being," "putting the psychosis in brackets and cultivating all that is healthy" (Bjornestrand et al., 2018). Interpersonal aspects are focused on in terms of the "inviting attentiveness" on the part of the professional, which offers the user a "vitalizing space" (Topor et al., 2014; Ljungberg et al., 2015).

These studies have given us important contributions to our understanding of the recovery journeys and of hindering and contributing factors. They are mostly about the person's own efforts and struggle. About the person's development of different ways to deal with their environment, their families, friends, professionals, and the vicissitudes of everyday life and of what was and often still are considered as symptoms (Deegan, 1988; Romme and Escher, 1989; Davidson et al., 2006; Topor et al., 2016b).

This relational aspect of de-constructing the patient and re- and co-constructing the person (Price-Robertson et al., 2017) constituted a challenge to traditional knowledge about the illnesses that these persons were said to be affected by, attacking their capacity for and interest in social relationships (Frith and Johnstone, 2003). The patient remains a person but hidden by the clinical gaze in different institutions, characterized by their loss of power. The professional has to break with a strict clinical worldview to re-establish the patient/client as a person in their own eyes, and as a partner in a possible joint venture.

Experience, Narrative, and Knowledge

The liberation of users' voices was of central democratic importance. However, these voices were sometimes given a special status, replacing what Foucault (1961/1972) called the monolog of reason (the psychiatrists) about madness (the patients) by a counter monolog as users were declared to be the experts about their own situation and thus, as the new experts, that could not be criticized (Bøe et al., 2021). However, accepting the patient as a person means accepting their storied experiences as everybody else's narratives and not as symptoms of illness to be interpreted by the holders of a special knowledge. Personal narratives might play different roles in everyday, therapeutic, political and research settings.

On an everyday, personal level the function of developing an experience-based narrative might be to create a personal understanding of one's history and could be of central importance in a recovery process (Boyle and Johnstone, 2018). The problem with the use of these narratives, as well as of professionals' narratives, in research is that the knowledges produced in both cases are the product of immediate individual experiences and the person's agenda. Complexity and contradictions are lost. They are also, like all narratives, influenced by dominating, master narratives (Hydén, 1995) about how a story should be told and what elements are accepted in different contexts (Llewellyn-Beardsley et al., 2020). In a period of psychiatrization of social processes and of our understanding of ourselves and our lives, a looping effect can be noticed, where persons accept and reproduce the definition of themselves as mentally ill and in need of a diagnosis and medication (Hacking, 1998; Mills, 2015). Personal narratives reflect important experiences but run the risk of missing the contributions and contradictions from contextual and social analysis of their conditions (Bøe et al., 2019). This opens for the possibility to analyze the psychiatrization of society as both a top-down and also a bottom-up process.

Thus, as important as individual narratives might be, they should be critically scrutinized to protect knowledge from what Bourdieu (1986) called the biographical illusion, where the chaos of life is ordered through a co-creative process between the person and the researcher; a constructed order where earlier events tend to be presented as causes of later developments. Definitions where recovery is seen as individual stories along a *temporal* trajectory lose from sight complexity and the social aspects of *spatial* interaction (Larsen et al., 2021).

Citizenship includes the right to tell one's story but also to be part of conflictual dialogs, replacing the monolog of Power/Reason. This could be seen as another aspect of the de-psychiatrization of mental illness and society.

FROM THE SOCIAL PERSON TO THE ISOLATED INDIVIDUAL—THE PSYCHIATRIZATION OF RECOVERY

If psychiatrization is defined as "a complex process of interaction between individuals, society and psychiatry…" (Beeker et al., 2021, p. 3) it is of core importance to study not only the impact of psychiatry on society, but how these three actors influence each other. The discovery of the probability of recovery from severe mental illnesses, of the importance of social, cultural and societal aspects and of the patient as a person and an agent coincides with a period of global political changes. De-institutionalization and de-psychiatrization ("anti-psychiatry" (Castel, 1981) and "Alternatives to psychiatry" (Collectif International, 1977) started at the end of the thirty years following World War 2 characterized, as we have seen, by different liberation movements and the construction of the modern welfare state. It also started at the beginning of a neo-liberal period in world economy, politics and understanding of human beings.

The medicalization of society, psychiatry and recovery can be understood as a result of tendencies in different fields during the ultimate decades of the twentieth century.

Regarding society it is about a neo-liberal shift that was expressed by different heads of states and concretized in political decisions jeopardizing the welfare states in different countries. In 1987, Margaret Thatcher, UK prime minister, declared that there was "no such thing as society, just men and women…" The same year, Ronald Reagan started his first presidency by putting an end to federal help to develop community mental health services.

Regarding *psychiatry* the DSM III (APA, 1980) was launched as psychiatry's return to real science and the first step to develop a scientific base to the proposed diagnosis and thus to be the base for the development of adequate treatments. It was followed by the arrival of the second-generation anti-depressant and anti-psychotic medicines with promises of high efficiency, finally proving that mental distress were illnesses like all other illnesses and psychiatry a branch of medicine. It is a paradox that despite these success stories the American Psychiatric Association (1994) continued to declare schizophrenia a chronic disorder.

The neo-liberal changes in policy and the medicalization of psychiatry became *a joint venture* with US president Georg Bush proclaiming the nineties as "The Decade of the Brain" (later to become "The century of the brain"). While the next president, Bill Clinton, 1996, declared that ≪The era of the big state is over...≫ and cut down different forms of social security systems (Wacquant, 2009). State money was instead dedicated to research about the biological causes of mental illnesses and to information to the public about mental illnesses that could be cured thanks to new medicines.

Regarding *the individuals*, neo-liberal ideology invaded policies and thereby our understanding of human beings and social problems (Evans-Campbell et al., 2006; Frances, 2013; Ramon, 2018). Public support for poor, discriminated and fragile persons was reduced and the single person's responsibility and capacity to control their own life was stressed (Wacquant, 2009). The ideal of the independent, self-made (wo)man became dominant (Cushman, 1995; Pearlin et al., 2006). Welfare discourses and agencies became penetrated by workfare. Policies where people are guaranteed support if in need were replaced by workfare's conditional aid where the same person first had to prove their willingness to work and to manage themselves before eventually getting some subsidies (Peck, 2001).

However, at the same time having a psychiatric diagnosis became the main road for poor people to get some support.

This psychiatrization of society is reflected in diverse, sometimes contradictory numbers. Such a contradiction is about welfare state interventions. At the same time these interventions were under attack, the number of persons receiving monetary support because of mental illness increased, from 1.25 million adult American citizens in 1987 to 4,2 million. Twenty-five years later (Whitaker and Cosgrove, 2015). In schools disturbing kids had to be transformed into disturbed kids to get any help one has to be diagnosed. Recovering, or at least claiming to be totally recovered, entails the risk to lose ones' means of subsistence.

Since the publication of the DSM-I we have witnessed an increased number of diagnoses. In this first edition, 1952, there were 152 distinct disorders. In 1984, with the publication of the third edition, there were 228 diagnoses and finally, in the present fifth edition, there are 541. Parallelly with this inflation of diagnoses a growing number of persons (adults and children) have been declared to present symptoms of mental illness. After the publication of DSM IV one third of the adult US population were considered to have a mental illness. Disturbing kids had to be transformed into disturbed kids. One of seven (age 8–15) were said to show symptoms corresponding to mental illness. This was connected to a huge increase in public spendings for psycho-pharmacological treatment; In the US, from 870 million dollars in 1987 to 35 billion, 2010 (Whitaker and Cosgrove, 2015, p 117). This development was mirrored in other high-income countries.

These numbers point at a dialectical relation between government policies (top-down) and citizens expressed needs (bottom-up). If the dominant ideology about social conflicts and their consequences is medical and if a diagnosis is the key to be helped, then people will reclaim diagnosis and interpret their problems and the distress connected to them as signs/symptoms of an illness inside of them. They will identify themselves as ill and claim for adequate diagnosis and, of course, for what is presented as high-quality, scientifically evidence-based interventions; medicine. The state will give priority to services quickly diagnosing their "consumers" and prompt to offer them such interventions. This self-reinforcing system is good at avoiding critical reviews as all the involved parties find at least short-term gains, even if resistance against psychiatrization can be noticed (Beeker et al., 2020).

This individualization and "responsabilization" came to affect our understanding of recovery and what kind of support people needed (Rose, 2014). However, few recovery studies problematized these changes; instead, most integrated an individualized and de-contextualized perspective (Duff, 2012; Karadzhov, 2021). The newly discovered capacities of persons with a diagnosis of severe mental problems were turned against them and used as an argument to reduce the supporting interventions directed to them in order not to create what were defined as negative dependencies instead of interconnectivity, solidarity and brother/sisterhood and the user as a consumer in a free market (Mills, 2014; Rose, 2014; Woods et al., 2019).

Thus, it might be considered as a paradox that the possibility of recovery came up on the agenda, at least in the US, while people with mental health problems were often dumped and abandoned in the streets to homelessness (Dear and Wolch, 1987; Knowles, 2000); at a time when new concepts were coined such as "the new chronic patients" with no place to stay (Scheper-Hugues and Lowell, 1986, p. 176).

At this point, the psychiatrization of society, transforming poor people into ill people, became connected to the psychiatrization of recovery.

Recovery as a Never-Ending Personal Journey

In summary, the discovery of the patient as a person, as an agent, and the ideology of a strong independent self together with the neo-liberal discourse about the individual's responsibility for their own fate created and reflected a new spirit. This spirit was distant from the original social, material and contextual understanding of people's recoveries in the complexities of lived life and construction of a more satisfying sense of self. Illnesses had to be treated medically and individually. Additional supports should then be directed to improving the person's understanding of their situation, and not to their factual situation, to avoid dependency.

This new spirit found its ultimate formulation in the most quoted definition of recovery (Anthony, 1993):

> Recovery is a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles.
>
> It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness.
>
> Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (p. 15).

In the light of the context we have presented so far, we suggest that three basic assumptions in Anthony's definition should be re-considered.

Firstly, Anthony's definition describes recovery processes as *an individual process* without connections to the relational, cultural, material, and societal context around people.

Secondly, the definition describes recovery processes as merely *an internal psychological process*, as if recovery was only about changing one's cognitions of the world and of oneself in it, without any changes of people's living conditions.

Thirdly, the definition frames the recovery processes *within the boundaries of an illness model and even of chronicity*.

At the center of this assumption, we find a division between the (biological) illness and the (social) lived life of the person. Even when people develop a good life, the illness puts limitations on it. Living a good life does not have an impact on the illness. Paradoxically, chronicity is part of the vision, because even if people can grow beyond the effects of the illness, they cannot grow beyond the illness itself. This division might reflect the division between bio-medical treatment, psychotherapy and rehabilitation, where treatment is directed toward the illness and its symptoms, psychotherapy to the person's understanding of their situation and rehabilitation to the consequences of the illness in everyday life.

But the psychiatrization of recovery to an individual and mostly cognitive process may have contributed to the acceptance of Anthony's vision by international, national, and local agencies as it does not question the pillars of the dominant bio-medical model in "The decade of the brain "(1990–1999) and then "The century of the brain" (Mills, 2015; Karadzhov, 2021). If social and societal factors can cause and cure an "illness," as the results from follow-up studies from the end of the twentieth century showed, then this illness might not be an illness, but a form of distress transformed/constructed as an illness.

The possibility of a total recovery includes the possibility to go not only beyond the consequences of the illness, but also beyond the illness itself. Total recovery opened the possibility to" become an ex" (Fuchs, 1988) and leave mental distress and services behind. On the contrary, Anthony's definition augment the number of persons judged to be in need of mental health services' interventions. The recognition of their specific experience-based knowledge opens for them careers as low-paid counselors in mental health structures with the obvious risk of adapting their knowledge to the dominant discourse, forming a kind of psychiatrized ≪sanctioned resistance≫ (Eriksson, 2015).

The life-long status of being in recovery reinforce the persons dependence of a psychiatric diagnosis to be able to receive different forms of social and economic support based on a recurring assessment of the individual need of the person. Thus, it hinders collective solutions to societal problems and creates users as agents of medicalization.

This is not to deny the hopeful message contained in the Anthony vision; that a decent and even good life is possible even when it comes to persons with a diagnosis of severe mental problems. But a close reading of his definition highlights that Anthony's a contextual understanding of recovery influences how we figure the relation between the lived life of people and their mental distress. It also influences our vision about how to support peoples' recovery journeys. In this way, the individualistic, cognitivistic, and illness limited understanding of recovery that has dominated the psy-field can be seen as a contribution to the psychiatrization of society.

The psychiatrization of our understanding of recovery reflects the diverse aspects (medicalization, individualization, bio-medicalization, pharmaceuticalization, and psychologization) included in the concept of psychiatrization mentioned in Mills (2015) and Beeker et al. (2021). The never-ending recovery process might be seen as old wine in new bottles, as it actualized mental distress as chronic and as illnesses. To live a fulfilling life becomes more a question of representations, personal will and capacity of adaptation than of actual resources in the form of social recovery capital (Tew, 2013).

FROM PSYCHIATRIZATION TO DE-PSYCHIATRIZATION?—ARE THE TIMES CHANGING?

Previously we have stressed the importance of connections between societal changes and developments in the psy-field. Is it now possible to notice actual societal changes that could strengthen social perspectives and their applications to official mental health policies, practices, and the dominant understanding of mental distress?

The Crisis of the Psychiatric Society

It is possible to argue that the actual neo-liberal period has led to growing inequalities and a growing proportion of persons who are not only marginalized but also excluded in high-income countries (Wacquant, 2009; Wilkinson and Pickett, 2018).

The dismantling of different sectors of the welfare state, such as reduction in school, health, financial and social support, together with the growing proportion of precariat on the work market have created an atmosphere of uncertainty and insecurity in large portions of the population in high-income countries (Castel, 1995; Peck, 2001). New Public Management as a way of organizing public services has led to a "proletarization" of mental health professions, reducing a growing part of their work to reproducing pre-determined interventions in narrowly defined evidence-based schema-bounded rituals (Pilgrim and McCranie, 2013).

In parallel to these societal developments, bio-medical psychiatry has strengthened its dominant position. However, at the same time, its shortcomings have become apparent (Rose, 2018). How can we explain the growing number of people given a psychiatric diagnosis? Frances (2013) wrote about an epidemic spread of diagnoses such as ADHD, depression and bipolar disorder. This epidemic can hardly be explained by a spreading of brain or genetic damages in the general population; instead, Frances points at the lack of scientific research behind the lowering of diagnostic criteria. Instead, he stresses the importance of the pressures of pharmacological companies (see also Brinkmann, 2016).

Despite repeated claims of being on the verge of discovering the biological bases of the major mental illnesses, bio-medical psychiatry has failed in this ambition (Priebe et al., 2013). This failure again came to light with the publication of the DSM-5 (Götzsche, 2013; Greenberg, 2013). Unable to give the ever-increasing number of diagnoses an acceptable reliability, bio-medical psychiatry still lacks a valid base for its practice (Imsel, 2013; Whitaker and Cosgrove, 2015; Johnstone et al., 2018).

Thus, we still lack studies showing statistical positive long-term effects of the major medicament interventions. As many studies are financed and controlled by the pharmacological companies, their results are in many cases biased and even then, are not so overwhelmingly positive (Moncrieff, 2009, 2013; Whitaker, 2010; Every-Palmer and Howick, 2014). Paradoxically, in the name of the Movement for Global Mental Health, pharmacological treatments and bio-medical classifications are introduced in low-income countries by the same WHO which has previously measured a greater possibility for recovery in these countries compared to bio-medicalized high-income countries (Mills, 2014).

New Horizons?

The combined incapacity of the neo-liberal politicians and of bio-medical psychiatry proponents to live up to their own expectations creates a critical space where different forms of protests and counter actions have been actualized. The general societal dissatisfaction has produced a range of movements, many of them along the lines of the ones we saw in the 1970th, such as "Black Lives Matter," and "Me Too," but also more global critics such as the "Gilets Jaunes" and the struggle for societal changes to preserve the environment.

A trial with a guaranteed basic income was earlier implemented in Canada (Forget, 2019). There are now some attempts to introduce general basic income in Finland, Sweden, and Spain to secure a decent income for all citizens, irrespective of the cause of their need for support. A main shift in the development of guaranteed basic income is to transform a negative definition of people receiving support as "dependent" into being part in a process of societal solidarity. A user network, "Recovery in the bin,"[1] formulates its fourth key principle of recovery as: "We want a robust 'Social Model of Madness & Distress' building upon the Social Model of Disability and Independent Living, meaning support where needed and not perpetual pressure toward unattainable self-sufficiency" (https://recoveryinthebin.org).

In the psy-field the contextualization of mental health and recovery has not limited itself to research. Social and societal mental health practices have developed. The best known might be the one in Trieste where the mental health services work completely without inpatient structures. Mental health centers are spread in the community and offer different interventions and possibilities to join cooperatives and to participate in cultural activities (Scheper-Hugues and Lowell, 1986; Mezzina, 2006). Trieste has inspired services in different parts of the world, but refuses to be a model (Burns and Foot, 2020).

The Open Dialog Approach, developed in Finland and now applied in diverse parts of the world (Lakeman, 2014; Seikkula, 2019), emphasizes that help should start immediately and outside psychiatric structures. Through social network meetings the practitioners aim to include the diversity represented in the network. Tolerance of uncertainty is emphasized in order to make possible a multi-voiced, transdisciplinary collaboration involving those concerned by the situation (Holmesland et al., 2010). In a recent paper it is explicitly argued that Open Dialogue Approach may offer a less psychiatrizing form of support through its potential to (1) limit the use of neuroleptics, (2), reduce the incidences of mental health problems, and (3) decrease the use of psychiatric services (Von Peter et al., 2021).

"Recovery in the bin" and the Hearing Voices Network are other signs of growing alternative approaches to distress. Public medicine-free inpatient treatment is carried out some places in Norway (Cooper et al., 2021). Service users' right to influence their treatment and to participate in research about mental health has been recognized in official documents in different countries. One application of this has been the instauration of the possibility for mental health service users to decide about self-referral admission at their local inpatient clinic (Møller Olsø et al., 2016).

THE DE-PSYCHIATRIZATION OF RECOVERY

During the last two decades, studies have been published about the role of contextual factors in mental health and recovery (Ware et al., 2007; Yanos et al., 2007; Read, 2010; Tew, 2013; Read et al., 2017; Ramon, 2018), about the shortcomings of a bio-medical understanding (Whitaker, 2010; Götzsche, 2013; Priebe et al., 2013; United Nations, 2017, 2021) resulting in a call for a paradigm shift from a bio-medical to a social paradigm (Priebe et al., 2013; Boyle and Johnstone, 2018).

A social and societal paradigm of the psy-field should include attention to aspects such as the construction of normality and deviance, and the transformation of deviance and distress into illnesses (Conrad and Schneider, 1992; Brinkmann, 2016; Rose, 2018). It should include the political decisions increasing inequalities causing distress (Priebe, 2016; Wilkinson and Pickett, 2018). It should also include the conditions for the development of social relationships and their impacts on people's sense of self (Davidson and Strauss, 1992; Schreiber, 1996; Sells et al., 2004). It should include the organization of support to people with mental distress, and finally it should include the social and societal context (Tew, 2013) and changes that impact on people's recovery processes (Boyle and Johnstone, 2018).

Social and societal factors should not be considered as mere triggers for an internal biological vulnerability. They are the basic conditions causing the development of mental distress (Read et al., 2009). Several contributions to a shift to a contextual understanding of distress and recovery in high-income countries have appeared recently. Just to mention a few:

The Power-Threat-Meaning framework defines behaviors and representations traditionally considered as symptoms of an illness as threat responses to abuse of power toward people in situations where they were fragile and could not mobilize enough resources to counter these threats (Boyle, 2020). Power imbalances tend to perpetuate themselves, deepening the distress and hindering changes in threat responses.

The concept of recovery capital (Tew, 2013) offers a way of mapping different aspects of core importance to initiating and maintaining a recovery journey. It is about economic (money at one's disposal), social (resources in one's social network), identity (relations with significant others), personal or mental (coping and ways of seeing oneself) and relationship capital (the quality of close relationships) at people's disposition and thus what kind of capital they might lack.

"Recovery in the bin" call themselves a critical theorist and activist collective. In one of their documents, they wrote:

> We stand opposed to mental health services using "recovery" ideology as a means of masking greater coercion. We believe that this rise is a symptom of neoliberalism and that a meaningful "recovery" is impossible for many of us because of the intolerable social and economic conditions, such as poor housing, poverty, stigma, racism, sexism, unreasonable work expectations, and countless other barriers (https://recoveryinthebin.org).

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[1] Recovery in the bin: https://recoveryinthebin.org.

Their main focus is on social inequalities and the risk that an individualizing understanding of recovery can become a tool for adaptation to a system producing distress.

The Cause of All Causes

According to the Power-Threat-Meaning framework, poverty might be considered as "the cause of all causes" (Johnstone et al., 2018, p. 5) and could be a good starting point for a practical application of the reasoning above.

The connection between a person's economic status and mental health was established early (Hollingshead and Redlich, 1958; Eaton, 2001; Mills, 2015). Hansson et al. (1999) observed that even in welfare states, poverty was mentioned as one of the three top worries by service users, even prior to symptom relief. Poverty affects different aspects of life such as "nutrition, clothing, housing, education, traveling, participation in cultural, and leisure activities" (Ramon, 2018, p. 8). Thus, it is easy to understand that living a life of poverty constitutes a stress for oneself and one's social surroundings. This is a realistic outcome. But the consequences of poverty for the individual are often constructed as symptoms of an illness, a mental illness. Cohen (1993) pointed out similarities between what are considered as symptoms of mental illness and characteristics of poor people, such as depression, anxiety, and social isolation. Thus, the consequences of poor living conditions are transformed into illnesses based on an imbalance in the individual's brain. The person's economic state is one of the five recovery capitals mentioned by Tew (2013).

Social isolation might have different causes in different contexts, but it is assumed to be a characteristic symptom in persons with a diagnosis of severe mental illness. However, in a recent follow-up study of a general population, Mood and Jonsson (2015) showed a connection between increased poverty and a shrinking social network. They also noticed an opposite development in the same population as a consequence of an improved financial state. Changes in the size and composition of social networks in a general population can hardly be considered to be a result of sudden changes in people's brain functions. Wilton (2003) shows how poverty could hinder persons with severe mental problems from visiting their family even if they lived in the same town, as they could not afford public transportation. Brown (2015) and Topor et al. (2016a) mentioned how a decreased mutuality in social relations because of economic limitations could lead to a thinning and even ending of social relationships, a process also noted with people without "mental illness" (Offer, 2012).

Looking at contributing conditions to a recovery process, several studies (Davidson et al., 2001a,b; Sheridan et al., 2015; Topor et al., 2016a,b; Topor and Ljungqvist, 2017) have described how an unconditional improved financial situation was associated both with an improved social life, but also with improvement regarding symptoms, quality of life and functional level. Thus, social policy expressed in welfare state financial interventions should be able to prevent the development of distress and to contribute to a recovery process. Having a decent home to invite friends and family, and the possibility to offer a coffee or a gift recreates a sense of reciprocity central to the construction of a sense of self based on "living a satisfying, hopeful, and contributing life" as Anthony wrote. Improved finances might make it possible to create a home out of a housing (Borg et al., 2005) and may also create the conditions for the person to widen their enabling or therapeutic landscape, thus meeting new persons, having new experiences, and discovering new aspects of life in new settings (Duff, 2011; Doroud et al., 2018; Larsen et al., 2021).

It is a paradox that studies referred to earlier (WHO, 1979; Hopper et al., 2007) showed that more people recover in low-income countries compared to high-income countries with developed welfare states. Besides the hypotheses that were presented earlier in this article (concerning extended families, permeable labor market, spiritual understandings of mental distress, and limited medicalization), it might be possible to see the welfare state as created to overcome situations connected to industrialized societies, including the end of previous forms of solidarity, the appearance of long-term illnesses, harsher conditions on the labor market, and greater social isolation and thus increased fragility in the population. In this perspective, on the one hand, welfare states could be considered as expressions of solidarity between citizens, in contrast to the growing dominance of discourses about self-made individuals and their private responsibility for their own fate. Thus, recovery might be facilitated through the presence of a *general* welfare state palliating the effects of inequalities and of lacks in the person's recovery capital (Tew, 2013). On the other hand, welfare interventions based on *individual* assessments of needs (regarding economic support, support measures in school, etc.), might be necessary, but have been criticized as often being patronizing and normalizing and, as we mentioned above, have increasingly become based on diagnosis, another sign of the psychiatrization of society. New models have been developed to overcome these tendencies, such as "relational welfare" (Cottam, 2011) aimed at counteracting further bureaucratization of individual-based welfare administration through ≪Co-creation approaches, linked to a "new public governance" perspective≫ (Von Heimburg and Ness, 2021, p. 641).

Sociopolitical decisions might be of great importance for people's possibility to create a decent social life and a sense of self as an agent in one's life. Community centers, offering low-cost coffee, meals and activities, are highly valued (Estroff, 1985; Larsen and Topor, 2017), but risk becoming segregated and segregating places if the persons visiting them do not also have the possibility to go to coffee shops and other commercial and cultural places in the city. Deegan (2004) once said "Our needs are not special. Our needs are the same as your needs. (…) We don't want what you are giving; we want what you have got" (p. 11).

A New Vision

The social is personal. This is the case both regarding the emergence of mental distress and recovery from mental problems (Mezzina et al., 2006; Topor et al., 2011; Tew et al., 2012; Rose, 2014; Boyle and Johnstone, 2018). Different research traditions have developed looking at peoples' recovery in context such as enabling places (Duff, 2012), post asylum landscapes (Högström, 2018), assemblage (Larsen et al., 2021), and relational (Price-Robertson, 2017). The centrality of civil rights and of social injustice has been stressed in different studies (Harper, 2020; Reis et al., 2022; Zeira, 2022).

In the light of both earlier and current research findings we think it would be justifiable and possible to update Anthony's widespread definition of recovery; as an anti-thesis to its psychiatrization.

As research has shown, recovery happens all the time in the most different situations. There cannot be one recovery method or one recovery plan that fits all, but, from above mentioned research, we know a lot about conditions distressing persons and hindering or facilitating the start and sustainability of processes of recovery in the global North (Priebe, 2015, 2016). Recovery is as much a question of social and material changes as it is of personal development; therefore, a tentative definition should situate the personal aspects within social aspects such as social relationships and living conditions:

> Recovery is a deeply social, unique, and shared process in which our living conditions, material surroundings, social relations and sense of self evolve.
>
> It is about striving to live satisfying, hopeful, and reciprocal lives, even though we may still experience threats, stressful social situations, and distress.
>
> Recovery involves engaging in encounters and dialogs where new ways of understanding and handling one's situation are created as we move beyond the psycho-social-material crisis.

The psychiatrization of society is a main hinder to recovery as it transforms distress based on social injustice and power imbalance into individual illness. The psychiatrized society demands diagnosis and medical treatment as a condition for economic and social support. However, we can see signs of resistance and the development of alternatives to this psychiatrized "guiding vision." Redefining recovery and recognizing the importance of social, material, cultural and relational aspects involved in recovery processes and thus behind mental distress is part of the challenge of de-psychiatrizing society.

AUTHOR CONTRIBUTIONS

AT, TDB, and IBL contributed to the formulation of the background and aim of the study. AT wrote a first draft of the article that was discussed on several occasions by all the authors. A second draft written by AT was then discussed and supplemented by TB and IL. All authors contributed to manuscript revision, read, and approved the submitted version.

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REFERENCES

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4rth Edn.* Washington, DC: APA.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders, Fourth Edition, Text Revision*, Arlington: American Psychiatric Association.

Anthony, W. A. (1993). Recovery from mental illness : the guiding vision of the mental health service system in the 1990s. *Psychosoc. Rehabil. J.* 16, 11–21. doi: 10.1037/h0095655

Barham, R., and Hayward, R. (1991). *From the Mental Patient to the Person.* London: Routledge.

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12:645556. doi: 10.3389/fpsyt.2021.645556

Beeker, T., Witeska-M?ynarczyk, A., te Meerman, S., and Mills, C. (2020). Psychiatrization of, with and by children: Drawing a complex picture. *Glob. Stud. Child.* 10, 12–25. doi: 10.1177/2043610619890074

Bjornestrand, J., Veseth, M., Davidson, L., Joa, I., Johannessen, J. O., Larsen, T. K., et al. (2018). Psychotherapy in psychosis: experiences of fully recovered service users. *Front. Psychol.* 9:1675. doi: 10.3389/fpsyg.2018.01675

Bleuler, E. (1911/1950). Dementia Praecox or the Group of Schizophrenia. New York, NY: International Universities Press.

Bleuler, M. (1978). *The schizophrenic Disorders: Long-Term Patient and Family Studies.* Yale University Press.

Bøe, T. D., Larsen, I. B., Bertelsen, B., and Topor, A. (2021). A qualitative fallacy: life trapped in interpretations and stories. *Qual. Res.* 1–18. doi: 10.1177/14687941211041916

Bøe, T. D., Larsen, I. B., and Topor, A. (2019). Nothing matters: the significance of the unidentifiable, the superficial and nonsense. *Int. J. Qual. Stud. Health Well-Being.* 14:1684780. doi: 10.1080/17482631.2019.1684780

Borg, M., Sells, D., Topor, A., Mezzina, R., Marin, I., and Davidson, L. (2005). What makes a house a home: the role of material resources in recovery from severe mental illness. *Am. J. Psychiatr. Rehabil.* 8, 243–256. doi: 10.1080/15487760500339394

Bourdieu, P. (1986). *L'illusion biographique, in P., Bourdieu (1994) Raisons pratiques – Sur la théorie de l'action*, Paris: Editions du Seuil.

Boyle, M. (2002). *Schizophrenia - A Scientific Delusion? 2nd Edn.* London: Routledge.

Boyle, M. (2015). "The persistence of medicalization: is the presentation of alternatives part of the problem?," in *Madness Contested—Power and Practice* eds. S. Coles, S. Keenan, and B. Diamond (Monmouth: PCCS books), 3–22.

Boyle, M. (2020). Power in the power threat meaning framework. *J. Constructivist Psychol.* 35, 27–40. doi: 10.1080/10720537.2020.1773357

Boyle, M., and Johnstone, L. (2018). The power threat meaning framework: an alternative nondiagnostic conceptual system. *J. Humanist. Psychol.* 1–18. doi: 10.1177/0022167818793289

Brinkmann, S. (2016). *Diagnostic Cultures. A Cultural Approach to the Pathologization of Modern Life.* New York, NY: Routledge. doi: 10.4324/9781315576930

Brown, B. (2015). Towards a critical understanding of mutuality in mental health care: relationships, power and social capital. *J. Psychiatr. Ment. Health Nurs.* 22, 829–835. doi: 10.1111/jpm.12269

Burns, T., and Foot, J. (eds) (2020). *Basaglia's International Legacy: From Asylum to Community.* Oxford: Oxford University Press.

Carta, M. G., Angermeyer, M. C., and Holzinger, A. (2020). Mental health care in Italy, Basaglia's ashes in the wind of the crisis of the last decade. *Int. J. Soc. Psychiatry* 66, 321–330. doi: 10.1177/0020764020908620

Castel, F., Castel, R., and Lowell, A. (1979). *La société psychiatrique avancée. Le modèle americain.* Paris: Grasset.

Castel, R. (1976). *L'ordre psychiatrique. L'age d'or de l'aliénisme*, Paris: Les éditions de minuit.

Castel, R. (1981). *La gestion des risques. De l'anti-psychiatrie à l'après psychiatrie (Risk management: From anti-psychiatry to post-psychiatry).* Paris: Les Editions de Minuit.

Castel, R. (1995). *Les metamorphoses de la question sociale - Une chronique du salariat*. Paris: Fayard. doi: 10.3406/agora.1995.1517

Chamberlin, J. (1978). *On Our Own - Patient-Controlled Alternatives to the Mental Health System.* New York, NY: Hawthorn Books, Inc.

Cohen, C. I. (1993). Poverty and the course of schizophrenia: implications for research and policy. *Hosp. Community Psychiatry* 44, 951–958. doi: 10.1176/ps.44.10.951

Cohen, P., and Cohen, J. (1984). The clinician's illusion. *Arch. Gen. Psychiatry*. 41, 1178–1182. doi: 10.1001/archpsyc.1984.01790230064010

Collectif International. (1977). *Réseau altertnative à la psychiatrie.* Paris.

Conrad, P., and Schneider, J. (1992). *Deviance and Medicalization - From Badness to Sickness*. Philadelphia, PA: Temple University Press.

Cooper, R. E., Mason, J. P., Calton, T., Richardson, J., and Moncrieff, J. (2021). The case for establishing a minimal medication alternative for psychosis and schizophrenia. *Psychosis* 13, 276–285. doi: 10.1080/17522439.2021.1930119

Cottam, H. (2011). Relational welfare. *Soundings* 48, 134–144. doi: 10.3898/136266211797146855

Cushman, P. (1995). *Constructing the Self, Constructing America*. A cultural history of psychotherapy. Reading: Addison-Wesley.

Davidson, L., Haglund, K., Stayner, D., Rakfeldt, J., Chinman, M., and Kraemer Tebes, J. (2001a). "It was just realizing… that life isn't one big horror": a qualitative study of supported socialization. *Psychiatr. Rehabil. J.* 24, 279–292. doi: 10.1037/h0095084

Davidson, L., Raakfeldt, J., and Strauss, J. (2010). *The Roots of the Recovery Movement in Psychiatry*. *Lessons Learned.* Chichester: Wiley-Blackwell.

Davidson, L., and Roe, D. (2007). Recovery from versus recovery in serious mental illness: One strategy for lessening confusion plaguing recovery. *J. Ment. Health.* 16, 459–470. doi: 10.1080/09638230701482394

Davidson, L., Shahar, G., Staeheli Lawless, M., Sells, D., and Tondora, J. (2006). Play, pleasure, and other positive life events: "Non-specific" factors in recovery from mental illness? *Psychiatry* 69, 151–163. doi: 10.1521/psyc.2006.69.2.151

Davidson, L., Stayner, D. A., Nickou, C., Styron, T. H., Rowe, M., and Chinman, M. L. (2001b). "Simply To Be Let In": inclusion as a basis for recovery. *Psychiatr. Rehabil. J.* 24, 375–388. doi: 10.1037/h0095067

Davidson, L., and Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *Br. J. Med Psychol.* 65, 131–145.

Dear, M., and Wolch, J. (1987). *Landscape of Despair*. *From Deinstitutionalization to Homelessness*. Polity Press: Cambridge.

Deegan, P. (2004). *Rethinking rehabilitation: Freedom, Presented at: The 20th World Congress of Rehabilitation International: Rethinking Rehabilitation*. Oslo, Norway. Available online at: https://www.patdeegan.com/sites/default/files/files/rethinking_rehabilitation.

Deegan, P. E. (1988). Recovery: the lived experience of rehabilitation. *Psychosoc. Rehabil. J.* 11, 11–19. doi: 10.1037/h0099565

Denhov, A., and Topor, A. (2012). The components of helping relationships with professionals in psychiatry: users' perspective. *Int. J. Soc. Psychiatry* 55, 417–424. doi: 10.1177/0020764011406811

DeSisto, M. J., Harding, C., McCormick, R. V., Ashikaga, T., and Gautam, S. (1995). The maine-Vermont three decade studies of serious mental illness. Matched comparision of cross-sectional outcome. *Br. J. Psychiatry.* 167, 331–338.

Doroud, N., Fossey, E., and Fortune, T. (2018). Places for being, doing, becoming and belonging: a meta-synthesis exploring the role of place in mental health recovery. *Health Place* 52, 110–120. doi: 10.1016/j.healthplace.2018.05.008

Duff, C. (2011). Networks, resources and agencies: on the character and production of enabling places. *Health Place* 17, 149–156. doi: 10.1016/j.healthplace.2010.09.012

Duff, C. (2012). Exploring the role of 'enabling places' in promoting recovery from mental illness: a qualitative test of a relational model. *Health* Place 18, 1388–1395. doi: 10.1016/j.healthplace.2012.07.003

Eaton, W. W. (2001). *The Sociology of Mental Disorders, 3rd Edn*. Westport: Praeger Publishers.

Eriksson, E. (2015). *Sanktionerat motstånd: Brukarinflytande som fenomen och praktik (Sanctioned resistance: User involvment as phenomenon and practice).* Lund University, Sweden.

Estroff, S. (1985). *Making It Crazy.* Berkeley: University of California Press.

Evans-Campbell, T., Lincoln, K. D., and Takeuchi, D. T. (2006). "Race and mental health: past debates and new opportunities," in *Mental Health, Social Mirror*. eds W. R. Avison, J. D. McLeod, and B. A. Pescosolido (New York: Springer), 169–190. doi: 10.1007/978-0-387-36320-2_8

Every-Palmer,. S., and Howick, J. (2014). How evidence-based medicine is failing due to biased trials and selective publication. *J. Eval. Clin. Pract*. 20, 908–914. doi: 10.1111/jep.12147

Ey, H. (1977). *La notion de schizophrénie*. Séminaire de Thuir. Alencon: Desclée de Brouer.

Farrelly, S., and Lester, H. (2014). Therapeutic relationships between mental health service users with psychotic disorders and their clinicians: a critical interpretive synthesis. *Health Soc. Care* 22, 449–460. doi: 10.1111/hsc.12090

Forget, E. (2019). *Basic Income for Canadians: The Key to a Healthier, Happier, More Secure Life for All.* Toronto: James Lorimer and Company Ltd.

Foucault, M. (1961/1972). *Histoire de la folie à l'age classique*, Paris: Gallimard.

Foucault, M. (1980). *Two lectures. Lecture one: 7 January 1976, in Power/knowledge: Selected interviews and other writings 1972–1977*, New York: Pantheon Books.

Foucault, M. (1980). *Two Lectures. Lecture One: 7 January 1976, in Power/Knowledge: Selected Interviews and Other Writings 1972 – 1977.* New York, NY: Pantheon Books.

Frances, A. (2013). *Saving Normal.* New York, NY: HarperCollins.

Freud, S. (1905/1997). *Dora: An Analysis of a Case of Hysteria*. Touchstone Books.

Frith, C., and Johnstone, E. (2003). *Schizophrenia. A Very Short Introduction.* Oxford: Oxford University Press. doi: 10.1093/actrade/9780192802217.001.0001

Fuchs, E. H. R. (1988). *Becoming An Ex: The Process of Role Exit.* Chicago, IL: The University of Chicago Press.

Goffman, E. (1976/1979). *Gender Advertisements.* New York, NY: Harper and Row, Publishers. doi: 10.1007/978-1-349-16079-2

Götzsche, P. C. (2013). *Deadly Medicines and Organised Crime. How Big Pharma Has Corrupted Healthcare*. London: Radcliffe.

Greenberg, G. (2013). *The Book of Woe*. The DSM and the unmaking of psychiatry. New York, NY: Plume.

Grim, K., Tistad, M., Schön, U.-K., and Rosenberg, D. (2019). The legitimacy of user knowledge in decision-making processes in mental health care: an analysis of epistemic injustice. *J. Psychosoc. Rehabil. Ment. Health* 6, 157–173. doi: 10.1007/s40737-019-00145-9

Hacking, I. (1998). *Mad Travelers. Reflections on the Reality of Transcient Mental Illness.* Cambridge, MA: Haward University Press.

Hansson, L., Middelboe, T., Merinder, L., Bjarnason, O., Bengtsson-Tops, A., Nilsson, L., et al. (1999). Predictors of subjective quality of life in schizophrenic patients living in the community. A nordic multicenter study. *Int. J. Soc. Psychiatry* 45, 247–258. doi: 10.1177/002076409904500403

Harding, C., Brooks, G., Takamaru,. A., Strauss, J., and Breier, A. (1987a). The Vermont longitudinal study of persons with severe mental illness, I: methodology, study sample, and overall status 32 years later. *Am. J. Psychiatry*. 144, 718–726. doi: 10.1176/ajp.144.6.718

Harding, C., Brooks, G., Takamaru,. A., Strauss, J., and Breier, A. (1987b). The Vermont longitudinal study of persons with severe mental illness, II: long-term outcome of subjects who retrospectively met DSM III criteria for schizophrenia. *Am. J. Psychiatry*. 144, 727–735. doi: 10.1176/ajp.144.6.727

Harding, C., Zubin, J., Strauss, J. (1987c). Chronicity in schizophrenia. Fact, partial fact or artefact. *Hos Commun Psychiat.* 38, 477–486.

Harper, A., Clayton, A., Bailey, M., Foss-Kelly, L., Sernyak, M. J., and Rowe, M. (2015). Financial health and mental health among clients of a community mental health center: making the connections. *Psychiatr. Serv*. 66,1271–1276. doi: 10.1176/appi.ps.201400438

Harper, D. (2020). Framing, filtering and hermeneutical injustice in the public conversation about mental health. *J. Constr. Psychol.* 35, 68–82. doi: 10.1080/10720537.2020.1773360

Harper, D., and Speed, E. (2014). "Uncovering recovery; The resistible rise of recovery and resilience," in *Demedicalizing Misery II. Society, Politics and the Mental Health Industry*, eds E. Speed, J. Moncrieff and M. Rapley (New York, NY: Palgrave MacMillan), 40–57. doi: 10.1057/9781137304667_3

Harrow, M., Jobe, T. H., and Faull, R. N. (2012). Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study. *Psychol. Med.* 42, 2145–2155. doi: 10.1017/S0033291712000220

Hegarty, J., Baldessarini, R., Tohen, M., Waternaux, C., and Oepen, G. (1994). One hundred years of schizophrenia: a meta-analysis of the outcome literature. *Am. J. Psychiatry* 151, 1409–1416. doi: 10.1176/ajp.151.10.1409

Högström, E. (2018). 'It used to be here but moved somewhere else': post-asylum spatialisations - a new urban frontier? *Soc. Cult. Geogr.* 19, 314–335. doi: 10.1080/14649365.2016.1239753

Hollingshead, A., and Redlich, F. (1958). *Social Class and Mental Illness: A Community Study*. New York, NY: John Wiley and sons. doi: 10.1037/10645-000

Holmesland, A. L., Seikkula, J., Nilsen, Ø., Hopfenbeck, M., and Arnkil, T. E. (2010). Open Dialogues in social networks: professional identity and transdisciplinary collaboration. *Int. J. Integr. Care*. 10:e53. doi: 10.5334/ijic.564

Hopper, K., Harrisson, G., Janca, A., and Sartorius, N. (eds) (2007). *Recovery From Schizophrenia*. An international perspective. A report from the WHO Collaborative project, The International Study of Schizophrenia, Oxford: Oxford University Press.

Hydén, L.-C. (1995). The rhetoric of recovery and change. *Cult. Med. Psychiatry* 19, 73–90. doi: 10.1007/BF01388249

Imsel, T. (2013). *Post by Former NIMH Director Thomas Insel: Transforming* Diagnosis, NIMH ≫ Transforming Diagnosis (nih.gov).

Johnstone, L., Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., et al. (2018). *The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, As An Alternative to Functional Psychiatric Diagnosis*. Leicester: British Psychological Society.

Karadzhov, D. (2021). Personal recovery and structural disadvantage: a critical conceptual review. *Health* 13634593211014250. doi: 10.1177/13634593211014250

Kirk, S., and Kutchins, H. (1992). *The selling of the DSM. The Rhetoric of Science in Psychiatry*. New York, NY: Walter de Gruyter.

Knowles, C. (2000). Burger King, Dunkin Donuts and community health care. *Health Place* 6, 213–224. doi: 10.1016/S1353-8292(00)00024-1

Kraepelin, E. (1919/1971). *Dementia Praecox and Paraphrenia 8th German Edn.* New York, NY: Robert E. Krieger Publishing CO INC.

Laing, R. D. (1960). *The Divided Self: An Existential Study in Sanity and Madness*. Harmondsworth: Penguin.

Lakeman, R. (2014). The Finnish open dialogue approach to crisis intervention in psychosis: a review. *Psychother. Aust*. 20, 28–35.

Langfeldt, G. (1937). The prognosis in schizophrenia and the factors influencing the course of the disease - A katamnestic study, including individual re-examinations in 1936 with some considerations regarding diagnosis, pathogenesis and therapy. *Acta Psychiatrica et Neurologica.* 73, 311–312.

Larsen, I. B., Friesinger, J. G., Strømland, M., and Topor, A. (2021). You realise you are better when you want to live, want to go out, want to see people: recovery as assemblage. *Int. J. Soc. Psychiatry* 00207640211019452. doi: 10.1177/00207640211019452

Larsen, I. B., and Topor, A. (2017). A place for the heart: a journey in the post-asylum landscape. Metaphors and materiality. *Health Place* 45, 145–151. doi: 10.1016/j.healthplace.2017.03.015

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., and Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *Br. J. Psychiatry* 199, 445–452. doi: 10.1192/bjp.bp.110.083733

Ljungberg, A., Denhov, A., and Topor, A. (2015). The art of helpful relationships with professionals: a meta-ethnography of the perspective of persons with severe mental illness. *Psychiatr. Q.* 86, 471–495. doi: 10.1007/s11126-015-9347-5

Llewellyn-Beardsley, J., Rennick-Egglestone, S., Bradstreet, S., Davidson, L., Franklin, D., Hui, A., et al. (2020). Not the story you want? Assessing the fit of a conceptual framework characterising mental health recovery narratives. *Soc. Psychiatry Psychiatr. Epidemiol.* 55, 295–308. doi: 10.1007/s00127-019-01791-x

Markström, U., Sandlund, M., and Lindqvist, R. (2004). Who is responsible for supporting "long-term mentally ill" persons?: reforming mental health practices in Sweden. *Can. J. Commun. Ment. Health*. 23, 51–63. doi: 10.7870/cjcmh-2004-0013

Mezzina, R. (2006). "Paradigm shift in psychiatry: processes and outcomes," in *Mental Health at the Crossroad. The Promise of the Psychosocial Approach*, eds S. Ramon, and J. Williams (Aldershot: Ashgate), 81–94.

Mezzina, R., Davidson, L., Borg, M., Marin, I., Topor, A., and Sells, D. (2006). The social nature of recovery: discussion and implications for practice. *Am. J. Psychiatr. Rehabil.* 9, 63–80. doi: 10.1080/15487760500339436

Mills, C. (2014). *Decolonizing Global Mental Health. The Psychiatrization of the Majority World.* London; New York, NY: Routledge. doi: 10.4324/9780203796757

Mills, C. (2015). The psychiatrization of poverty: Rethinking the mental health-poverty nexus. *Soc. Personal Psychol. Compass.* 9, 213–222. doi: 10.1111/spc3.12168

Møller Olsø, T., Buch Gudde, C., Opheim Moljord, I. E., Evensen, G. H., Antonsen, D. Ø., and Eriksen, L. (2016). More than just a bed: mental health service users' experiences of self-referral admission. *Int. J. Ment. Health Syst.* 10:11. doi: 10.1186/s13033-016-0045-y

Moncrieff, J. (2009). *The Myth of the Chemical Cure*. A critique of psychiatric drug treatment. New York, NY. Palgrave McMillan.

Moncrieff, J. (2013). *The Bitterest Pills – The Troubling Story of Antipsychotic Drugs*. New York, NY: Palgrave McMillan. doi: 10.1057/9781137277442

Mood, C., and Jonsson, J. O. (2015). The social consequences of poverty: an empirical test on longitudinal data. *Soc. Indic. Res.* 127, 633–652. doi: 10.1007/s11205-015-0983-9

Offer, S. (2012). The burden of reciprocity: processes of exclusion and withdrawal from personal networks among low-income families. *Curr. Sociol.* 60, 788–805. doi: 10.1177/0011392112454754

Pearlin, L. I., Avison, W. R., and Fazio, E. M. (2006). "Sociology, psychiatry, and the production of knowledge about mental illness and its treatment," in *Mental Health, Social Mirror*, eds W. R. Avison, J. D. McLeod, and B. A. Pescosolido (New York: Springer), 33–54. doi: 10.1007/978-0-387-36320-2_2

Peck, J. (2001). *Workfare States*. New York, NY: The Guilford Press.

Pilgrim, D., and McCranie,. A. (2013). *Recovery and Mental Health. A Critical Sociological Account. Macmillan International Higher Education.* doi: 10.1007/978-1-137-35889-9

Price-Robertson, R., Obradovic, A., and Morgan, B. (2017). Relational recovery: beyond individualism in the recovery approach. *Adv. Ment. Health* 15, 108–120. doi: 10.1080/18387357.2016.1243014

Priebe, S. (2015). The political mission of psychiatry. *World Psychiatry* 14, 1–2. doi: 10.1002/wps.20172

Priebe, S. (2016). A social paradigm in psychiatry – themes and perspectives. *Epidemiol. Psychiatr. Sci*. 25, 521–527. doi: 10.1017/S2045796016000147

Priebe, S., Burns, T., and Craig, T. (2013). The future of academic psychiatry may be social. *Br. J. Psychiatry* 202, 319–320. doi: 10.1192/bjp.bp.112.116905

Ramon, S. (2018). The place of social recovery in mental health and related services. *Int. J. Environ. Res. Public Health*. 15:1052. doi: 10.3390/ijerph15061052

Read, J. (2010). Can poverty drive you mad? 'Schizophrenia', socio-economic status and the case for primary prevention. *N. Z. J. Psychol*. 39, 7–19.

Read, J., and Beavan, V. (2013). "Gender and psychosis," in *Models of Madness - Psychological, Social and Biological Approaches to Psychosis,* eds J. Read and J. Dillon (London: Brunner-Routledge), 210–219.

Read, J., Bentall, R. P., and Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiol. Psichiatr. Soc.* 18, 299–310. doi: 10.1017/S1121189X00000257

Read, J., Johnstone, L., and Taitimu, M. (2013). "Psychosis, poverty and ethnicity," in *Models of Madness – Psychological, Social and Biological Approaches to Psychosis, 2th Edn*. eds. J. Read and J. Dillon (London: Brunner-Routledge), 191–200.

Reis, G., Bromage, B., Rowe, M., Restrepo-Toro, M. E., Bellamy, C., Costa, M., et al. (2022). Citizenship, social justice and collective empowerment: living outside mental illness. *Psychiatr. Q.* 1–10. doi: 10.1007/s11126-021-09968-x

Romme, M., and Escher, S. (1989). Hearing voices. *Schizophr. Bull.* 15, 209–216. doi: 10.1093/schbul/15.2.209

Romme, M., Escher, S., Dillon, J., Corstens, D., and Morris, M. (eds) (2009). *Living With Voices: 50 Stories of Recovery*. Birmingham: PCCS Books/Birmingham City University.

Rose, D. (2014). The mainstreaming of recovery. *J. Ment. Health*. 23, 217–218. doi: 10.3109/09638237.2014.928406

Rose, D., and Kalathil, J. (2019). Power, privilege and knowledge: the untenable promise of co-production in mental "health". *Front. Sociol.* 4:57. doi: 10.3389/fsoc.2019.00057

Rose, N. (2018). *Our Psychiatric Future*. Cambridge: Polity.

Rotelli, F. (1994). *Per la normalita - Taccuino di uno psichiatria*, Trieste: Edizione e.

Sandhu, S., Arcidiacono, E., Aguglia, E., and Priebe, S. (2015). Reciprocity in therapeutic relationships: a conceptual review. *Int. J. Ment. Health Nurs*. 24, 460–470. doi: 10.1111/inm.12160

Scheper-Hugues, N., and Lowell, A. M. (1986). Breaking the circuit of social control: lessons in public psychiatry from Italy and Franco Basaglia. *Soc. Sci. Med*. 23, 159–178. doi: 10.1016/0277-9536(86)90364-3

Schreiber, R. (1996). (Re)defining myself: Women's process of recovery from depression. *Qual. Health Res*. 6. 469–491. doi: 10.1177/104973239600600402

Scull, A. T. (1984). *Decarceration*. Community treatment and the deviant - a radical view, Worcester: Polity press.

Seikkula, J. (2019). Psychosis is not illness but a survival strategy in severe stress: a proposal for an addition to a phenomenological point of view. *Psychopathology*. 52, 1–8. doi: 10.1159/000500162

Sells, D., Stayner, D., and Davidson, L. (2004). Recovering the self in schizophrenia: an integrative review of qualitative studies. *Psychiatr. Q*.75, 87–97. doi: 10.1023/B:PSAQ.0000007563.17236.97

Shattell, M. M., Starr, S. S., and Thomas, S. P. (2007). Take my hand, help me out': mental health service recipients' experience of the therapeutic relationship. *Int. J. Ment. Health Nurs*. 16, 274–284. doi: 10.1111/j.1447-0349.2007.00477.x

Sheridan, A., Drennan, J., Coughlan, B., O'Keeffe, D., Frazer, K., Kemple, M., et al. (2015). Improving social functioning and reducing social isolation and loneliness among people with enduring mental illness: report of a randomized controlled trial of supported socialization. *Int. J. Soc. Psychiatry* 61, 241–250. doi: 10.1177/0020764014540150

Slade, M. (2009). *Personal Recovery and Mental Illness. A Guide For Mental Health Professionals.* London: Cambridge University Press. doi: 10.1017/CBO9780511581649

Strauss, J. S. (1994). The person with schizophrenia as a person II approaches to the subjective and complex. *Br. J. Psychiatry*. 164, 103–107. doi: 10.1192/S0007125000292830

Szasz, T. S. (1961). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York, NY: Harper and Row.

Tew, J. (2013). Recovery capital: what enables a sustainable recovery from mental health difficulties? *Eur. J. Soc. Work*. 16, 360–374. doi: 10.1080/13691457.2012.687713

Tew, J., Ramon, S., Slade, M., Bird, V., Melton, J., and Le Boutillier, C. (2012). Social factors and recovery from mental health difficulties: a review of the evidence. *Br. J. Soc. Work* 42, 443–460. doi: 10.1093/bjsw/bcr076

Topor, A., Andersson, G., Denhov, A., Holmqvist, S., Mattsson, M., Stefansson, C.-G., et al. (2014). Psychosis and poverty - Coping with poverty and severe mental illness in everyday life. *Psychosis* 6, 117–127. doi: 10.1080/17522439.2013.790070

Topor, A., Borg, M., Di Girolamo, S., and Davidson, L. (2011). Not just an individual journey: social aspects of recovery. *Int. J. Soc. Psychiatry*. 57, 90–99. doi: 10.1177/0020764010345062

Topor, A., and Denhov, A. (2015). Going beyond – Users' experiences of helpful professionals. *Psychosis* 7, 228–236. doi: 10.1080/17522439.2014.956784

Topor, A., Denhov, A., Bülow,. P., and Andersson, G. (2018). The many dimensions of recovery – Definitions, problems, and possibilities. *Am. J. Psychiatr. Rehabil.* 11, 141–166.

Topor, A., and Ljungqvist, I. (2017). Money, social relationships and the sense of self: the consequences of an improved financial situation for persons suffering from serious mental illness. *Community Ment. Health J*. 53, 823–831. doi: 10.1007/s10597-017-0146-3

Topor, A., Ljungqvist, I., and Sandberg, E.-L. (2016a). Living in poverty with severe mental illness - coping with double trouble. *Nord. Soc. Work Res*. 6, 201–210. doi: 10.1080/2156857X.2015.1134629

Topor, A., Ljungqvist, I., and Strandberg, E.-L. (2016b). The cost of friendship: severe mental illness, poverty and social isolation. *Psychosis* 8, 336–345. doi: 10.1080/17522439.2016.1167947

United Nations. (2017). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/HCR/35/21.*

United Nations. (2021). *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. A/HRC/44/48.*

Von Heimburg, D., and Ness, O. (2021). Relational welfare: a socially just response to co-creating health and wellbeing for all. *Scand. J. Public Health* 49, 639–652. doi: 10.1177/1403494820970815

Von Peter, S., Bergstrøm, T., Nenoff-Herchenbach, I., Hopfenbeck, M. S., Pocobello, R., Anderhol, V., et al. (2021). Dialogue as a response to the psychiatrization of society? potentials of the open dialogue approach. *Front. Sociol.* 6, 806437. doi: 10.3389/fsoc.2021.806437

Wacquant, L. J. D. (2009). *Punishing the Poor*. *The Neoliberal Government of Social Insecurity*. Durham; London: Duke University Press. doi: 10.1215/9780822392255

Ware, N. C., Hopper, K., Tugenberg, T., Dickey, B., and Fisher, D. (2007). Connectedness and citizenship: redefining social integration. *Psychiatr. Serv*. 58, 469–474. doi: 10.1176/ps.2007.58.4.469

Warner, R. (2004). *Recovery From Schizophrenia: Psychiatry and Political Economy, 3rd Edn.* New York, NY: Routledge.

Waxler, N. (1979). Is outcome for schizophrenia better in nonindustrial societies? - The case of Sri Lanka. *J. Nerv. Ment. Illn*. 167, 144–158. doi: 10.1097/00005053-197903000-00002

Whitaker, R. (2010). *Anatomy of an Epidemic – Magic Bullets, Psychiatric Drugs and the Astonishing Rise of Mental Illness in America.* New York, NY: Random House Inc.

Whitaker, R., and Cosgrove, L. (2015). *Psyhiatry Under Influence*. *Institutional Corruption, Social Injury and Perspcriptions for Reform.* New York, NY: Palgrave Macmillan. doi: 10.1057/9781137516022

WHO (1979). *Schizophrenia - An International Follow-Up Study*. Chichester: John Wiley and sons.

Wilkinson, R., and Pickett, K. (2018). *The Inner Level. How More Equal Societies Reduce Stress, Restore Sanity and Improve Everyone's Well-Being*. London: Penguin Books Ltd.

Wilton, R. D. (2003). Poverty and mental health: a qualitative study of residential care facility tenants. *Community Ment. Health J.* 39, 139–156. doi: 10.1023/A:1022662704461

Woods, A., Hart, A., and Spandler, H. (2019). The recovery narrative: politics and possibilities of a genre. *Cult Med Psychiatry*. 1–27. doi: 10.1007/s11013-019-09623-y

Yanos, P. T., Knight, E. L., and Roe, D. (2007). "Recognizing a role for structure and agency: integrating sociological perspectives into the study of recovery from severe mental illness," in *Mental Health, Social Mirror*, eds W. R. Avison, J. D. McLeod, B. A. Pescosolido (New York: Springer), 407–433. doi: 10.1007/978-0-387-36320-2_17

Zeira, A. (2022). Mental health challenges related to neoliberal capitalism in the United States. *Commun. Ment. Health J.* 58, 205–212. doi: 10.1007/s10597-021-00840

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De-psychiatrizing our own research work

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Introduction

In this brief opinion piece, I focus on the processes of psychiatrization of one's own work. Regardless of our intentions, what we do can, in the long term, ultimately enforce the very phenomenon that we seek to expose and disrupt. I challenge the belief that the psychiatrization of society can be interrogated from any knowledge-making site that is itself safe from psychiatrization, and hope to re-direct the analysis from a rather general notion of "society" toward our own work. Adopting Oliver's understanding of research as social production (1992), I engage with our own responsibility for the ways in which we design and conduct inquiries, and the potential of the research process itself to ultimately replicate or transform the status quo.

Do we need further proof of the psychiatrization of society?

Beeker et al. (2021) call for transdisciplinary research to "empirically prove that psychiatrization exists, developing valid indicators for its extent" (p. 8) and to "empirically assess causes, mechanisms and effects of psychiatrization" (p. 1). Undeniably, it is important to understand how psychiatrization occurs, particularly given its ever subtler modes of operation. However, taking into account the history of psychiatry, it is hard to comprehend the requirement to prove that "[o]n a societal level, psychiatrization *might* boost medical interventions which incite individual coping with social problems, instead of encouraging long-term political solutions" (Beeker et al., 2021, emphasis added). A considerable body of scholarship has already demonstrated that the individualization and medicalisation of social problems are at the heart of psychiatry (see for example Foucault, 1973; Conrad, 1992; Burstow, 2015—to mention just a few). Various thinkers (e.g., Foucault, 1977; Kanani, 2011; Joseph, 2015) have traced psychiatry's historical role in upholding regimes of oppression on the grounds of their "medical" justification. The repeated psychiatrization and subsequent de-psychiatrization of particular lives goes hand in hand with broader social changes. This trend can be observed in the establishment and subsequent abandonment of particular diagnoses, from drapetomania[1] and dysaesthesia aethiopica[2] to homosexuality and transsexualism. The psychiatrization of society can be understood as integral to psychiatry's purpose and social function. Rather than signifying a contemporary development yet to be empirically proven, this process goes back to the creation of first psychiatric institutions and the formation of psychiatry as a medical discipline. Acknowledging the psychiatrization of society as factual, rather than hypothetical, could straightforwardly direct research efforts toward de-psychiatrization. However, the requirement to provide *evidence* of the lived reality and experiential knowledge of many typifies the "slowness of science and urgency of need" (Russo and Stastny, 2009). This approach to knowledge production obscures the need to act upon the already available evidence, and has far-reaching consequences in maintaining the status quo. Commitment to de-psychiatrization, though, requires a shift "from needing more knowledge to needing values that allow us to take a stand with respect to what we know" (Frank, 2000, p. 363).

Reducing psychiatrization vs. de-psychiatrization

The release of DSM-5 (American Psychiatric Association, DSM-5 Task Force, 2013) raised many concerns "that clients *and the general public* are negatively affected by the continued and continuous medicalization of their natural and normal responses to their experiences" (British Psychological Society, 2011, emphasis added). The call to put this development on the official research agenda comes after a sufficiently large population is affected (American Psychological Association Division 32, 2011) and hardly anybody in the Western world can be safe from receiving a psychiatric diagnosis and treatment. Furthermore, the adoption of the Convention on Rights of Persons with Disabilities (United Nations, 2007) has ushered in an era characterized by the introduction of human rights discourse in a heretofore exclusively medical realm. This climate sharpens antagonisms within the psychiatric establishment (see the debate in World Psychiatry, 2019) and gives rise to in-house initiatives to humanize psychiatry. However, there is a significant difference between long-term efforts to scrutinize and challenge psychiatrization as a dominant social response to madness and distress (e.g., Szasz, 1961; Burstow, 2015; Russo and Sweeney, 2016) on one side and attempts to limit its scope to a reasonable number of "severely ill cases" on the other. The latter approach is exemplified in the following statement by Beeker et al. (2021):

> "While individuals with minor disturbances of well-being might be subjected to overdiagnosis and overtreatment, psychiatrization could also result in undermining mental healthcare provision for the most severely ill by promoting the adaption of services to the needs and desires of the rather mild cases."

The contested presumption of the biomedical nature of madness and distress remains implicit in the work of many critical psychiatry scholars who seek to engage in "less psychiatrizing forms of psychosocial support" (von Peter et al., 2021) or routinely assume the existence of "apolitical or irreducible distress" (Logan and Karter, 2022). This kind of subtle but persistent othering subverts efforts to eradicate the psychiatrization of human experience as a matter of principle (LeFrançois et al., 2013; Burstow et al., 2014; Russo and Sweeney, 2016; Beresford and Russo, 2021), regardless of its spread—and despite circumstances that can turn "mental illness" into an acceptable explanatory framework that legitimizes medical "solutions" to the complexities of living. The latter trend is acknowledged as "bottom up psychiatrization" (Beeker et al., 2021; Logan and Karter, 2022) but overlooks the many intersections of knowledge-making processes in which top-down and bottom-up psychiatrization merge. Given that knowledge-production takes place at precisely these junctures, it is crucial to illuminate that blank space and render the research labor visible. The failure to even position ourselves and our own research work in relation to what we study is still widespread, and is paradigmatic to dominant understandings of research. In the case of psychiatrization (see Figure 1 provided by Beeker et al., 2021), this kind of detachment suggests that we, as researchers, have little or no role in the processes we are supposed to investigate. In reality, however, our inquires do not occur at some safe, distant remove from, but rather from the midst of psychiatrized societies' institutions, their dominant paradigms and related criteria of what constitutes evidence. We cannot explore the psychiatrization of society without looking at our role as knowledge-producers and, most importantly, considering our own agency and responsibility for the contributions we make.

The vicious circle of official knowledge-making on madness and distress

Regardless of our own theoretical, methodological, personal or political backgrounds, taking part in the official production of knowledge on madness and distress inevitably means entering a realm dominated by the biomedical conceptualization of "mental illness." The discipline of psychiatry not only maintains definitional power in terms of the identities, treatments and

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[1] *Enslaved Africans Fleeing Captivity*. Available online at: https://en.wikipedia.org/wiki/Drapetomania.

[2] *Laziness Among Slaves*. Available online at: https://en.wikipedia.org/wiki/Dysaesthesia_aethiopica.

ideology it produces, but also forces all official knowledge-making into an ongoing dialogue with the biomedical model. Attempts to establish alternatives to this model are subjected to this same process: in order to prove eligible and fundable at officially recognized knowledge-making sites, such projects need to satisfy the current criteria of what constitutes scientific validity and evidence base. The psychiatrization of society is therefore inseparable from the psychiatrization of knowledge-production on madness and distress—or, in the words of the UK long-term survivor activist Campbell (1996):

> "Psychiatry would see itself as the servant of society. Yet it is naive to suppose that a profession with such an individual and collective power does not *form* as well as reflect public attitudes. If we think of emotional distress as mental illness it is psychiatry that has seduced us so." (p.57, emphasis added).

The fundamental challenge faced by researchers committed to working against, or despite, the dominant paradigm is how to break the self-perpetuating mechanism that, in the end, annexes and psychiatrizes all advancements in knowledge, including practices and epistemologies that have nothing to do with the biomedical approach to begin with. Here I particularly mean research, theoretical concepts and a variety of collective, non-medical, self-organized responses to madness and distress, developed by individuals and organizations of people who have been on the receiving end of psychiatric "care." Personally, I am more familiar with the developments in highly psychiatrized Western societies, but similar processes of co-optation can be seen in the movement for global mental health that targets countries of the Global South (Logan and Karter, 2022) and "merges psychiatric knowledge with the idea of a 'social movement"' (Fey and Mills, 2021:193). Survivor research (Sweeney, 2016a,b) and other work that explicitly aims at de-psychiatrization—informed by our experiences and knowledge gained through the de-psychiatrization of our own biographies – continues to be selectively employed to extend and supplement the biomedical paradigm with "lived-experience" perspectives. The low status of first-person knowledge, combined with extremely unequal distribution of resources, renders our efforts susceptible to re-psychiatrization (Costa et al., 2012; Penney and Prescott, 2016; Russo, 2016). In his excellent analysis of how emancipatory ideas and practices dissolve and can subsequently turn into their opposite, Fabris (2016) highlights that even "writing as a form of protest can easily be usurped by the systems seeking 'newness"' (p. 99) and reminds us that community treatment orders were "once a rosy deinstitutional notion" (p. 97). Other, similar developments include the insertion of "peer specialists" into psychiatric practice (Davidow, 2013; Brown and Stastny, 2016) and "service user involvement" in mental health research (Staddon, 2013). How, then, are we supposed to work for change while being aware of the system's need and power to co-opt? This is a complex question that calls for a variety of individual answers and context-specific strategies, rather than any universal solution. How to actually enact transformative research within, beside or outside of the existing structures of knowledge production is a whole different issue, worth exploring on its own. Turning to areas outside of those with which we are familiar, and in which we often feel stuck, can help us understand some common patterns and develop new perspectives. In his seminal work on the structures of scientific revolutions, Kuhn (1996) explores how paradigm shifts actually occur. He suggests "that there are excellent reasons why revolutions have proved to be so nearly invisible" and that most of them "have customarily been viewed not as revolutions but as additions to scientific knowledge" (p. 136). Accepting this course as logical and unavoidable might help us re-examine our understanding of what constitutes success, and persist in our efforts despite not seeing tangible changes in the way we expect to see them.

Emancipating research labor

In this brief opinion piece, I have criticized the framing of the psychiatrization of society as a contemporary development and suggested that the release of the DSM-5 (2013) marks just one of the pinnacles of that process, rather than its beginning. I point to the role of knowledge-production in the psychiatrization of society and argue for a straightforward shift toward de-psychiatrization. What remains impossible to provide is any general answer to the question of how to prevent (re)psychiatrization of one's own research work. I hope for future debates, alliances and action around this crucial issue.

It is clear that we cannot determine the long-term journeys of the outputs we create and the many ways in which our work can be utilized. But there are important aspects that we can influence—from ensuring the ethics, quality, and the transformative power of the research process itself, to prioritizing our audiences and determining how we communicate our work. The disability researcher and theoretician Oliver (1992, 2009) approaches research as a form of social production and understands it not as "attempt to change the world through the process of investigation but an attempt to change the world by producing ourselves and others in differing ways from those we have produced before" (2009, p. 116). Adopting this view brings us back to our own work and our responsibility for what we create within the radius of our own projects, no matter how limited that radius might appear. De-psychiatrizing our own research is therefore both a personal issue and a matter of politics and strategy. Although I am convinced that there are ways to emancipate our approaches from the (retrograde) currencies of our respective disciplinary fields, such emancipation might not be possible from within the particular field of psychiatry, for the reasons outlined above.

Author contributions

The author confirms being the sole contributor of this work and has approved it for publication.

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References

American Psychiatric Association, DSM-5 Task Force (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*^{TM}. American Psychiatric Publishing, Inc.

American Psychological Association Division 32. *Open Letter to the DSM-5 Task Force and the American Psychiatric Association* (2011). Available online at: https://www.ipetitions.com/petition/dsm5 (accessed March 25, 2022).

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12, 645556. doi: 10.3389/fpsyt.2021.645556

Beresford, P., and Russo, J. (Ed.). (2021). *The Routledge International Handbook of Mad Studies*. London: Routledge.

British Psychological Society (2011). *Response to the American Psychiatric Association: DSM-5 Development*. Available online at: https://dxrevisionwatch.files.wordpress.com/2012/02/dsm-5-2011-bps-response.pdf (accessed March 25, 2022).

Brown, C., and Stastny, P. (2016). "Peer workers in the mental health system: a transformative or collusive experiment?," in *Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies*, Eds J. Russo and A. Sweeney (Monmouth: PCCS Books), 183–191.

Burstow, B. (2015). *Psychiatry and the Business of Madness: An Ethical and Epistemological Accounting*. New York, NY: Palgrave Macmillan.

Burstow, B., LeFrançois, B. A., and Diamond, S. (Ed.). (2014). *Psychiatry Disrupted: Theorizing Resistance and Crafting the (r)Evolution*. Montreal, QC; Kingston, ON; McGill-Queen's University Press.

Campbell, P. (1996). "Challenging loss of power," in *Speaking Our Minds. An Anthology*, Eds. J. Read and J. Reynolds (London: Macmillian Press, Ltd.), 56–62.

Conrad, P. (1992). Medicalization and social control. *Ann. Rev.* Sociol. 18, 209–232.

Costa, L., Voronka, J., Landry, D., et al. (2012). Recovering our stories: a small act of resistance in studies in social justice. *Stud. Social. Justice* 6, 85–101. doi: 10.26522/ssj.v6i1.1070

Davidow, S. (2013). *Cheers for Peers. Mad in America*. Available online at: https://www.madinamerica.com/2013/07/cheers-for-peers/ (accessed March 25, 2022).

Fabris, E. (2016). "Community Treatment Orders: once a rosy deinstitutional notion," in *Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies*, Eds. J. Russo and A. Sweeney (Monmouth: PCCS Books), 97–105.

Fey, J., and Mills, C. (2021). "The (global) rise of anti-stigma campaigns," in *The Routledge International Handbook of Mad Studies*, Eds P. Beresford and J. Russo (London: Routledge), 190–201.

Foucault, M. (1973). *The Birth of the Clinic*. New York, NY: Vintage.

Foucault, M. (1977). *Discipline and Punish*. New York, NY: Random.

Frank, A. W. (2000). The standpoint of storyteller. *Qual. Health Res.* 10, 354–365. doi: 10.1177/104973200129118499

Joseph, A. J. (2015). The necessity of an attention to Eurocentrism and colonial technologies: an addition to critical mental health literature. *Disabil. Soc.* 30, 1021–1041. doi: 10.1080/09687599.2015.1067187

Kanani, N. (2011). Race and madness: locating the experience of racialized people with psychiatric histories in Canada and the United States. *Crit. Disabil. Discourses* 3, 1–14. Available online at: https://cdd.journals.yorku.ca/index.php/cdd/article/view/31564

Kuhn, T. S. (1996). *The Structure of Scientific Revolutions*, 3rd Edn. Chicago, IL: London: The University of Chicago Press.

LeFrançois, B. A., Menzies, R. J., and Reaume, G. (Ed.). (2013). *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto, ON: Canadian Scholar's Press Inc.

Logan, J., and Karter, J. M. (2022). Psychiatrization of resistance: the co-option of consumer, survivor, and ex-patient movements in the global south. *Front. Sociol.* 7, 784390. doi: 10.3389/fsoc.2022.784390

Oliver, M. (1992). Changing the social relations of research production? *Disabil. Handicap Soc.* 7, 101–114.

Oliver, M. (2009). *Understanding Disability: From Theory to Practice*, 2nd Edn. Basingstoke: Palgrave Macmillan.

Penney, D., and Prescott, L. (2016). "The co-optation of survivor knowledge: the danger of substituted values and voice," in *Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies*, Eds J. Russo and A. Sweeney (Monmouth: PCCS Books), 35–45.

Russo, J. (2016). In dialogue with conventional narrative research in psychiatry and mental health. *Philos. Psychiatry Psychol.* 23, 215–228. doi: 10.1353/ppp.2016.0021

Russo, J., and Stastny, P. (2009). "Beyond involvement. Looking for a common perspective on roles in research," in *Handbook of Service User Involvement in Mental Health Research*, Eds J. Wallcraft, B. Schrank, and M. Amering (West Sussex: Wiley-Blackwell), 61–72.

Russo, J., and Sweeney, A. (Ed.). (2016). *Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies*. Monmouth: PCCS Books.

Staddon, P. (Ed.). (2013). *Mental Health Service Users in Research: Critical Sociological Perspectives*. Bristol: Policy Press.

Sweeney, A. (2016a). "The transformative potential of survivor research," in *Searching for a Rose Garden. Challenging Psychiatry, Fostering Mad Studies*, Eds J. Russo and A. Sweeney (Monmouth: PCCS Books), 49–59.

Sweeney, A. (2016b). Why mad studies needs survivor research and survivor research needs mad studies. Intersectionalities. *Glob. J. Soc. Work Anal. Res. Polity Pract.* 5, 36–61. Available online at: https://journals.library.mun.ca/ojs/index.php/IJ/article/view/1614/1330

Szasz, T. (1961). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York: Harper and Row.

United Nations (2007). *Convention on the Rights of Persons with Disabilities*. New York, NY: United Nations.

von Peter, S., Bergstrøm, T., Nenoff-Herchenbach, I., Hopfenbeck, M. S., Pocobello, R., et al. (2021). Dialogue as a response to the psychiatrization of society? Potentials of the open dialogue approach. *Front. Sociol.* 6, 806437. doi: 10.3389/fsoc.2021.806437

World Psychiatry (2019). *Official Journal of the World Psychiatric Association*, Vol. 18. Available online at: https://onlinelibrary.wiley.com/toc/20515545/2019/18/1 (accessed July 3, 2022).

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Psychiatrization of adoption practices in contemporary Poland

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In this article, I propose to take a closer look at the practices of kinning in the context of adoption in contemporary Poland. I am interested in the social production of this 'unfamiliar kind of kinship' and the positions of various actors involved in defining the "adoptable" children and the "families of excess" capable of adopting. My focus will be on the ways in which the psy-knowledge and practices are implied in these social processes of defining and delimiting the norm, the proper, and the ideal. This process can be called a progressing psychiatrization of kinning, this time developing on a specific terrain of adoption (i.e., the most desired state of exception from ideal family—nuclear, heteronormative, based around married, and non-divorced couple). I will consider both top-down and bottom-up processes within which the individuals, state institutions, and psy-knowledge interact. Thus, I propose to look at a sub-process of psychiatrization, which takes place in the specific ethnographic context at the intersection of family and social policies, medicalization and psychologization of familial relations, and troubled, disconnected biographies. Throughout the article, I discuss how the adoptive families become patient-consumers within the system of healthcare. It is despite the fact that when they enter the adoption network, they start to take part in the political process of solving the social problem. In fact, they become a part of the network, which enables privatization of the social problem and works toward individualizing the responsibility for solving it.

KEYWORDS

adoption, Poland, psychiatrization, social policy, biogovernmentality, diagnostic cultures, psy-disciplines

Psychiatrization of kinning

> *The authority affects how we experience our bodies [...]. It also affects how a society supports or fails to support our bodily suffering and struggles (Wendell, 1996, p. 9).*

Beeker et al. (2021) invite social researchers to discuss psychiatrization of society. The term means the complex processes through which people's lives are being increasingly affected by psy-knowledge and practices (Rose, 1989, 1996). Psychiatrization, as diverse as it is, influences many aspects of contemporary human life. In this article, I will attend ethnographically to the ways in which psychiatrization alters the adoption processes in contemporary Poland.[1]

On a very general level, psychiatrization means a growing tendency to describe people's behaviors in terms of mental health, using cultural tools created not only by psychiatrists but also by psychologists, therapists, educators, or neuroscientists (Beeker et al., 2021). The notion of psychiatrization marks how the increasing amount of people's experiences is being observed, interpreted, and acted upon through language, concepts, and technologies, as well as by the institutional practices submerged with biomedical psychiatry (Coppock, 2020, p. 3). The expansion of psy-disciplines (Rose, 1989; Foucault, 2003) implies their entanglement in the new forms of government that no longer imply exclusively "disciplining" and "imposing from above." Theoreticians speak about the new mechanisms of power ("biopower" or "biogovernmentality") operating through dispersed networks or complex interconnections between sovereign, disciplinary, and biopolitical forms (Foucault, 2008), resulting in the internalized and embodied modes of managing the self (Rose, 1989). The responsibility is increasingly being placed in individual hands, making people manage their and their closed ones' wellbeing as if it depended on their own will and dispositions. People get access to medical categories by which they describe the states they are in. They further interpret what is going on in their families. They act upon the scripts they learn. Made widely available and legitimized by the state institutions and various psy-experts, the conceptualizations of mental health and specific problems defined within psy-disciplines have become the dominant, authoritative knowledge, which affects not only the way the body is experienced but also how the society deals with human suffering embedded in unequal social relations (Wendell, 1996). Psy-knowledge and practice mediate not only the management of ill-health but also the complex processes of kinning managed by the state bureaucracy. The lay appropriation of medical and psychological frames of reference and the material artifacts produced along these lines help the processes of psychiatrization settle down in the culture of everyday life, making the political aspects of social suffering less obvious. This is particularly the case when the psychiatric language and practice focusing attention on individual deficits infiltrate the public institutions responsible for managing lives of children taken away from their first families due to neglect, violence, or other serious breaches in practices of care. In such cases, the "psy" categories are being used to organize the politicized life of children.

Taking the unfamiliar kind of kinship (Carsten, 2004) as a topic, I aim to highlight the progressing psychiatrization of kinning ethnographically as it develops in contemporary Poland. I will consider both the material (e.g., the adoption centers along with the diagnostic apparatuses) and the ideational aspects of psychiatrization (e.g., the emergent definitions and therapeutic imageries), using top-down and bottom-up processes within which individuals, state institutions, and psychiatric knowledge interact (Beeker et al., 2021). My focus will be on a sub-process of psychiatrization that takes place at the intersections of family and social policies, medicalization and psychologization of familial relations, and troubled, disconnected biographies of children.[2] Hence, in this article, I look at the order in the making as the kind of knowledge structuring the interactions concerned with foster care and adoption has transformed, and the new categories of subjects defined in the psy-language have emerged.

The research

The work presented in this article is a part of a larger anthropological research project titled "Adoption as a process, experience and institution – an anthropological perspective" conducted by the Childhood Interdisciplinary Research Team at the University of Warsaw in Poland.[3] The project commenced in 2018, and it was extended beyond the 3-year time frame due to pandemic. During the research, a group of anthropologists used a mixed methodology—participant observation, ethnographic interviews, discourse analysis, and the research techniques taken from the childhood studies—in order to explore the experiences of adoption in contemporary Poland. The aim of the project was to analyze adoption from the anthropological perspective, taking into account its complexity and diversity, as well as the voices of various actors involved in the process (candidates for parents, adoptive parents, adoptees, foster carers, and experts).

This article is based on some of the materials gathered during the project. In particular, I derived data from the ethnographic in-depth, open-ended interviews conducted in Poland with over 50 actual or prospective adoptive parents (mainly mothers), eight people involved in foster care, 18 young people and adults who were adopted and their siblings, and nearly 30 people working in adoption centers, in courts, in counseling centers, and as social

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[1] I discuss the "psychiatrization" processes as they have unfolded in the Polish context in reference to children more broadly in a chapter titled "Enacting ADHD diagnosis in the landscape of care in Poland" (Witeska-Młynarczyk, 2018).

[2] This paper does not highlight the children's perspectives nor it places individual children's biographies in the center of the analysis. I discuss the psychiatrization of adoption as seen from the perspective of a minor person who was adopted in greater detail elsewhere (Witeska-Młynarczyk, 2022b).

[3] More about the research team can be found on its website: www.childhoods.uw.edu.pl.

workers.[4] I further relied on the ethnographic fieldwork I conducted in institutions responsible for implementing the social policy in regard to children taken away from their biological parents. Moreover, I relied on informal conversations, observations, and fragmentary insights obtained in everyday situations. A significant inspiration for my reflections was from the autoethnographic group composed of the foster carers and adoptive parents that I had organized and run within the framework of this project (Witeska-Młynarczyk, 2022b).

The personal details of the people whom I, or my colleagues, talked to are fully anonymized. Some of the details contained in individual stories were changed so as not to allow for identification. Also, the details allowing for recognizing specific adoption centers and their employees were modified. For this reason, no specific geographical locations are mentioned in this article.

The children-in-waiting

Currently in Poland, there are 64 operating adoption centers that connect the couples[5] who want to become adoptive parents with children who were separated from their first families by the court decisions due to neglect, violence, or other serious issues. Each year, qualified couples adopt around 3,000 children (Wykonywanie zadań przez ośrodki adopcyjne, 2017). The average adoption process lasts 2 years—from the moment the candidates are registered as qualified till the moment the court issues a decision confirming adoption (Wykonywanie zadań przez ośrodki adopcyjne, 2017). The prospective parents may wait for the qualification and the training another 2 years. There are many more number of people who want to adopt than the number of children whose legal situation allows for adoption. Approximately 98% of children qualified for adoption get adopted (Wykonywanie zadań przez ośrodki adopcyjne, 2017). The majority of the employees in the adoption centers in Poland are trained as psychologists or pedagogues, so they assess the families and the children using their psy-competences. The main tasks of the institution are to qualify children for adoption, to select and prepare the prospective adoptive parents for adoption, to support women who want to give away a child for adoption, to manage the paper work necessary for the legal procedure of adoption, and to store the personal data connected to the adoption process. The prospective parents, when selected, are assessed by the adoption centers in terms of mental health, economic resources, and social networking.

The children are assessed as suitable or not suitable for adoption, as I understand from the interviews, primarily on the basis of their health, the ability to attach, and the possible existence of attachment to the current caregivers.[6] The processes of psychiatrization and diagnosis are far from definite. They should be approached as emergent in the area of adoption in Poland. For example, the post-adoption support understood as a special category of social and medical service is almost non-existent in Poland. This is another field of psy-expertise, which may potentially grow. Some of the adoption centers offer therapeutic groups for adoptive parents or consultations, yet, these services are scarce, and many adoptive families are ambivalent about contacting the adoption centers in case of problems partially because they associate the institution with assessment and control. As argued by Frank Furedi, "the therapeutic culture conveys a strong sense of unease toward the private sphere" (Furedi, 2004, p. 66). The prospective adoptive parents we talked to in this research repeatedly reported that the interaction with "their" adoption center was strained. The main source of unease was suspicion they felt toward themselves and the fear dictating that it was better not to share everything. Eventually, when the court issues a decision constituting the new family, the adoptive family starts to function "as any other family." Hence, any support sought for by the families in the post-adoption phase is supposed to be a part of the non-specialized, both public and private, system of mental healthcare.

Foster care encompasses various care arrangements, which differ from adoption. In case of adoption,

> "The privacy of the adoption family is prioritized and protected while no contact is maintained with the first family. The new birth certificate replaces the first one and the previous last name is overwritten by the surname of the adoptive parents. The adoptive parents can also change the first name of the child if they wish to do so" (Maciejewska-Mroczek and Witeska-Młynarczyk, 2021, p. 78).

The foster care is organized in forms of family-like (related and unrelated, professional and non-professional) and institutional care running under the auspices of local authorities.

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[4] It is important to note that the research continued during COVID-19 pandemic, and the methodology had to be adjusted to the new circumstances. Approximately one-fourth of the interviews were conducted online with the use of various communicators and phone.

[5] By requiring the candidates for adoptive parents to be a married, heterosexual couple with some years of experience, the adoption centers delimit a social norm—a proper family. The detailed demands vary between adoption centers.

[6] The Supreme Audit Office reported a number of incorrections committed in this field by various adoption centres like: the actual absence of assessment, qualifying children despite the lack of needy opinions (including psychological and medical examinations), making no effort in looking for a family willing to adopt siblings and hence separating related children (Wykonywanie zadań przez ośrodki adopcyjne, 2017, p. 12).

These forms of care differ in terms of benefits, access to special educational programs or supervision, or the fact of biological relatedness with children. Unlike in the case of adoption, within these arrangements, children normally maintain contact with their first families. They keep their names, and they gain no rights to succeed from the foster carers.

Currently, in regard to the first families, the Polish state promotes the reintegration policy. When families are spotted by social workers as in need of intervention, among others, due to bad care provided to children, the state invests in supporting them so that the children could be reintegrated with their first carers and properly cared for in their initial homes (Dzieci sie licza, 2017). Despite such defined strategic and ideological aim, the number of court decisions to separate children from their families for the reasons of bad care, neglect, or insecurity grew from 4,400 decisions in the year 2000 to 10,675 decisions in the year 2015 (Dzieci sie licza, 2017). The majority of children whose parents were recognized as unable to perform their parental obligations and rights live in some form of foster care, including the care provided by the near of kin. In 2015, the number of young people in this situation reached 62,036. In 2015, 2,947 decisions about adoption were issued by the courts, including 199 adoption arrangements according to which Polish children were sent abroad (Przysposobienie w latach 2000-2018 oraz w pierwszym półroczu 2019, 2019). The remaining children were adopted within the country by the families which met the criteria and were selected by the adoption centers. Hence, the children qualified for adoption constitute a small fraction of the larger group of children somehow diagnosed by the system as being endangered by their familial environments. In the years 2015–2017, the children qualified for adoption transited to adoptive families from the family foster care (3,469), biological families (1,326), and institutional foster care (1,214; Wykonywanie zadań przez ośrodki adopcyjne, 2017, p. 11).

I propose to approach this group—the children separated from their first families, as yet another category of children-in-waiting (Witeska-Młynarczyk, 2020).[7] I paraphrase here Timmermans and Buchbinder's term "patients-in-waiting" used "for those under medical surveillance between health and disease" (Timmermans and Buchbinder, 2010, p. 1). According to these authors, the patients-in-waiting inhabit a liminal state between pathology and normalcy. As argued by Maria Liegghio, psychiatric knowledge and practice rely on this binary opposition of normal/abnormal, and the diagnostic process is meant to mark the individual as healthy or unhealthy (Liegghio, 2016, p. 114). In this article, I will describe the many shades of the processes of defining and diagnosing implied in the adoption practices. The psy-language has been increasingly used to define the life situations of the Polish children and the regime of state-involved care they encounter. I will point to the ways in which the process of diagnosis is being scattered and delegated to the non-medical institutions managed by the state, composed of people, to various extent, educated in psycho-disciplines. Lingering on the moment of transition (a child/prospective parents are to be qualified for adoption), I highlight the social and political practices of delimiting the normativity implied within the adoption practices formulated as "family of excess," "adult who coped with loss well," or "adoptable child." Patients-in-waiting inhabit a liminal state between pathology and normalcy. The children taken away from their first families are marked by "the extraordinary conditions" (Jenkins, 2015) and experiences, and they are waiting for a possibility of entering the "state of normalcy," which is imagined as a movement of joining the chosen "families of excess" (the emic term used by the people working in the adoption centers for marking the selected prospective adoptive parents who have more than enough). The prospective parents, most commonly dealing with the issue of childlessness and hence touched by a psychological notion of loss (the state of which is also being assessed by the adoption center), are meant to create a proper family, which, in the case of adoption, is increasingly conceptualized as reliant on the psychiatric and psychological help in order to heal the trauma understood as an integral part of the child's biography.

The biopolitical bureaucracy

The analytical focus on adoption practices allows for capturing the processes of expansion of the psy-complex beyond the medical space. In particular, it is interesting to observe how the new psy-conceptualizations are interwoven with the politics of the state on a microlevel. Nissen and Bech Risør (2018) used the concept of "biopolitical bureaucracy" in order to highlight the multiplicity of human and non-human actors involved in the processes of medical diagnoses. I see adoption centers and other institutions involved in the practices of adoption and foster care as constituting biopolitical bureaucracy, yet I locate them at the margins of the medical practice. At the same time, I recognize them as central for defining the adoption stage in psychiatric terms. The entire network of institutions and knowledge that work toward the assessment and elaboration of children's and candidates for parents' subjectivities and their destinies are increasingly reliant on the psy-knowledge and practice. Howell (2006), who researched the adoption practices in the United States, proposed a similar term—the "psychotechnocrats"—to highlight the influence of psy-language and practices undertaken by the state officials working in such institutions as adoption centers for the intimacy of children and their carers. The state employees, relying on the various regimes of knowledge (psychological, psychiatric, technocratic, neurological, economic, etc.) and on the socially accepted values, assist the carers in producing the imaginarium of good care. This may include the differentiation between the temporary

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[7] I discuss in more detail the concept of liminality in regards to adoption in another text (Witeska-Młynarczyk, 2022b).

foster carer and an adoptive parent as different types of carers who are meant to generate different types of attachment with children, or more specific elaboration on ways in which to handle children's past. Along the same line, Brunila and Lundahl (2020) argued that the politics of therapy represent a new form of biogovernmentality as they link the individual subjectivities with the state policies. In the case of adoption, the politics of therapy imply finding families that could perform a therapeutic work for children with adverse childhood experiences while acting as a regular family. Through the trainings and other practices, the psychobureaucrats assist in the carers' efforts to become successful caregivers (Krawczak, 2022). The carers are set in an interactional framework with the publicly formulated expectations each time they try to perform good care for their children (Roux and Vozari, 2017). The adoption centers have been gradually integrating new psy-knowledge into practice. From the interviews, it seems that the psychiatrization of adoption practices should be considered not only using a top-down but also the bottom-up process in which non-governmental actors played an important role of popularizing the new knowledge about adoption and demanding change.

Capturing the change

> "[...] 'science' doesn't have the power to impose itself. If it spreads, this is because there are actors outside the laboratory who associate themselves with it. And they may pick through what is on offer and take bits and pieces. They do not get overwhelmed by a massive structure or a coherent episteme" (Mol, 2002, p. 64).

Poland supports the "closed" model of adoption (see Maciejewska-Mroczek and Witeska-Młynarczyk, 2021), which means that the privacy of the adoptive family is prioritized over the right of children to know their roots or the first family's right to maintain contact with the children. Until recently, adoption has been typically kept secret within the families, in particular the children often were not informed about their past and about the fact that they were adopted until they reached adulthood, which added to the culture of secrecy (Maciejewska-Mroczek and Witeska-Młynarczyk, 2021). The employees of the adoption centers talk about the late 1990's as the period when new knowledge and practice started to permeate their professional circles. Among others, the centers have gradually introduced the elements of advice on how to talk to children about their past to the training program.[8] Also, the knowledge about specific diagnoses like FAS, ADHD, and RAD started to circulate. The attachment theory, including the knowledge about the attachment styles, took the central stage. In fact, what happens with the knowledge conveyed by the adoption centers is completely up to the adoptive family according to the family's right to privacy. The adoptive families have a large pool of sources of psy-knowledge not connected with the adoption centers like non-governmental organization, other professionals or the social media. I suggest that one of the ways in which the largely unknown past is managed and tamed by the newly constituted families is through therapeutic interventions and the focus on the bodily manifestations of the past in the present. These are being named in the psy-language in a form of diagnosis like attachment disorder. This phenomenon could be named a psychologization of the embodied past.

The character of adoption in Poland has changed over the years. The cultural transformations influencing adoption practices are manifold, and the encroaching psychiatrization is entangled in the more complex societal processes including normalization of single motherhood; opening of the public debate concerned with the reproductive rights; the easier access to new reproductive technologies; encroaching culture of confession and therapy; reconfiguration of family dynamics; the increased significance being given to children, their rights, and their psychological wellbeing; the growing professionalization of state bureaucracy; the increase in transnational flow of psycho-expertise, knowledge, and practice; and the lessening of the tabu posed on family violence. Marlena, a women in her 40's, a manager of one of the adoption centers in Poland explained to me the practical difference that had unfolded during her career:

> Marlena: At the beginning of our work these were mostly newborns left by single mothers in the hospitals. I talk about the majority of adopted children. Meanwhile now, we hardly meet these kind of mothers. The children we deal with now have been in the foster care for some time already and their parents or caregivers were deprived of their rights to care. Most commonly, these children have experienced all kinds of violence or serious neglect in the critical 1st years of their lives.

This observation points to the crucial qualitative change that took place within the field of adoption. Adopted children are now being recognized as marked by the adversary experiences definable in the psy-language and treatable through therapeutic conceptualizations and techniques. This means that a larger and more complicated network of actors, definitions, and discourses have become involved in the process of separation of children from their first parents and the acts of relating them to unfamiliar adults.

The children meant for adoption are more and more frequently talked about by the employees of the adoption centers as "traumatized" early in the prenatal period and in the initial years of their lives:

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[8] Despite the fact that more and more parents make no secret out of adoption *vis-à-vis* their children, still during this research, I met parents who did not tell their children they were adopted. This example points to the slow cultural change.

> Zuzanna (a manager of the adoption center): But the majority of these children come from alcoholic pregnancies, so, basically, during the entire pregnancy they lived through trauma and stress. They were exposed to violence, because the alcohol consumption during the pregnancy should be considered an act of violence against children. Additionally, they were exposed to the results of bad treatment, also when the children were taken away from their family houses by the means of police intervention.

At the same time, as expressed by Mirka, another manager in one of the adoption centers in Poland, and this information came up repeatedly in the interviews with other employees of adoption centers, the expectations of the candidates for adoptive parents are quite unified:

> Mirka: The most common expectation is that the child will be healthy and young.

In this situation, there is some work of elaboration going on in the realm of expectations and understanding the supply side in the adoption process. Since the adoption centers have less and less newborns and they are increasingly aware of the extent of the "invisible disabilities" (Blum, 2015) the children qualified for adoption embody, and the scant diagnostic and therapeutic possibilities they have, they take on themselves the task of "enablement" (in polish *urealnienie*) *vis-à-vis* the prospective parents. This emic term used by the psychobureaucrats conveys the desire on the side of the state employees to make the prospective parents aware of the type of children currently available for adoption. Kasia, a psychologist working in one of the adoption centers, said about the prospective parents:

> Kasia: Well, they are more realistic now. They used to think - *this is a poor child of well- educated parents, who died in a car accident, a blond girl with blue eyes.* [...] Now, the parents know how the child gets into the system and what are the possible reasons for the biological parents not to be able to take care of the child. So this is changing.

Individual awareness and the diminishing ethos of public responsibility

The prospective parents' awareness of the possible/uncertain disorders to be treated in future is being developed during the trainings provided by the adoption centers. At the same time, there is a lack of solid diagnostic work prior to adoption, and there is no decent post-adoptive support provided by the state. As argued by Frank Furedi, one of the defining features of the therapeutic ethos is "awareness" (Furedi, 2004, p. 73). To be aware of the correlations between individual and family pathology means gaining an insight into the ways in which mental health issues are managed (Furedi, 2004, p. 76). The awareness of the connection between the child's health and the context of its first family is built by the adoption centers throughout the training sessions prepared for prospective parents. Eventually, the new parents are imagined as a "therapeutic" family for the adopted children and the main guarantee of the wellbeing of adoptees. They are chosen as capable of helping the children in lifting up the trauma.

From the economic point of view, adoption is the cheapest option for the state that is responsible for the wellbeing of its children-citizens.[9] Talked about by the employees of the adoption center as "a miracle," the best possible option the child-in-waiting can dream of, marks the decline of an "ethos of public responsibility" (Furedi, 2004, p. 72). The adoptive family is imagined as the one that has the resources (both economically and emotionally and as educated and aware citizens) to take the individual responsibility for the child's transition into "normalcy.[10]" The intensive education of candidates for adoptive parents on the theme of possible disorders increases their awareness and promotes their urgency for self-diagnosing and organizing therapies. When the adoption process is complete, the adoptive families become consumers "who actively seek out diagnosis and treatments based upon their self-assessments of symptoms" (Ebeling, 2011, p. 826). They take on themselves the sole responsibility for the stumbles (Witeska-Młynarczyk, 2022b). The adoption centers perform the work of preliminary diagnostic practices mainly by increasing the awareness of disorders. As such, I recognize the adoption centers as the "brokers for psychiatrization.[11]" Psychotechnocrats (Howell, 2006) play a role in the preliminary diagnostic work (Dew and Jutel, 2014) as "disease-spotters"

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[9] The costs of institutional care for children-in-waiting are quite diverse. The calculations discussed by the psychotechnocrats at the meeting which I attended pointed to the monthly costs amounting to over 4,000 Polish zlotys per person per month. These costs grow depending on the kind of institutional care provided. The most expensive care discussed was the care provided in the so-called "therapeutic" institutions, where a psychologist and various therapists are employed. Such placement costed the state over 8,000 Polish zlotys. During the discussions, it was also mentioned that an autistic child requires 1:1 care and that the cost of such institutional care equals 12,000 Polish zlotys.

[10] When diagnosed, the prospective parents are treated with suspicion. Once this diagnostic process and the selection process are made, and the child and the adult carers are paired, the unease toward the private sphere is suspended, and the notion of "miracle" of adoption and a movement to "normalcy" are promoted. Distrust is turned into a complete trust given to the new carers as no serious supervision of the adoption process follows.

[11] I reframe the term "brokers for ADHD" coined by Philips (2006).

(Philips, 2006, p. 434)[12]—that is, the initiators who push families onto their diagnostic journeys.

> Mirka: We say: "unfortunately, our children are like this, you have to accept the possibility that something will go wrong." They [the parents, AWM] start to open themselves for this. However, a child with some evident disabilities have no chance for being adopted [. . .]. Yet, even if there is no FAS diagnosis, there is a really big chance that something will be wrong because the mother was drinking alcohol during pregnancy.

Changes in the imageries around adoptive kinning have been gradual. The pivotal moment that psy-technocrats point to is the year 2000, when the new knowledge started to infiltrate the circles of psychologists and social workers. At this point, prospective parents are confronted during the trainings with very specific diagnostic knowledge. The disorders discussed can be enumerated. The pedagogue working in one of the adoption centers in Poland narrates it in the following way:

> After the year 2000, there begins the knowledge about FAS (Fetal Alcohol Syndrom), FASD (Fetal Alcohol Spectrum Disorder), RAD (reactive attachment disorder), traumas. The trainings for the foster care called PRIDE began. The standard of knowledge was imposed by the people from the Association Our Home. There is a number of projects, for example Martynka's Friends' Foundation—they take a lot from Italy, from the USA.

The flow of knowledge influencing the adoption practices has been mediated by various bodies, including non-governmental organizations or professional associations. As such, the psychiatrization of kinning is advancing by both the bottom-up and top-down flows of knowledge, which is transnational in its nature.

Biomedicalization, or, to be more precise, psychiatrization has become increasingly relevant in the case of adoptive families as the health of the adopted child marks the adoptive family's success or failure. Child's health and the quality of attachment itself become a commodity (Clarke et al., 2003), a condition (e.g., a proper attachment) which is sought for, something that has to be maintained or rather actively produced after the child is adopted, among others, by the reliance on the psy-knowledge and help of the experts.

The adoptive families are increasingly being imagined as in need of assistance in the process of working out proper family relationships. On the one hand, they are meant to be like any other family, yet, at the same time, they are imagined as a special kind of family (Maciejewska-Mroczek and Witeska-Młynarczyk, 2022).

Agata, an adoptive mother of a girl, in her 40's, who has actively searched for possible pieces of training and workshops during which she and her husband could have worked on their attachment styles and readiness to emotionally support their child (despite the fact that the girl holds no diagnosis), actually sees the training provided by the adoption center as useful:

> Agata: It [the training, AWM] helps to recognize certain behaviors. If something is happening, it has a cause, so, we shall be aware of it. Trauma, because different behaviors come as a consequence of trauma and different as a result of the attachment disorder, so, this is. . . [. . .]. It helped me a lot. And there were some embittered voices hearable [of the other adoptive parents—AWM] complaining that this was insufficient [the knowledge conveyed during the training in the adoption center—AWM]. That the issues were merely signaled. But I agree that there actually was not enough space during the training. And apart from that, as far as you don't find yourself in some specific situation, it remains a theory.

As noticed by Roux and Vozari who conducted research with adoptive parents in France in the context of contemporary adoption, it is not enough to be a parent; one has to become a very particular caregiver. In such sense, the discourse of adoptive parenting should be considered as something more than a moral discourse. It becomes an instrument of power (Roux and Vozari, 2017, p. 13). According to these authors, the institutions of social care promote the particular kind of ethics, the one which implies autoregulation, the constant effort of improving oneself. Adoption processes serve as a lens through which we may observe the contemporary forms of political power and the ways in which the socially situated actors interact with them (Roux and Vozari, 2017, p. 19). The state remains a pivotal regulatory actor of the family life, even when immersed in the network of non-governmental and private bodies. "Therapeutic governance" represents a new form of governmentality (Brunila and Lundahl, 2020) as it links the practices of constituting the individual subjectivities along with the ways in which the state functions. It is relevant in this context to take a look at what is stated as good, true, and desired in the practices performed by the state institutions (Brunila and Lundahl, 2020).

In the course of the adoption process, in particular during the training offered to the prospective parents by the adoption centers, the "diagnostic power is removed from the exclusive purview of medical authority" (Ebeling, 2011, p. 831) and placed in the hands of psychotechnocrats; such arrangement opened up a space for negotiation and meaning making invoving many actors and streched in time; the expectations put on adoptive families to become therapeutic families generate the feelings of anxiety and an immense effort put in trying to succeed

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[12] A similar reflection was developed by Claudia Malacrida for Canada and the Great Britain in the context of ADHD, where teachers, special educators, and school psychologists "identify, assess, and administer medication to ≪problematic≫ children" (Malacrida, 2004, p. 61).

to rescue the child. The parents are made to believe that the result depends solely on their efforts (Witeska-Młynarczyk, 2022b).

Seeking for normalcy

While the adoptive parents are made aware of the uncertainty of children's health, they are educated in the possible psychological interpretations of the problems they may encounter after adoption, and there actually is no demand for disabled children or the children with serious medical diagnoses, including psychiatric diagnoses. The situation of adoption is still highly marked by the expectations and desires to become "a normal family" (Maciejewska-Mroczek and Witeska-Młynarczyk, 2022). Mirka, a manager of the adoption center in Poland, notices:

> Mirka: Certainly, there is no openness for disabled children and such children are more and more numerous.
>
> [...]
>
> Researcher: Does it often happen that the candidates indicate the readiness to adopt a disabled child from the very beginning?
>
> Mirka: These are extremely rare situations.

The "invisible disabilities" (Blum, 2015, p. 42–50) become a non-human actor shaping the processes of adoption relying on some forms of diagnostic work. According to Linda Blum, the term "invisible disabilities" means neurodevelopmental disorders that are not immediately noticeable and more difficult to diagnose than the physical disability. This lack of visibility opens up the field of anxiety, the unknown, but it opens up the space for hope and political game. It is particularly so in the case of attachment as it is understood as a relational thing, depended upon two parties. In the practices of adoption, we have interwoven the contemporary version of the myth of control. As argued by Susan Wendell, what comes along with it are the burdens of blame and guilt that are fostered by the myth (Wendell, 1996, p. 9). At the same time, the responsibility is transferred from the state to a single family. This transfer of responsibility was narrated by Marlena, a manager of adoption center, during an interview:

> Researcher: Well, and another challenge for the adoptive parents is the reactive attachment disorder. Is that correct? Do you diagnose it in children?
>
> Marlena: We have to state our opinion about it and, during the training, we are preparing the candidates for it.
>
> Researcher: Aha.
>
> Marlena: For these reactive attachment disorders, it seems to me, they are prepared to deal with those. I also think that, even though there are no research results to rely on, with such a wise, therapeutic approach of the adoptive parents, well, this is the kind of thing that they are able to fix.

Unlike Marlena, many employees of the adoption centers we talked to recognize the child suffering from the reactive attachment disorder as unsuitable for adoption. I suggest that this collective reflection results from a recognition of the demand side and the actual unreadiness of the majority of the prospective parents to build a family which is not "like any other family" or which becomes a family for an older child or siblings. When I asked a psychologist and a pedagogue in one of the centers whether there are children who are "unadoptable", at first they said:

> Almost each child younger than 18 is adoptable, but a 17 years old and disabled female teenager actually is not.

In a further conversation, they explained that those children who are adoptable actually show an ability to attach to another person. They expressed uncertainty about the ability of children suffering from FAS to develop attachment. In fact, they voiced their concern about the actual possibility of diagnosing children. It is so because the problems are imagined to be located in the brain—"but, physiologically, on the level of the brain, whether the child will be able to develop attachment, we do not know it. It will develop a different kind of connection," they stated (from fieldnotes). I understand it as a commentary on the condition of the diagnostic uncertainty and the actual inability of the state bureaucrats to tame and understand and reliably communicate the children's biographies inscribed in their bodies. Their structural position is ethically difficult, and they try to navigate uncertainty by reference to the psy-knowledge, which gives some possible answers and refers to medical authority, yet considering future development of a child.

Toward definitions

In the specialized psychiatric literature, both adopted children and children in foster care start to be recognized as separate subjects worth attention due to problems with mental health. Such formulations are relatively new in the Polish medical literature (Szmajda and Gmitrowicz, 2018).

Szmajda and Gmitrowicz (2018) argue that children and adolescents reared in foster care more often than their peers brought up in two-parent families suffer from self-injuries and make suicide attempts. They notice that the average age of psychiatric diagnosis in such children is lower than that in the rest of the population, and they are more often hospitalized. Hence, institutional care, including family foster care, is recognized as a risk factor for children (Szmajda and Gmitrowicz, 2018). Pawliczuk and Kazmierczak-Mytkowska (2014) is cited as the only research conducted in Poland on this topic with the conclusion that over 50% of children reared in institutional care suffer from mental health problems. This includes psychiatric diagnoses. This argument strengthens the imagery of adoption as an ideal place. Yet, some adoptive families we talked to turn attention to difficulties they encounter every day. Marta, an adoptive mother of two girls, was apparently not ready to take the entire responsibility for the struggles that came along with adoption:

> Well, so this training [about the training provided for the candidates for adoptive parents]… no one prepared us for the kind of problems we encounter […]. We reflected together with my husband that if they had told the people, how much would the adoption rates fall? I think it is better for adoption rates to fall and for the people to be prepared and for the adoption to bring about good results. And instead, we are tired, our frustrations are being transferred on the kids. Because sooner or later this is what happens. And you have no chance to avoid it.

The image of adoption as a struggle is rarely evoked. The Internet opened up the space for discussion on the fora run by non-governmental bodies like Nasz Bocian—an association meant to provide the professional support for the people coming to terms with childlessness; yet, while lifting up the sense of failure it still strengthens the individual efforts focused on providing the proper care. The myth of adoption as an ideal solution, a miracle, and as something that can be controlled through therapies predominates, and the alternative narratives rarely see the public light (see Janus, 2022; Potocka, 2022). Failed adoptions are spoken about rarely. While the official number is lower than one percent of adoptions each year, that is, adoptions which are legally dissolved, many adoptive relationships remain seriously strained (Janus, 2022; Witeska-Młynarczyk, 2022a).

The psy-experts start to recognize the struggle by defining the adopted children as another group worth a systematic study and focus. Skiepko and Brągoszewska underline that "adopted children, in comparison to the children brought up in biological families, constitute a higher proportion of patients appearing at the psychiatric consultations and being hospitalized" (Skiepko and Brągoszewska, 2009, p. 207). The crystallization of the category of adopted child in psychiatric discourse and practice may further influence the adoption practices. The adoptive parents are meant to fulfill the role of a therapeutic parent, which becomes a measure of success for the adoption project. Successful projects will need a professional ally. A troubled child will be the focus here.

Practicalities of care

Social practices of defining children suitable for certain types of care take place within the institutional walls, where state bureaucrats have a chance to collectively reify the reality which they face every day. As stated by Susan Wendell, "Questions of definition arise in countless practical situations, influence social policies, and determine outcomes that profoundly affect the lives of people with disabilities" (Wendell, 1996, p. 11). The following is the fragment of my fieldnotes illustrating ways in which the social workers negotiate order by relying on the psychiatric vocabulary.

From fieldnotes

> It is April 2019. I participate in an assembly of the local family centers (Powiatowe Centra Pomocy Rodzinie, PCPR). The manager of the regional office for social policy (Regionalny Ośrodek Polityki Społecznej, ROPS) agreed for me to take part in the meeting. ROPS manages the institutions responsible for the implementation of social policy created for the families and children. It further supervises the adoption centers. PCPR is an institution that supervises the foster families. Before the year 2011 (the law was amended), the foster families were cooperating with the adoption centers. Now, the adoption centers specialize in adoption only. During the meeting, one of the representatives of the local family center notified she wanted to have a voice. She started to refer a problem which she classified as "children with opinions" or "children with psychiatric diagnosis." She referred that in the voivodeship there were 399 children with such diagnosis in foster families, including 114 in the institutional care. She described this as a "new terrain," "a recent problem" dating a dozen or so years back and that the largest group of children with diagnosis can be found in the institutionalized care. In her short statement, she made a reification by distinguishing between "the children with psychiatric problems"—defining them as those whose behavior is disorderly and "the children with pedagogic problems" or various problems appearing in the practices of care. She suggested for the children with psychiatric problems not to be placed in the foster care. As an example of a child with psychiatric problems who should not be placed in foster care she brought about a story of a 14 years old girl, who had attempted suicide and who had sexual contact with adult man and the court decided to place her in the foster care. "This kind of child should not be placed in the foster care"—exclaimed woman in a concerned tone.

In this social situation, there emerged a category of children who do not fit foster care. The local bureaucrat, in her speech act, proposed to use psychiatric diagnosis as a way to identify children who should not be embraced by a certain kind of care. It was said, but, I assume, she meant such children to be meant for hospitalization. Here, we have a social attempt at identifying a micro-process of negotiating order with a usage of the psychiatric apparatus. My feeling is that the women made practical distinctions between more and less valuable lives using the psy-language (Judith Butler in Gessen, 2020). This ethnographic example pictures a micro-movement that may gain no larger relevance; however, it tells about the presence of the psy-language. It is illustrative of the ways in which the psychiatric knowledge, taken away from the medical context, is being used by the state officials to order reality, to categorize children with an aim of organizing care for them. It is typical for psychiatrization movement outside the medical space. It implies the merging of the language of psychiatry with governmentality practiced by the state apparatus in the field of social policy. Eventually, it may be considered as part of the process of "vulgarization of psychiatry."

Diagnosing the ability to connect

One of the elements of the encroaching process of the psychiatrization of kinning is that children are stratified based on their abilities to connect. The imaginary of their abilities is now being fed by new neuroscientific and neuropsychological discourses and research, as well as it is based on the constantly developing attachment theory. On the brain level, they may be unable to form the kind of attachment that is imagined as proper for the adoptive family. They may form other kind of connections (not attachment) that does not fit a model of an adoptive family, which is to imitate a "normal" family. At the level of the state institutions like adoption centers, complex processes of elaboration are taking place. These processes imply categorizing children suitable for adoption based on their medical condition and the demand side.

When the parents of the children placed in the temporary foster care are being deprived of their parental rights by the court, the children are marked as "legally free" and they may be considered for adoption. If such children appear in the system, the employees of the adoption center need to gather information about them. Marta, a psychologist in one of the adoption centers in Poland, describes this process as scattered among many actors and material objects. From her position, the difficulty is to rely on the information given by another institution and passed on paper:

> Marta: Gathering information, completing the history, about the first family of the child, it requires a lot of effort from us, and, actually, much trust being put in the people who generate this knowledge, that they will provide us with satisfying set of documents. The prospective parents will ask questions.
>
> Researcher: Can you explain in more details about how the information is gathered?
>
> Marta: It is all described in the legal act.
>
> Researcher: Ok, but apart from being described legally, there are people who gather the information and pass them on. How is the information passed on?
>
> Marta: On paper.
>
> Researcher: So you mostly deal with the information passed on paper.

Framing the children as adoptable is an action taken jointly by many different actors: social workers, judges, foster carers, employees of the adoption center, the diagnostic articles prepared by psychologists or psychiatrists, and many others, like buildings, technologies, and knowledge. The categorization does not come as a discrete act. It rather emerges through the actions taken by various institutionally affiliated people located in various spaces and acting upon certain ideas of children's interest, proper care, or proper diagnosis (Witeska-Młynarczyk, 2018).

In order to get to know the children's situation in more detail, the employee of the adoption center needs to require information from the institution managing the foster care. The documents may include a psychological diagnosis, an opinion about the child, and the social worker's opinion about their first family.

> Researcher: So, the child is diagnosed.
>
> Marta: Well, the institution supervising the foster care sends us the information. [...] Depending on whether they already have it or not, they make an assessment of the child's situation and they send us the complete files. Or, like the last time, I replaced my colleague, they sent one document and all the others were missing. [...] So, everything depends on the institution which manages the foster care.

Marta expresses her feeling of lack of trust toward the competences and reliability of other institutions she cooperates with in the adoption process. Once the files are complete, the employees may go to see the children and proceed with their own diagnosis. Marta's colleague—Kasia—explains:

> Kasia: It may happen that we make our own diagnosis. If the diagnosis sent by the-
>
> Marta: -by the organizer is-
>
> Kasia: -is insufficient.
>
> Marta: Of low quality, so-

> Kasia: It does not meet our expectations. [...] So then, apart from the conversation, actually, there is an element of the diagnosis in this meeting, meaning observation, sometimes it even implies a diagnostic test, like developmental.
>
> Researcher: What happens when you see that the child perhaps needs a deeper neurodevelopmental diagnosis? Does it happen? What can happen in such situation? Can you demand such a diagnosis from the carer?
>
> Kasia: On the stage of qualification well, my opinion is that in Poland children, or at least here, children are underdiagnosed or very badly diagnosed. A neurologist writes that everything is ok, while it is not ok. So, the level of diagnosis is low.

A diagnosis is often understood as a critical moment leading to a healing procedure. It can be understood as a term or a category that puts the world in order. You get to know that your children are suffering from adverse childhood experiences. Yet, the diagnosis can also be understood as a process (Jutel, 2018). It is increasingly talked about not as an act but as a "diagnostic work" and as a "disorderly process" (Jutel, 2011; Goodwin and Mc Connell, 2014; Nissen and Bech Risør, 2018) engaging various actors, things, ideas, and places. It implies "doing" (Mol, 2002) also performed in non-medical spaces and shaped by expert and non-expert voices and judgments (Büscher et al., 2010). Nissen and Bech Risør note that:

> "Processes of a diagnosis include any activity surrounding investigations, assessments and negotiations pertaining to clinical and non-clinical judgments of ill-health. Different actors with their skills, experiences and sensing bodies are involved in these processes, in conjunction with technology and instruments of measurement. Studies of such processes have explored the enactment and the making of a diagnosis with particular focus on subtle intersubjective processes between health professionals and patients" (Nissen and Bech Risør, 2018, p. 15).

In the adoption network, adoptive parents are well-rooted in the social networks discussing the adoption process and the psychiatric knowledge related to it. Adoption centers are institutions devoted solely to the selection and training of adoptive parents, as well as to pairing children and parents. These are interwoven into other institutions of social care responsible for managing the first families and children taken away from them.

Both children taken away from their first families and the foster and adoptive carers are increasingly exposed to medical knowledge and practice both through their involvement in the biosiocialities, the expert discourse circulating in the popular media, and through the contact with the state officials who supervise and select them. People working in the adoption centers become agents of psychiatrization, yet their role in diagnostic processes varies. The adoption centers educate the prospective parents about FASD and RAD, yet most of the time, they face the lack of specialists prepared to diagnose small children. In addition, the actors involved in the interim care for children sometimes are inconsistent in taking responsibility for the diagnostic process. Another thing is the accessibility and financial availability of the diagnostic processes. There is also a conviction that children would not be adopted if a FASD or RAD diagnosis is given, which brings about ethical dilemmas into the every-day life of social workers. Because prospective parents are assessed by the adoption centers, they most of the time do not feel they can demand transparency or quality information (including medical information). In the interviews, they reported feeling impeded by the fact that these employees of the adoption centers eventually decide upon them gaining a possibility of adopting. They know they function as an element of the economy of lack, and they recognize the game is to be played carefully with those who are in the position to decide.

The economy of lack

The contemporary adoption scene in Poland undergoes the process of transformation and should be recognized as the economy of lack, that is, the demand for a particular kind of children is much higher than the supply of, what I will call, adoptable children.

> Marlena (the manager at the adoption center): At this point, I can say for now, for the 2019, that the most difficult is this knowledge that people have basically no chances for adopting. So this is an absolutely hopeless situation, and the fact that we are doing our job nonetheless—we train them, we support them, but the perspective for them to become parents is so far that, in my opinion, we could say it is unreal. And it will probably be the biggest problem... their anger.
>
> Martha (a manager of the adoption center): Those candidates who are waiting the longest, they are from 2014th.
>
> (Researcher): Oh.
>
> Martha: They are the ones who came [to the center] in 2014. It is 5 years now, so it is a lot. Anna: Oh. And how many people do you have on the waiting list?
>
> Martha: Like 25 couples.

The supply of "adoptable" children is not sufficient for those waiting. Despite the discourse of "the best interest of the child" (Maciejewska-Mroczek and Witeska-Młynarczyk, 2021), the system caters for the needs of candidates for adoptive parents.

The employees of the adoption centers during interviews often explained how they would protect the parents by not offering them more than one child as they would not cope with more. During the interviews, we also heard about the siblings separated and given to different families, which is a straightforward expression of favoring the rights of the prospective parents over the best interest of children. Among other, the psy-knowledge plays an important role in defining adoptable and non-adoptable children, that is, it becomes a crucial ingredient of the dividing practices performed under the auspices of the state.

Hence, what has been happening with the influx of knowledge and the new diagnostic possibilities is a set of redefining practices, which work toward delimiting what is possible within the adoption process. What comes as a result of these tendencies is, I call, the tightening of the adoption system.

Adoption works toward reproducing the social hierarchies between the deserving adoptive family and the unsuitable providers of children (Briggs, 2012). As argued by Leinaweaver, to frame adoption by the rescuing metaphor (in Poland, the metaphor of miracle is more commonly used), blocks the possibility of a critical discussion about the social inequalities and the situation of the families from which the children are taken away (Leinaweaver, 2018, p. 9) and the children themselves. Adoption understood as an act of mercy—a miracle that takes place, thanks to the practice of unconditional love or deep therapeutic work—silences different shades of this process, that is, adoption experienced as a challenge, as an "epistemic struggle" (Jenkins, 2015)—both for a child and for the parents (see Potocka, 2022), as well as the first parents, whose rights are recognized only as long as the policy of reintegration is considered.

Brunila and Siivonen (2014) pointed out how neoliberalism (understood as a political ideology and a way of governing by the reference to individual rationality, freedom of choice, and attachment to the market) facilitates the spread of therapeutic cultures focused on improving psychological and emotional vulnerabilities ascribed to persons (Brunila and Siivonen, 2014). The therapeutic cultures and the focus on the individual feed well into the biomedicalization of human life. We recognize the increasing amount of problems encountered by a human being in the life course, as assessed as a medical issue possible to be solved through therapy (Nowakowski, 2015, p. 52–53). The lay people and experts in various cultural contexts align themselves with the processes of medicalization in order to meet their needs and cultural expectations.

The political stake

As argued by Wendell,

> Disability is socially constructed by such factors as social conditions that cause or fail to prevent damage to people's bodies; expectations of performance; the physical and social organization of societies on the basis of a young, non-disabled, "ideally-shaped," healthy, adult male paradigm of citizens; the failure or unwillingness to create ability among citizens who do not fit the paradigm; and cultural representations, failures of representation, and expectations (Wendell, 1996, p. 45).

Constructed as they are at the moment, the adoption practices in contemporary Poland should be recognized as social conditions that fail to prevent damage to people's bodies. Among others, the expectations of normality, the ideal, play a role here. Marlena's words illustrate this imagery of the adoptive parents as "ideally shaped" citizens:

> Researcher: How many of these families, do you think, would require some kind of psychological or therapeutic help later on?
>
> Marlena: I think not many. [...] A few years ago we came up with a motto that we are to prepare them in such a way so as not to face them coming back. We are to work with them in such away so as to make them aware, conscious and ready, so that they have such resources. And this is the idea imprinted in the law.

Following the contemporary practices of adoption in Poland ethnographically, I suggest that the Polish state, through the acts performed by the psychotechnocrats, works toward distancing itself from responsibility for the children-in-waiting described as "adoptable." The adoption process is an integral part of the larger social project of stratifying children-in-waiting using psy-knowledge. The dividing practices reliant on the psy-language allow for distinguishing different kinds of children meant for different kinds of care. The distancing from responsibility is possible by reference to the family's right to privacy, the pursuit toward "normalcy," and the realization of "the best interest of the child" envisaged as a placement in a nuclear, heteronormative family run by a well-selected and diagnosed married couple. By educating the prospective parents about the social milieu from which the children available for adoption currently come from and teaching about the findings in neuropsychology and trauma studies, the employees of the adoption centers hint "at something" while leaving ambivalent and unclear whether children are actually sick and, if so, what their sickness would entail (see Timmermans and Buchbinder, 2010, p. 417). The uncertainty of the state of child's health results from the insufficient diagnostic infrastructure,[13] the actual lack of interest

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[13] The child and youth psychiatry in Poland is recognized as one of the most neglected areas of medical care. The waiting time and the accessibility of the specialist are low. While each year in Poland, a few

of the state representatives to perform a proper diagnosis in light of the fact that the prospective parents seek for healthy and small children (a proper diagnosis would entail the risk of lowering the demand side), and the tendency to lower state's costs (and in fact the failure to provide with the proper medical assistance for the children in foster care).

These structural conditions are imposed on prospective adoptive parents who desire to adopt a child and whose ideal model of life is a nuclear, heteronormative family in which a child develops from early years. In these conditions, a generic uncertainty is being produced (the unknown state of a young child who will be managed and taken care of by the new parents). I suggest to treat it as a by-product of the logic of state policy, which works along the economic rationality of demand and supply intermingled with the conservative ideology favoring the imagery of a nuclear, heteronormative family as an ideal place for a child to develop and distancing from responsibility. The state bureaucrats discipline the adoptive parents to take individual responsibility for diagnosing and going through numerous therapeutic interventions meant to turn an adopted child into an expected citizen with little costs on the side of the state.

The private solving of the social problem

The new knowledge generated in neuropsychiatry and trauma studies help define a group of children whose adverse childhood experiences make them prone to being narrativized as in need of healing relationships, possible to be provided only by the idealized nuclear family who is well chosen—resilient, economically well-off, with a proper approach—"a family of excess," as the employees of the adoption centers say. As Timmermans and Buchbinder put it,

> The production of patients-in-waiting relates to the way screening and testing is implemented with shifting alliances between vocal patient groups, testing companies, and public health programs, combined with varying heuristic practices for interpreting results (Timmermans and Buchbinder, 2010, p. 418).

Paraphrasing Timmermans and Buchbinder (2010), I interpret adoption as an element of the management of children-in-waiting. This process implies screening and defining who is adoptable and who can adopt. These politicized diagnostic processes are implemented through the network of institutions of social care, juridical bodies, and medical authorities, as well as they are rooted in larger policies of thus far failed deinstitutionalization and the conservative pro-familia solutions. The material and ideational aspects of psychiatrization become the crucial knots in this network, within which the wellbeing of children taken away from their first-families is being acted upon.

Svend Brinkmann called a contemporary situation in which human suffering is being increasingly interpreted in terms of psychiatric conceptions and diagnostic categories as "diagnostic cultures" (Brinkmann after Nissen and Bech Risør, 2018). The moral regimes created by the infrastructure of adoption are based on psy-nomenclature, and they put much pressure on adoptive parents and children by promoting the model of individual responsibility for the possible failures. The tensions embedded in the adoption practices (Maciejewska-Mroczek and Witeska-Młynarczyk, 2022) will be actively elaborated by the state bureaucrats and the bottom-up initiatives in the upcoming decades. The psychiatric knowledge and practice will play a significant role here.

Currently, the adoptive families become patient-consumers within the system of healthcare, even though when they enter the adoption network, they start to take part in the political process of solving the social problem. They become part of the network, which enables the social problem to become privatized and the responsibility for its solution individualized (Witeska-Młynarczyk, 2022b).

Conclusion

By bringing forward an ethnographic material from a larger study focused on the adoption practices in contemporary Poland, I meant to illustrate how the psy-knowledge and the processes of psychiatrization have become intertwined with the political process of governing children's biographies by the Polish state administering adoptions. I showed particular institutionalized forms of managing care in which various elements of psy-knowledge play an increasingly important role. In particular, the attachment theory, trauma studies, and diagnosis like RAD, FASD, or ADHD start to order the social relations between the carers, and the children

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1,000 young people are hospitalized due to mental health problems, and an equal number of them are placed in residential care and other facilities for "troubled teens" (Golightley, 2020), there is also an alarmingly high number of youth attempting suicide (Dzieci sie licza, 2017). The media discourse depicts the system of child and youth mental healthcare as a catastrophe (Walewski, 2018; Pucułek, 2019). The journalists and experts, among others, point to the numerous shortages in staff and public resources allocated to child and youth psychiatry, as well as the unresolved emergencies and abuses, including sexual abuses and homophobic acts aimed against young people committed in their environments and spaces of care (Chotkowska and Parzuchowska, 2019; Bereś and Schwertner, 2020).

and their past. The intimate practices of "kinning" are heavily intermediated by the state employees who are both bureaucrats and psy-experts. I discussed how the relationships performed among the people involved in the adoption network result in increased privatization and individualization of responsibility, as well as they lead to the strengthening of the diagnostic culture of which "adoption" is becoming a distinctive part.

Data availability statement

The original contributions presented in the study are included in the article/supplementary materials, further inquiries can be directed to the corresponding author.

Ethics statement

The ethical review was provided during the review process by the granting body. No special ethical review and approval was required for the study on human participants in accordance with the local legislation and institutional requirements. Written or verbal informed consent to participate in this study was provided by each participant (when relevant also by the legal guardian/next to kin).

Author contributions

The author confirms being the sole contributor of this work and has approved it for publication.

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Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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References

Beeker, T., Mills, C., Bhugra, D., Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatr.* 12, 645556. doi: 10.3389/fpsyt.2021.645556

Bereś, W., and Schwertner, J. (2020). *Szramy. Jak psychosystem niszczy nasze dzieci*. Warszawa: Wielka Litera.

Blum, L. (2015). *Raising Generation RX: Mothering Kids with Invisible Disabilities in an Age of Inequality*. New York, NY: New York University Press.

Briggs, L. (2012). *Somebody's Children: The Politics of Transracial and Transnational Adoption*. Durham, NC: Duke University Press.

Brunila, K., and Lundahl, L. (2020). *Youth on the Move. Tendencies and Tensions in Youth Policies and Practices*. Helsinki: Helsinki University Press. doi: 10.33134/HUP-3

Brunila, K., and Siivonen, P. (2014). The making of entrepreneurial subjectivity in adult education. *Stud. Continuing Educ.* 36, 160–172. doi: 10.1080/0158037X.2014.904776

Büscher, M., Goodwin, D., and Mesman, J. (2010). *Ethnographies of Diagnostic Work. Dimensions of Transformative Practice*. New York, NY: Springer. doi: 10.1057/9780230296930

Carsten, J. (2004). *After Kinship*. Cambridge; New York, NY, Melbourne; Madrid; Cape Town; Singapore; São Paulo: Cambridge University Press.

Chotkowska, K., and Parzuchowska, K. (2019). "Prawa pacjenta psychiatrycznego I standardy opieki psychiatrycznej," in *II Mental Health Congress, 3rd June 2019, Warsaw*.

Clarke, A. E., Mamo, L., Fishman, J. R., Shim, J. K., and Fosket, J. R. (2003). Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. *Am. Sociol. Rev*. 68, 1519765. doi: 10.2307/1519765

Coppock, V. (2020). Psychiatrised childhoods. *Glob. Stud. Childhood.* 10, 3–11. doi: 10.1177/2043610620901361

Dew, K., and Jutel, A. (2014). "Introduction," in *Social Issues in Diagnosis. An Introduction for Students and Clinicians*, eds K. Dew and A. Jutel (Chicago, IL: Johns Hopkins University Press), 1–14. doi: 10.1057/9781137332646.0004

Dzieci sie licza (2017). *Raport o zagrozeniach bezpieczeństwa i rozwoju dzieci w Polsce (2017). Dziecko krzywdzone. Teoria, badania, praktyka*, 16. Fundacja Dajemy Dzieciom Siłe: Warszawa.

Ebeling, M. (2011). "Get with the Program!": pharmaceutical marketing, symptom checklists and selfdiagnosis. *Social Sci. Med.* 73, 825–832. doi: 10.1016/j.socscimed.2011.05.054

Foucault, M. (2003). *Abnormal: Lectures at the Collège de France, 1974–1975 (1st Picador USA ed., Lectures at the Collège de France)*. New York, NY: Picador.

Foucault, M. (2008). *The Birth of Biopolitics: Lectures at the Collège de France 1978-1979*. New York, NY: Palgrave, Macmillan.

Furedi, F. (2004). *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. London; New York, NY: Routledge.

Gessen, M. (2020). *Judith Butler Wants Us to Reshape Our Rage. Interview*. The New Yorker. Available online at: https://www.newyorker.com/culture/the-new-yorker-interview/judith-butler-wants-us-to-reshape-our-rage?mbid=social_facebook&utm_source$=$facebook&utm_brand$=$tny&utm_social-type$=$owned&utm_medium$=$social&fbclid$=$IwAR1zUj7ctFLJu42lHmtwgHP8i-ioX84GqBiqmrKTHUlZ6Bm_nNhxc7b263E (accessed August 28, 2020).

Golightley, S. (2020). Troubling the "troubled teen industry: adult reflections on youth experiences of therapeutic boarding schools. *Glob. Stud. Childhood* 10, 53–63. doi: 10.1177/2043610619900514

Goodwin,D., and Mc Connell, T. (2014). "Diagnostic work: a disorderly process," in *Social Issues in Diagnosis. An Introduction for Students and Clinicians*, eds K. Dew and A. Jutel (Chicago, IL: Johns Hopkins University Press), 33–46.

Howell, S. (2006). Adoption of the unrelated child: Some challenges to the anthropological study of kinship. *Ann. Rev. Anthropol.* 38, 149–166. doi: 10.1146/annurev.anthro.37.081407.085115

Janus, Z. (2022). "Zataczam koło. Zapiski opiekuna zastepczego," in *Dzieci z nie-miejsc. Kiedy doświadczenie staje sie opowieścia*, eds A. Witeska-Młynarczyk, E. Maciejewska-Mroczek, and A. Krawczak (Oficyna Naukowa: Warszawa), *[in print]*.

Jenkins, J. (2015). *Extraordinary Conditions. Culture and Experience in Mental Illness*. Oakland, CA: University of California Press. doi: 10.1525/9780520962224

Jutel, A. (2011). *Putting a Name to It. Diagnosis in Contemporary Society*. Baltimore, MD: Johns Hopkins University Press.

Jutel, A. (2018). "Foreword," in *Diagnostic Fluidity: Working with Uncertainty and Mutability*, eds N. Nissen and M. Bech Risør (Tarragona: URV Publications), 7–10.

Krawczak, A. (2022). "Dzieci z nie-miejsc. Fikcyjna autoetnografia skonstruowanego rodzicielstwa," in *Dzieci z nie-miejsc. Kiedy doświadczenie staje sie opowieścia*, eds A. Witeska-Młynarczyk, E. Maciejewska-Mroczek, and A. Krawczak (Oficyna Naukowa: Warszawa), *[in print]*.

Leinaweaver, J. (2018). "Adoption," in *The Cambridge Encyclopedia of Anthropology*, eds F. Stein, S. Lazar, M. Candea, H. Diemberger, J. Robbins, A. Sanchez, et al. (Cambridge: Cambridge University Press), 18. doi: 10.29164/18adopt

Liegghio, M. (2016). Too young to be mad: disabling encounters with 'normal' from the perspectives of psychiatrized youth. *Intersectionalities* 5, 110–129.

Maciejewska-Mroczek, E., and Witeska-Młynarczyk, A. (2021). Managing the Past in the Context of (Dis)Closed Adoption in Poland. *Revue des sciences sociales*. 66, 78–87. doi: 10.4000/revss.7377

Maciejewska-Mroczek, E., and Witeska-Młynarczyk, A. (2022). "Powiedzenie, ze jesteśmy troszke inna rodzina, nie jest niczym złym. O procesach cywilizowania w kontekście adopcji w Polsce," in *Procesy cywilizowania dzieci*, eds Z. Boni, and M. Rakoczy (Oficyna Naukowa: Warszawa), [in print].

Malacrida, C. (2004). Medicalization, ambivalence and social control. Mother's descriptions of educators and ADD/ADHD. *Health* 1, 61–80. doi: 10.1177/1363459304038795

Mol, A. (2002). *The Body Multiple. Ontology in Medical Practice*. Durham: Duke University Press. doi: 10.1215/9780822384151

Nissen, N., and Bech Risør, M. (2018). "Configurations of diagnostic processes and practices. an introduction," in *Diagnostic Fluidity. Working with Uncertainty and Mutability*, eds N. Nissen and M. Bech Risør (Terragona: Publications URV), 11–32.

Nowakowski, M. (2015). *Medykalizacja i demedykalizacja. Zdrowie i choroba w czasach kapitalizmu zdezorganizowanego*. Lublin: Wydawnictwo UMCS.

Pawliczuk, W., and Kazmierczak-Mytkowska, A. (2014). Zaburzenia psychiczne oraz potrzeby terapeutyczne dzieci i młodziezy przebywajacych w placówkach opiekuńczo-wychowawczych (domach dziecka). *Psychiatria i Psychologia Kliniczna*. 14, 140–144. doi: 10.15557/PiPK.2014.0021

Philips, Ch. (2006). Medicine goes to school: teachers as sickness brokers for ADHD. *PLoS Med.* 3, 433–435. doi: 10.1371/journal.pmed.0030182

Potocka, B. (2022). "Adopcja Joanny," in *Dzieci z nie-miejsc*. Kiedy doświadczenie staje sie opowieścia, eds A. Witeska-Młynarczyk, E. Maciejewska-Mroczek, and A. Krawczak (Oficyna Naukowa: Warszawa),1.

Przysposobienie w latach 2000-2018 oraz w pierwszym półroczu 2019 (2019). *Ministerstwo Rodziny i Polityki Społecznej*. Available online at: https://www.gov.pl/web/rodzina/667informacje-statystyczne (accessed January 30, 2022).

Pucułek, A. Nie ma dnia bez próby samobójczej (2019). *Gazeta Wyborcza 08.03.2019*.

Rose, N. (1989). *Governing the Soul: The Shaping of the Private Self*. London: Free Association Books.

Rose, N. (1996). *Inventing Ourselves: Psychology, Power, and Personhood (Cambridge Studies in the History of Psychology)*. Cambridge; New York, NY: Cambridge University Press. doi: 10.1017/CBO9780511752179

Roux, S., and Vozari, A. (2017). *Parents at Their Best: The Ethopolitics of family bonding in France. Ethnography*. London: SAGE Publications, 1–22. doi: 10.1177/1466138116687592

Skiepko, M., and Brągoszewska, J. (2009). Zaburzenia psychiczne u dzieci adoptowanych. *Psychiatria i Psychologia Kliniczna* 9, 207–213.

Szmajda, R., and Gmitrowicz, A. (2018). Selected mental health problems in institutionally reared children. *Psychiatria i Psychologia Kliniczna* 4, 354–363. doi: 10.15557/PiPK.2018.0043

Timmermans, S., and Buchbinder, M. (2010). Patients-in-waiting: living between sickness and health in the genomics era. *J. Health Soc. Behav*. 51, 408–423. doi: 10.1177/0022146510386794

Walewski, P. (2018). Psychiatria dziecięca na zakręcie? Już za nim. Właśnie runęła w przepaść" in *Tygodnik Polityka 14.12.2022*.

Wendell, S. (1996). *The Rejected Body. Feminist Philosophical Reflections on Disability*. New York, NY; London: Routledge.

Witeska-Młynarczyk, A. (2018). "Enacting ADHD diagnosis in the landscape of care in Poland," in *Diagnostic Fluidity: Working With Uncertainty and mutability*, eds N. Nissen and M. Bech Risor (Tarragona: URV Publicacions), 1.

Witeska-Młynarczyk, A. (2020). "Neurotechnology goes to Polish school. An ethnographic story about scanning ADHD. *Ethnologia Polona* 40, 67–90. doi: 10.23858/EthP40.2019.005

Witeska-Młynarczyk, A. (2022a). "Opieka na pograniczu," in *Dzieci z nie-miejsc*. Kiedy doświadczenie staje sie opowieścia, eds A. Witeska-Młynarczyk, E. Maciejewska-Mroczek, and A. Krawczak (Warszawa; Oficyna Naukowa), *[in print]*.

Witeska-Młynarczyk, A. (2022b). Potkniecia. Etnograficznie o psychiatryzacji dzieci i młodziezy w kontekście adopcji zamknietej w Polsce. *Etnografia: Praktyki, Teorie, Doświadczenia*. 8 [in print].

Wykonywanie zadań przez ośrodki adopcyjne (2017). *Informacja o wynikach kontroli*. Najwyzsza Izba Kontroli: Warszawa. Available online at: https://www.nik.gov.pl/kontrole/P/17/044/ (accessed January 30, 2022).

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Teachers With Special Needs. De-Psychiatrization of Children in Schools

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Psychiatrization not only affects adults. Ever more children in Western countries are being diagnosed with a mental disorder of behavior, such as ADHD. Children may often be labelled with the best intentions, for example in order to be able to provide them with suitable care and guidance. However, this labelling can have exclusionary effects and often entails the consequence that important discussion about contextual factors that give rise to (the perception of) unwelcome behavior or academic underperformance rarely, if at all, takes place. In this article we contend that although children are of central concern to schools and the design of pupils' education, it is important not to make pupils the sole owner of problems that arise. It is therefore high time that a far more critical normative stance towards inclusive education is taken, in which the presently widespread biomedical approach is met with a school community response that focuses not on the nature of individual disorders but on the special need for additional capacity that *schools* and *teachers* have in meeting (perceived) deviant behaviors and emotions and/or academic underperformance. We argue that teaching should not set out to remedy individual diagnoses, but that teachers should be supported to extend their professional competence to the benefit of all pupils.

Keywords: education, psychiatrisation, special educational needs, inclusive education /schools, teacher competence, teacher agency

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INTRODUCTION

Psychiatrization not only affects adults. Compared with adult mental health care, the mental health care of young people in Western countries has increased even more rapidly (Olfson et al., 2014; Steinhausen, 2015). Epidemiological studies estimate that one in eight children nowadays meet criteria for a mental disorder (Polanczyk et al., 2015; Barican et al., 2021). Parent surveys in the US found child diagnosis rates of 9.5% for ADHD, 7.4% for behavioral/conduct disorders, 7.1% for anxiety, 3.2% for depression, and 2.5% for autism spectrum disorder (Ghandour et al., 2019; Zablotsky et al., 2019). The vast majority of these diagnosed children exhibit mild to moderate problems, while only around 10% of cases are perceived as severe. Despite that, the sharp rise in childhood psychiatric diagnoses has coincided with increased psychotropic medication use among children. A recent meta-analysis on the annual pediatric psychotropic drug prescription prevalence reports global estimates of 15.3% for ADHD medications, 6.4% for antidepressants and 5.5% for antipsychotics (Piovani et al., 2019).

Concerns about the long term safety of medication, overtreatment and overdiagnosis of youths have increased alongside the rapid rise in child psychiatric classifications and treatments (Frances and Batstra, 2013; Rapoport, 2013; Barnett et al., 2020). Especially in the large group of children and youngsters with mild to moderate problems, the benefits of a classification—such as greater understanding and support—may not outweigh its potential harms, like stigma, self-stigma, underperformance due to self-fulfilling prophecies, and side-effects of medical treatment (Batstra et al., 2012). While diagnosis can promote social identification and acceptance, and children themselves sometimes actively engage in their own psychiatrization, it can also lead to social alienation, invalidation and stigmatization (O'Connor et al., 2018; Beeker et al., 2020). Psychiatric diagnoses in youth are associated with social exclusion in later life (Ringbom et al., 2021). A final drawback of diagnostic inflation is that expansive diagnostic procedures and specialized treatments for mild problems entail problematically high youth care costs and draw resources away from severely troubled children and families, who need it the most.

Various scholars (e.g., Timimi, 2015) and governments (e.g., Health Council of the Netherlands, 2014) appeal for the demedicalization and normalization of child emotional and behavioral problems. If we do wish to turn the tide on the rising rate of childhood mental disorder diagnoses, one of the first places to start are schools. Schools and teachers often play an important role in initiating the first steps toward psychiatric assessments and treatments of children (Sax and Kautz, 2003; Harwood and Allen, 2014; Russell et al., 2016; Wienen, 2019). This article takes a closer look at this process and offers one suggestion likely to contribute to less labelling and greater inclusion of children with diverse emotions and behaviors.

REIFICATION IN SCHOOLS

Why do teachers tend to suspect that a psychiatric disorder is present in a child that underperforms and/or exhibits challenging or internalizing behavior? There are countless variables present in children and their environments, in teachers, teaching and school environments, and in educational systems generally, that are at least as influential as children's mental states. One answer to the question is the widespread tendency to mistake a confirmed diagnosis for an explanation for the problems at hand: this factor plays an important role in the rise in childhood psychiatric diagnosis. The process behind this is called reification, which literally means making a thing out of something that lacks object qualities. In the case of psychiatric disorders, it means that our descriptions and naming of groups of problematic behaviors and emotions—notably the mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), a handbook consulted by psychiatrists and psychologists all over the world—are transformed into concrete neurobiological entities that are believed to cause adverse behaviors and emotions, whereas the latter are in fact merely *described* (Hyman, 2010).

In the words of one of the most influential English philosophers of the 19th century, John Stuart Mill (1806-73), the tendency to reify is the tendency "to believe that whatever received a name must be an entity or being, having an independent existence of its own". This tendency is strongly present in the now dominant biomedical paradigm (Scull, 2021). A main focus in biomedical research and in biomedical education about disorders is the supposed biological underpinnings of mental disorders. However, despite decennia of expensive brain research with ever better equipment and technologies, not a single biomarker has been found for any of the disorders defined in the DSM (Scull, 2021). Nevertheless, publication bias in favour of positive study results (Glasziou and Chalmers, 2017) push ambitious brain researchers to exaggerate their findings. Small detected average group differences are reported as if they apply to every single person with a disorder (Meerman et al., 2020). This so-called ecological fallacy, or the erroneous generalization of a mean group difference to the individual, is both widespread and persistent.

In today's demanding school environments, hitting upon a suitable neurobiological label that is thought to explain underperformance and deviant behaviors can be a godsend. When a psychiatric diagnosis is made in a child, underachievement and challenging behaviors can be attributed to the disorder, removing guilt and responsibility from teachers, parents and pupils (Wienen et al., 2019). This makes room for a new starting point in the dialogue between parents, teachers and children, along with a shared disorder language and new intervention ideas (Honkasilta et al., 2016). While this collaboration may in principle benefit children, it also makes them the sole owner of problems that in fact arose in a specific context. In addition, an individual diagnosis may create the spurious impression that the cause of problems has been identified. This in turn may stop teachers from trying to find the underlying issues or triggers for problematic behavior or poor academic performance, so that the impact of contextual factors on those remains hidden and in place.

INCLUSIVE EDUCATION: TWO MODELS

The dominance of individual over contextual approaches is also visible in the application of inclusive education (Wienen, 2019). Inclusive education is the policy ideal that all children receive education at a regular school. This ideal is defined in the UNESCO Salamanca Statement and Framework for Action (UNESCO, 1994, p. 8). Regular schools with an inclusive orientation are seen as the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society, and achieving education for all.

Roughly speaking, two different approaches to inclusive education can be identified: the biomedical and the community approach (Wienen, 2019). The first takes individual children with a disorder or disability as the starting point and is based on the notion that either education must be adapted to enable each child to attend school, or that individual children need specialist help in adjusting to a life in school. The approach essentially presupposes that a gap exists between how some children are and what school expects of them, and that specialists are needed to try and close that gap. The second approach on the other hand, takes education in context and community life as starting points. The focus is on organizing educational context in such a way that every unique child can flourish and be educated, so that special educational needs cease to exist. This alternative approach essentially presupposes and values diversity, so that good fit between children and schooling is inevitably a matter of constant mutual adjustment, involving the entire school community in making suitable accommodations and enable diverse childhoods. Moreover, the approach facilitates the idea that the ability to adjust to and accommodate difference is a skill that is commensurate with—and perhaps even essential to—the exercise of democracy and the practice of tolerance. Worth noting perhaps is that the distinction between biomedical and community approaches seems to reduplicate a distinction between categorical and relational perspectives that has long been commonplace in Nordic reasoning about inclusive education ambitions (Nilholm 2005). It also reflects the individual versus the social models of disability, which were developed in the mid-1970s by the Union of the Physically Impaired Against Segregation and popularized by the British sociologist Mike Oliver in the early 1980s (Oliver, 2013). The point of pursuing a social rather than medical model of disability was to stimulate professionals to work more from the standpoint that people are not disabled by handicap but by disabling barriers they face in society.

Even a cursory glance at how education is presently organized and what sort of expertise tends to be applied to problems of fit between children and schooling makes it clear that the biomedical model dominates in present inclusive education, even though it is based on the conflicting reasoning of first excluding a child by labelling it as disordered (e.g., ADHD, autism, ODD) and then take this disorder as a reason for inclusion (Dalkilic and Vadeboncoeur, 2016). The language used to describe problems in the classroom influences teachers' expectations and interactions with pupils (Heagele and Hodge, 2016). When child behavior problems are perceived to be the result of a neurobiological disorder that causes "symptoms" like hyperactivity, teachers may feel less responsible and self-efficient than when behavior is viewed as the result of many factors, including interactions that take place in the school context (Meerman et al., 2017).

Following a 1978 report by Mary Warnock in the UK (Warnock, 1978) that introduced the term special educational needs (SEN), the educational sciences have strived to replace a discourse of social misfits, deviancy and disorder with a discourse that emphasizes that children's needs are either ordinary and so fully met by regular educational provisions, or special and thereby requiring substantive additional effort on the part of teachers. Supposedly, the question should no longer be what the child *has*, but should focus on what the child *needs* (Warnock, 2005). However, making the distinction between ordinary and special needs still involves highly normative and subjective (that is: *pragmatic*) value judgements of what is normal and what is deviant. The judgment also still presupposes that there is suitably independent, reliable, equitable and widely recognized professional expertise on hand to make safe judgments about who is special and who is not. Further, this distinction still rests essentially in (and perhaps even naturalizes) a process of categorization and the labelling of children. Aside from this being potentially stigmatizing, it reinforces and perpetuates the idea of education performing an important sorting function in the social system (Abbs, 1994; Luhmann and Schorr, 2000), with the power to predetermine life courses. In light of the need for independent and dependable judgment across categories that are both stable and able to generate widespread social assent, it is hardly surprising that the "special need" rhetoric now commonplace across education systems the world over has itself too come to be based on the biomedical model with its individualistic, psycho-medical, "natural kind" assumptions about the nature and origins of disability and difference, in which all the problems are explained by the individual's biological or somatic deficits (Vehmas, 2010). Hence, the field of special education has itself contributed to the psychiatrization and educational displacement of children. The community, relational or social disability approach of inclusive education, in which schools are organized in such a broadly accommodating and welcoming manner that special education needs cease to exist—and as important, mirror the wide variation among children at all levels of school staffing—still seems far away from todays' reality (Oliver, 2013).

TEACHERS WITH SPECIAL NEEDS

If one wished to pursue a community approach of inclusive education, and leave behind the trap of biomedical reasoning in which some children are first singled out as unacceptably different, then labelled with having special needs and then made a target for educational inclusion, a simple change in language might be a good start. The change proposed here is to replace the common phrase "pupils with special needs" by "teachers with special needs". A discourse that focuses on the needs that teachers encounter while addressing specific problems in their class, shifts the focus from considering disorders within children towards problems that teachers *de facto* have with educating some pupils. This may counterbalance the rise in confirmed psychiatric diagnoses in children and facilitate implementation of the community approach of inclusive education.

A second advantage of speaking of teachers with special needs has to do with the connotation of the word "special". While "special" can contain either a positive or a negative value judgement, in its connection with the phrase "children with special needs" it usually refers to an undesirable characteristic or way of functioning of the child (Wilson, 2002). Would we use it for the needs of teachers however, special might point in a more neutral or even positive direction, for example towards making a challenging job successful or having an optimistic attitude towards solving classroom problems. To make true inclusive education happen, teachers and education professionals generally might be encouraged to think and communicate about what they need in order to realize an inclusive educational environment, one in which all or most children can flourish. Hence, with the special needs we propose, teachers have concern for their need for training, coaching and development as a professional in the context of particular challenges to successful teaching.

A last important potential benefit of adopting the proposed change in language would be the agency and responsibility it gives back to teachers. While individualistic medical assumptions and language disempower teachers and ask them to accept recommendations and conclusions suggested by non-educational specialists such as psychiatrists and doctors, speaking in terms of teacher needs when dealing with problems in the context of the classroom brings the agency and responsibility back to them and to pedagogy (Meerman et al., 2017). The dominant biomedical framing of emotional, behavioral and learning problems diverts attention and resources towards biomedical professionals, at the expense of educational professionals. Those resources might instead be available to education professionals, such as teachers, who are directly involved in the education and development of children on a daily basis.

POLICY AND PRACTICE

Internationally agreed goals of educational equity are captured in “school for all” and inclusive education policy, as well as in the UN’s 4th sustainable development goal, which is about access to quality education for all. With respect to educational policy, we note that our call to arrest the growing trend towards psychiatrization and medicalization of child behavior, implies that no major change in policy direction is necessary. Instead of altering policy, we suggest rigorously moving the focus of educational policy implementation away from conceiving of children as having educational needs, to recognizing that children, whatever their individual characteristics and capacities, all have exactly the same access and participation rights. It is education systems and schools that need to deliver parity, and towards that end teachers need to develop special capacities. Our call is therefore not to change policy, but to attend far more critically to the true object of that policy.

This highlights the contrary effects of what the biomedical language that is presently used foregrounds—namely, individual children being labelled as needy—and what that language hides: that education systems, schools and teachers need to develop a special capacity for educational inclusion. Within a community approach of inclusive education the child is not fit to the demonstrable needs of the education system, but professional capacities in schools are raised towards teaching that better fits ever more diverse classrooms.

Our proposal to re-center the meaning of special education on the problems that schools apparently have with educating some children may seem radical or even reactionary to some supporters of special or inclusive education. Yet this idea is neither without precedent nor without good practice. Existing descriptions of educational consulting and schools-based intervention have centered on the assumption that classroom problems are substantively inherent in how schools and classrooms work, in the roles that teachers play and in the assumptions they make (Dinkmeyer et al., 2016). Similarly, in the Netherlands a national network of school support services have long included a form of educational consulting whereby questions that teachers have about teaching pupils are consistently treated as issues of pedagogy and didactics. It is thought that this consultatory foregrounding of pedagogy and didactics are part of a prevention strategy or “good care perspective” aimed at resolving classroom problems before they become a hindrance (Meijer, 2019). A key practice component entailed in the Dutch “CLB” approach (*consultatieve leerlingbegeleiding*, or consultative learner guidance) is that trained coaches guide teachers into framing all discussion of problems that teachers report to them as challenges to professional teaching in a given classroom context. Hence, we could also name this practice Consultative *Teacher* Guidance. The coaching focuses on alternative choices that might be made in pedagogy, didactics, resources, classroom management, and so on—instead of supposing that problems originate in the traits of a particular pupil. The guiding assumption is that a classroom of pupils will inevitably entail a mix of mental and physical traits, while an exciting challenge of teaching is precisely to meet pupils’ learning with optimally adjusted classroom practice even so. The value of this kind of approach was confirmed in empirical studies that assessed the role that educational consultation can play in resolving problems that arise between pupils, parents and educators (Sheridan et al., 1990; Elliott and Sheridan, 1992), including such consultation providing a solid basis for standards of accountability that schools have for educating all pupils (Roach and Elliott, 2009).

DISCUSSION

We have argued that the rise in childhood disorders will in part be attributable to the widespread support there is in contemporary education praxis for biomedical views on children who are taken to deviate substantively from implicit norms set for standard (as opposed to special) educational effort. This routine sorting of children in the education system into supposedly “normal” children and “special” children (or children with special needs) has historical antecedents and has long made special education a growth sector (Dekker, 2009; Tomlinson, 2012). Yet with the rise of clinical psychiatry and diagnosis, this sorting mechanism has been given a new biomedical foundation and warrant, and given it entirely new growth potential. The symbiosis that has developed, between the psychiatric diagnosis of supposed childhood mental disorders and the sorting of children across regular and special education, has most likely contributed to inflating the numbers of children classified with mental disorders, as well as increased the amount of childhood psychotropic drug prescriptions in the last few decades.

Locating the problems that teachers have with educating some children in an expanding range of individual conditions may be considered progressive in clinical or medical terms, but the consequence of doing so is that children become the sole owners of what are in essence pedagogical issues and challenges in teaching. Diagnosing children with mental disorders inevitably involves a stigmatizing form of subjecting children to potentially lifelong treatment or management of internalized mental conditions. There is meantime little evidence that raising teacher's awareness of supposedly neuropsychiatric conditions in fact brings about more successful educational inclusion, and indeed regular school teachers generally remain weary of including children with more severe conditions in their classrooms (Pijl, 2010; Saloviita, 2020).

One way out of the far-reaching consequences of present high levels of psychiatric diagnosis of mental disorder in children is to explicitly recognize that education systems sort children by the level of special effort that teachers need to make in educating them. A first step in reversing the psychiatrization of children in education is therefore to recognize that teachers have special needs. Depending on the level of variation among pupils in a given classroom, they may need particular support in order to do inclusive education well. This acknowledges that teachers are likely to face special teaching problems that need then to be addressed with additional resources, effort or professional development. In a *truly* inclusive education system, no child has special educational needs. Instead, teachers are enabled to muster the special powers that they may sometimes need in order to support and nurture every child's capacities for learning equally, while valuing childhood diversity. Our proposal of shifting the attention in policy and discourse from pupils to teachers having special needs draws a principled pedagogical conclusion from an undesirable state of affairs: the increasing reification of biomedical knowledge is making individual pupils, rather than school communities, the stigmatized owners of problems that arise in education and the education system.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author.

AUTHOR CONTRIBUTIONS

All authors listed have made a substantial, direct, and intellectual contribution to the work and approved it for publication.

REFERENCES

Abbs, P. (1994). *The Educational Imperative: A Defence of Socratic and Aesthetic Learning*. London: Falmer Press.

Barican, J. L., Yung, D., Schwartz, C., Zheng, Y., Georgiades, K., and Waddell, C. (2021). Prevalence of Childhood Mental Disorders in High-Income Countries: a Systematic Review and Meta-Analysis to Inform Policymaking. *Evid. Based Ment. Health*, ebmental-2021-300277. Advance online publication. doi:10.1136/ebmental-2021-300277

Barnett, E. R., Trepman, A. Z., Fuson, H. A., Acquilano, S. C., McLaren, J. L., Woloshin, S., et al. (2020). Deprescribing Psychotropic Medications in Children: Results of a National Qualitative Study. *BMJ Qual. Saf.* 29 (8), 655–663. doi:10.1136/bmjqs-2019-010033

Batstra, L., Hadders-Algra, M., Nieweg, E., Van Tol, D., Pijl, S. J., and Frances, A. (2012). Childhood Emotional and Behavioral Problems: Reducing Overdiagnosis without Risking Undertreatment. *Dev. Med. Child. Neurol.* 54 (6), 492–494. doi:10.1111/j.1469-8749.2011.04176.x

Beeker, T., Witeska-Młynarczyk, A., te Meerman, S., and Mills, C. (2020). Psychiatrization of, with and by Children: Drawing a Complex Picture. *Glob. Stud. Child.* 10 (1), 12–25. doi:10.1177/2043610619890074

Centers for Disease Control and Prevention (2013). Mental Health Surveillance Among children-United States, 2005–2011. *Morbidity Mortality Weekly Rep.* 62 (02), 1–35.

Dalkilic, M., and Vadeboncoeur, J. A. (2016). Re-conceptualizing Inclusive Education through the Capability Approach: Elaborating the Theory and Practice of Relational Inclusion. *Glob. Edu. Rev.* 3 (3), 122–137.

Danielson, M. L., Bitsko, R. H., Ghandour, R. M., Holbrook, J. R., Kogan, M. D., and Blumberg, S. J. (2018). Prevalence of Parent-Reported ADHD Diagnosis and Associated Treatment Among U.S. Children and Adolescents, 2016. *J. Clin. Child. Adolesc. Psychol.* 47 (2), 199–212. doi:10.1080/15374416.2017.1417860

Dekker, J. J. H. (2009). Children at Risk in History: A story of Expansion. *Paedagogica Historica* 45 (1–2), 17–36. doi:10.1080/00309230902746206

Dinkmeyer, D. C., Carlson, J., and Michel, R. E. (2016). *Creating School-Based Interventions*. 4th edition. New York: Routledge.

Elliott, S. N., and Sheridan, S. M. (1992). Consultation and Teaming: Problem Solving Among Educators, Parents, and Support Personnel. *Elem. Sch. J.* 92 (3), 315–338. doi:10.1086/461695

Frances, A., and Batstra, L. (2013). Why So many Epidemics of Childhood Mental Disorder? *J. Dev. Behav. Pediatr.* 34 (4), 291–292. doi:10.1097/DBP.0b013e31829425f5

Ghandour, R. M., Sherman, L. J., Vladutiu, C. J., Ali, M. M., Lynch, S. E., Bitsko, R. H., et al. (2019). Prevalence and Treatment of Depression, Anxiety, and Conduct Problems in US Children. *J. Pediatr.* 206, 256–e3. e3. doi:10.1016/j.jpeds.2018.09.021

Glasziou, P., and Chalmers, I. (2017). *Can it Really Be True that 50% of Research Is Unpublished?* The BMJ Opinion. Available at: https://blogs.bmj.com/bmj/2017/06/05/paul-glasziou-and-iain-chalmers-can-it-really-be-true-that-50-of-research-is-unpublished/.

Haegele, J. A., and Hodge, S. (2016). Disability Discourse: Overview and Critiques of the Medical and Social Models. *Quest* 68 (2), 193–206. doi:10.1080/00336297.2016.1143849

Harwood, V., and Allan, J. (2014). *Psychopathology at School: Theorizing Mental Disorders in Education*. Abingdon: Routledge.

Health Council of the Netherlands (2014). *Participation by Young People with Mental Health Problems*. The Hague: Health Council of the Netherlands. publication no. 2014/18.

Honkasilta, J., Vehkakoski, T., and Vehmas, S. (2016). 'The Teacher Almost Made Me Cry' Narrative Analysis of Teachers' Reactive Classroom Management Strategies as Reported by Students Diagnosed with ADHD. *Teach. Teach. Edu.* 55 (4), 100–109. doi:10.1016/j.tate.2015.12.009

Hyman, S. E. (2010). The Diagnosis of Mental Disorders: the Problem of Reification. *Annu. Rev. Clin. Psychol.* 6, 155–179. doi:10.1146/annurev.clinpsy.3.022806.091532

Luhmann, N., and Schorr, K. E. (2000). *Problems of Reflection in the System of Education*. Waxmann.

Te Meerman, S., Batstra, L., Grietens, H., and Frances, A. (2017). ADHD: a Critical Update for Educational Professionals. *Int. J. Qual. Stud. Health Well-being* 12 (Suppl. 1), 1298267. doi:10.1080/17482631.2017.1298267

Te Meerman, S., Batstra, L., Freedman, J. E., Hoekstra, R., and Grietens, H. (2020). ADHD and Brain Anatomy: What Do Academic Textbooks Used in the Netherlands Tell Students? *Child. Soc.* 34 (2), 136–150. doi:10.1111/chso.12362

Meijer, W. (2019). *Consultatieve leerlingbegeleiding: Professionalisering en onderwijsverbetering*. 's-Hertogenbosch: Gompel&Svacina.

Nilholm, C. (2005). Specialpedagogik: Vilka är de grundläggande perspektiven? *Pedagogisk forskning i Sverige* 10 (2), 124–138.

O'Connor, C., Kadianaki, I., Maunder, K., and McNicholas, F. (2018). How Does Psychiatric Diagnosis Affect Young People's Self-Concept and Social Identity? A Systematic Review and Synthesis of the Qualitative Literature. *Soc. Sci. Med.* 212, 94–119. doi:10.1016/j.socscimed.2018.07.011

Olfson, M., Blanco, C., Wang, S., Laje, G., and Correll, C. U. (2014). National Trends in the Mental Health Care of Children, Adolescents, and Adults by

Office-Based Physicians. *JAMA psychiatry* 71 (1), 81–90. doi:10.1001/jamapsychiatry.2013.3074

Oliver, M. (2013). The Social Model of Disability: Thirty Years on. *Disabil. Soc.* 28 (7), 1024–1026. doi:10.1080/09687599.2013.818773

Pijl, S. J. (2010). Preparing Teachers for Inclusive Education: Some Reflections from the Netherlands. *J. Res. Spec. Educ. Needs* 10 (1), 197–201. doi:10.1111/j.1471-3802.2010.01165.x

Piovani, D., Clavenna, A., and Bonati, M. (2019). Prescription Prevalence of Psychotropic Drugs in Children and Adolescents: an Analysis of International Data. *Eur. J. Clin. Pharmacol.* 75 (10), 1333–1346. doi:10.1007/s00228-019-02711-3

Polanczyk, G. V., Salum, G. A., Sugaya, L. S., Caye, A., and Rohde, L. A. (2015). Annual Research Review: A Meta-Analysis of the Worldwide Prevalence of Mental Disorders in Children and Adolescents. *J. Child. Psychol. Psychiatry* 56 (3), 345–365. doi:10.1111/jcpp.12381

Rapoport, J. L. (2013). Pediatric Psychopharmacology: Too Much or Too Little? *World Psychiatry* 12 (2), 118–123. doi:10.1002/wps.20028

Ringbom, I., Suvisaari, J., Kääriälä, A., Sourander, A., Gissler, M., Ristikari, T., et al. (2021). Psychiatric Disorders Diagnosed in Adolescence and Subsequent Long-Term Exclusion from Education, Employment or Training: Longitudinal National Birth Cohort Study. *Br. J. Psychiatry*, 1–6. doi:10.1192/bjp.2021.146

Roach, A. T., and Elliott, S. N. (2009). Consultation to Support Inclusive Accountability and Standards-Based Reform: Facilitating Access, Equity, and Empowerment. *J. Educ. Psychol. Consultation* 19 (1), 61–81. doi:10.1080/10474410802463320

Russell, A. E., Moore, D. A., and Ford, T. (2016). Educational Practitioners' Beliefs and Conceptualisation about the Cause of ADHD: A Qualitative Study. *Emotional Behav. Difficulties* 21 (1), 101–118. doi:10.1080/13632752.2016.1139297

Saloviita, T. (2020). Teacher Attitudes towards the Inclusion of Students with Support Needs. *J. Res. Spec. Educ. Needs* 20, 64–73. doi:10.1111/1471-3802.12466

Sax, L., and Kautz, K. J. (2003). Who First Suggests the Diagnosis of Attention-Deficit/hyperactivity Disorder? *Ann. Fam. Med.* 1 (3), 171–174. doi:10.1370/afm.3

Scull, A. (2021). American Psychiatry in the New Millennium: a Critical Appraisal. *Psychol. Med.* 51, 1–9. doi:10.1017/S0033291721001975

Sheridan, S. M., Kratochwill, T. R., and Elliott, S. N. (1990). Behavioral Consultation with Parents and Teachers: Delivering Treatment for Socially Withdrawn Children at Home and School. *Sch. Psychol. Rev.* 19 (1), 33–52. doi:10.1080/02796015.1990.12087337

Steinhausen, H. C. (2015). Recent International Trends in Psychotropic Medication Prescriptions for Children and Adolescents. *Eur. Child. Adolesc. Psychiatry* 24 (6), 635–640. doi:10.1007/s00787-014-0631-y

Timimi, S. (2015). Children's Mental Health: Time to Stop Using Psychiatric Diagnosis. *Eur. J. Psychotherapy Counselling* 174, 342–358. doi:10.1080/13642537.2015.1094500

Tomlinson, S. (2012). The Irresistible Rise of the SEN Industry. *Oxford Rev. Edu.* 38 (3), 267–286. doi:10.1080/03054985.2012.692055

UNESCO (1994). *The Salamanca Statement and Framework for Action on Special Needs Education*. Paris: UNESCO.

Vehmas, S. (2010). Special Needs: a Philosophical Analysis. *Int. J. Inclusive Edu.* 14 (1), 87–96. doi:10.1080/13603110802504143

Warnock, M. (2005). *Special Educational Needs: A New Look. Impact Series, No. 11 in a Series of Policy Discussions.* Philosophy of Education Society of Great Britain.

Warnock, M. (1978). *Special Educational Needs: Report of the Committee of Enquiry into the Education of Handicapped Children and Young People (Warnock Report)*. HMSO.

Wienen, A. W. (2019). *Inclusive Education: From Individual to Context*. Groningen: Thesis University of Groningen.

Wienen, A. W., Sluiter, M. N., Thoutenhoofd, E., de Jonge, P., and Batstra, L. (2019). The Advantages of an ADHD Classification from the Perspective of Teachers. *Eur. J. Spec. Needs Edu.* 34 (5), 649–662. doi:10.1080/08856257.2019.1580838

Wilson, J. (2002). Defining 'special Needs'. *Eur. J. Spec. Needs Edu.* 17 (1), 61–66. doi:10.1080/08856250110099024

Zablotsky, B., Black, L. I., Maenner, M. J., Schieve, L. A., Danielson, M. L., Bitsko, R. H., et al. (2019). Prevalence and Trends of Developmental Disabilities Among Children in the United States: 2009-2017. *Pediatrics* 144 (4), e20190811. doi:10.1542/peds.2019-0811

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Corrigendum: Teachers with Special Needs. De-Psychiatrization of Children in Schools

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In the original article, there was an error.

Substantive text flow breaking and reduplication of text has occurred throughout the text due to a physical error in the final proof-corrected manuscript.

A correction has been made to

The text as a whole, starting from the introduction (after the key words) up until the start of the bibliography.

The title, authors, affiliation, abstract, key words and bibliography are not affected.

The authors apologize for this error and state that this does not change the scientific conclusions of the article in any way. The original article has been updated.

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INTRODUCTION

Psychiatrization not only affects adults. Compared with adult mental health care, the mental health care of young people in Western countries has increased even more rapidly (Olfson et al., 2014; Steinhausen, 2015). Epidemiological studies estimate that one in eight children nowadays meet criteria for a mental disorder (Barican et al., 2021; Polanczyk et al., 2015). Parent surveys in the US found child diagnosis rates of 9.5% for ADHD, 7.4% for behavioral/conduct disorders, 7.1% for anxiety, 3.2% for depression, and 2,5% for autism spectrum disorder (Ghandour et al., 2019; Zablotsky et al, 2019). The vast majority of these diagnosed children exhibit mild to moderate problems, while only around 10% of cases are perceived as severe. Despite that, the sharp rise in childhood psychiatric diagnoses has coincided with increased psychotropic medication use among children. A recent meta-analysis on the annual pediatric psychotropic drug prescription prevalence reports global estimates of 15.3% for ADHD medications, 6.4% for antidepressants and 5.5% for antipsychotics (Piovani et al., 2019).

Concerns about the long term safety of medication, overtreatment and overdiagnosis of youths have increased alongside the rapid rise in child psychiatric classifications and treatments (Barnett et al., 2020; Frances & Batstra, 2013; Rapoport, 2013). Especially in the large group of children and youngsters with mild to moderate problems, the benefits of a classification—such as greater understanding and support—may not outweigh its potential harms, like stigma, self-stigma, underperformance due to self-fulfilling prophecies, and side-effects of medical treatment (Batstra et al., 2012). While diagnosis can promote social identification and acceptance, and children themselves sometimes actively engage in their own psychiatrization, it can also lead to social alienation, invalidation and stigmatization (Beeker et al, 2020; O'Connor et al., 2018). Psychiatric diagnoses in youth are associated with social exclusion in later life (Ringbom et al., 2021). A final drawback of diagnostic inflation is that expansive diagnostic procedures and specialized treatments for mild problems entail problematically high youth care costs and draw resources away from severely troubled children and families, who need it the most.

Various scholars (e.g. Timimi, 2015) and governments (e.g. Health Council of the Netherlands, 2014) appeal for the demedicalization and normalization of child emotional and behavioral problems. If we do wish to turn the tide on the rising rate of childhood mental disorder diagnoses, one of the first places to start are schools. Schools and teachers often play an important role in initiating the first steps toward psychiatric assessments and treatments of children (Harwood & Allen, 2014; Russell et al., 2016; Sax & Kautz, 2003; Wienen, 2019). This article takes a closer look at this process and offers one suggestion likely to contribute to less labelling and greater inclusion of children with diverse emotions and behaviors.

REIFICATION IN SCHOOLS

Why do teachers tend to suspect that a psychiatric disorder is present in a child that underperforms and/or exhibits challenging or internalizing behavior? There are countless variables present in children and their environments, in teachers, teaching and school environments, and in educational systems generally, that are at least as influential as children's mental states. One answer to the question is the widespread tendency to mistake a confirmed diagnosis for an explanation for the problems at hand: this factor plays an important role in the rise in childhood psychiatric diagnosis. The process behind this is called reification, which literally means making a thing out of something that lacks object qualities. In the case of psychiatric disorders, it means that our descriptions and naming of groups of problematic behaviors and emotions—notably the mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), a handbook consulted by psychiatrists and psychologists all over the world—are transformed into concrete neurobiological entities that are believed to cause adverse behaviors and emotions, whereas the latter are in fact merely described (Hyman, 2010).

In the words of one of the most influential English philosophers of the nineteenth century, John Stuart Mill (1806-73), the tendency to reify is the tendency "to believe that whatever received a name must be an entity or being, having an independent existence of its own". This tendency is strongly present in the now dominant biomedical paradigm (Scull, 2021). A main focus in biomedical research and in biomedical education about disorders is the supposed biological underpinnings of mental disorders. However, despite decennia of expensive brain research with ever better equipment and technologies, not a single biomarker has been found for any of the disorders defined in the DSM (Scull, 2021). Nevertheless, publication bias in favour of positive study results (Glasziou & Chalmers, 2017) push ambitious brain researchers to exaggerate their findings. Small detected average group differences are reported as if they apply to every single person with a disorder (Meerman et al., 2019). This so-called ecological fallacy, or the erroneous generalization of a mean group difference to the individual, is both widespread and persistent.

In today's demanding school environments, hitting upon a suitable neurobiological label that is thought to explain underperformance and deviant behaviors can be a godsend. When a psychiatric diagnosis is made in a child, underachievement and challenging behaviors can be attributed to the disorder, removing guilt and responsibility from teachers, parents and pupils (Wienen et al, 2019). This makes room for a new starting point in the dialogue between parents, teachers and children, along with a shared disorder language and new intervention ideas (Honkasilta et al., 2016). While this collaboration may in principle benefit children, it also makes them the sole owner of problems that in fact arose in a specific context. In addition, an individual diagnosis may create the spurious impression that the cause of problems has been identified. This in turn may stop teachers from trying to find the underlying issues or triggers for problematic behavior or poor academic performance, so that the impact of contextual factors on those remains hidden and in place.

INCLUSIVE EDUCATION: TWO MODELS

The dominance of individual over contextual approaches is also visible in the application of inclusive education (Wienen, 2019). Inclusive education is the policy ideal that all children receive education at a regular school. This ideal is defined in the UNESCO Salamanca Statement and Framework for Action (UNESCO, 1994, p. 8). Regular schools with an inclusive orientation are seen as the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society, and achieving education for all.

Roughly speaking, two different approaches to inclusive education can be identified: the biomedical and the community approach (Wienen, 2019). The first takes individual children with a disorder or disability as the starting point and is based on the notion that either education must be adapted to enable each child to attend school, or that individual children need specialist help in adjusting to a life in school. The approach essentially presupposes that a gap exists between how some children are and what school expects of them, and that specialists are needed to try and close that gap. The second approach on the other hand, takes education in context and community life as starting points. The focus is on organizing educational context in such a way that every unique child can flourish and be educated, so that special educational needs cease to exist. This alternative approach essentially presupposes and values diversity, so that good fit between children and schooling is inevitably a matter of constant mutual adjustment, involving the entire school community in making suitable accommodations and enable diverse childhoods. Moreover, the approach facilitates the idea that the ability to adjust to and accommodate difference is a skill that is commensurate with—and perhaps even essential to—the exercise of democracy and the practice of tolerance. Worth noting perhaps is that the distinction between biomedical and community approaches seems to reduplicate a distinction between categorical and relational perspectives that has long been commonplace in Nordic reasoning about inclusive education ambitions (Nilholm 2005). It also reflects the individual versus the social models of disability, which were developed in the mid-1970s by the Union of the Physically Impaired Against Segregation and popularized by the British sociologist Mike Oliver in the early 1980s (Oliver, 2013). The point of pursuing a social rather than medical model of disability was to stimulate professionals to work more from the standpoint that people are not disabled by handicap but by disabling barriers they face in society.

Even a cursory glance at how education is presently organized and what sort of expertise tends to be applied to problems of fit between children and schooling makes it clear that the biomedical model dominates in present inclusive education, even though it is based on the conflicting reasoning of first excluding a child by labelling it as disordered (e.g. ADHD, autism, ODD) and then take this disorder as a reason for inclusion (Dalkilic & Vadeboncoeur, 2016). The language used to describe problems in the classroom influences teachers' expectations and interactions with pupils (Heagele & Hodge, 2016). When child behavior problems are perceived to be the result of a neurobiological disorder that causes 'symptoms' like hyperactivity, teachers may feel less responsible and self-efficient than when behavior is viewed as the result of many factors, including interactions that take place in the school context (Meerman et al., 2017).

Following a 1978 report by Mary Warnock in the UK (Warnock, 1978) that introduced the term special educational needs (SEN), the educational sciences have strived to replace a discourse of social misfits, deviancy and disorder with a discourse that emphasizes that children's needs are either ordinary and so fully met by regular educational provisions, or special and thereby requiring substantive additional effort on the part of teachers. Supposedly, the question should no longer be what the child has, but should focus on what the child needs (Warnock,2005). However, making the distinction between ordinary and special needs still involves highly normative and subjective (that is: pragmatic) value judgements of what is normal and what is deviant. The judgment also still presupposes that there is suitably independent, reliable, equitable and widely recognized professional expertise on hand to make safe judgments about who is special and who is not. Further, this distinction still rests essentially in (and perhaps even naturalizes) a process of categorization and the labelling of children. Aside from this being potentially stigmatizing, it reinforces and perpetuates the idea of education performing an important sorting function in the social system (Abbs, 1994; Luhmann and Schorr 2000), with the power to predetermine life courses. In light of the need for independent and dependable judgment across categories that are both stable and able to generate widespread social assent, it is hardly surprising that the 'special need' rhetoric now commonplace across education systems the world over has itself too come to be based on the biomedical model with its individualistic, psycho-medical, 'natural kind' assumptions about the nature and origins of disability and difference, in which all the problems are explained by the individual's biological or somatic deficits (Vehmas, 2010). Hence, the field of special education has itself contributed to the psychiatrization and educational displacement of children. The community, relational or social disability approach of inclusive education, in which schools are organized in such a broadly accommodating and welcoming manner that special education needs cease to exist —and as important, mirror the wide variation among children at all levels of school staffing—still seems far away from todays' reality (Oliver, 2013).

TEACHERS WITH SPECIAL NEEDS

If one wished to pursue a community approach of inclusive education, and leave behind the trap of biomedical reasoning in which some children are first singled out as unacceptably different, then labelled with having special needs and then made a target for educational inclusion, a simple change in language might be a good start. The change proposed here is to replace the common phrase 'pupils with special needs' by 'teachers with special needs'. A discourse that focuses on the needs that teachers encounter while addressing specific problems in their class, shifts the focus from considering disorders within children towards problems that teachers de facto have with educating some pupils. This may counterbalance the rise in confirmed psychiatric diagnoses in children and facilitate implementation of the community approach of inclusive education.

A second advantage of speaking of teachers with special needs has to do with the connotation of the word 'special'. While 'special' can contain either a positive or a negative value judgement, in its connection with the phrase 'children with special needs' it usually refers to an undesirable characteristic or way of functioning of the child (Wilson, 2002). Would we use it for the needs of teachers however, special might point in a more neutral or even positive direction, for example towards making a challenging job successful or having an optimistic attitude towards solving classroom problems. To make true inclusive education happen, teachers and education professionals generally might be encouraged to think and communicate about what they need in order to realize an inclusive educational environment, one in which all or most children can flourish. Hence, with the special needs we propose, teachers have concern for their need for training, coaching and development as a professional in the context of particular challenges to successful teaching.

A last important potential benefit of adopting the proposed change in language would be the agency and responsibility it gives back to teachers. While individualistic medical assumptions and language disempower teachers and ask them to accept recommendations and conclusions suggested by noneducational specialists such as psychiatrists and doctors, speaking in terms of teacher needs when dealing with problems in the context of the classroom brings the agency and responsibility back to them and to pedagogy (Meerman et al., 2017). The dominant biomedical framing of emotional, behavioral and learning problems diverts attention and resources towards biomedical professionals, at the expense of educational professionals. Those resources might instead be available to education professionals, such as teachers, who are directly involved in the education and development of children on a daily basis.

POLICY AND PRACTICE

Internationally agreed goals of educational equity are captured in ‘school for all’ and inclusive education policy, as well as in the UN’s 4th sustainable development goal, which is about access to quality education for all. With respect to educational policy, we note that our call to arrest the growing trend towards psychiatrization and medicalization of child behavior, implies that no major change in policy direction is necessary. Instead of altering policy, we suggest rigorously moving the focus of educational policy implementation away from conceiving of children as having educational needs, to recognizing that children, whatever their individual characteristics and capacities, all have exactly the same access and participation rights. It is education systems and schools that need to deliver parity, and towards that end teachers need to develop special capacities. Our call is therefore not to change policy, but to attend far more critically to the true object of that policy.

This highlights the contrary effects of what the biomedical language that is presently used foregrounds—namely, individual children being labelled as needy—and what that language hides: that education systems, schools and teachers need to develop a special capacity for educational inclusion. Within a community approach of inclusive education the child is not fit to the demonstrable needs of the education system, but professional capacities in schools are raised towards teaching that better fits ever more diverse classrooms.

Our proposal to re-center the meaning of special education on the problems that schools apparently have with educating some children may seem radical or even reactionary to some supporters of special or inclusive education. Yet this idea is neither without precedent nor without good practice. Existing descriptions of educational consulting and schools-based intervention have centered on the assumption that classroom problems are substantively inherent in how schools and classrooms work, in the roles that teachers play and in the assumptions they make (Dinkmeyer, Carlson and Michel, 2016). Similarly, in the Netherlands a national network of school support services have long included a form of educational consulting whereby questions that teachers have about teaching pupils are consistently treated as issues of pedagogy and didactics. It is thought that this consultatory foregrounding of pedagogy and didactics are part of a prevention strategy or ‘good care perspective’ aimed at resolving classroom problems before they become a hindrance (Meijer, 2019). A key practice component entailed in the Dutch ‘CLB’ approach (consultatieve leerlingbegeleiding, or consultative learner guidance) is that trained coaches guide teachers into framing all discussion of problems that teachers report to them as challenges to professional teaching in a given classroom context. Hence, we could also name this practice Consultative *Teacher* Guidance. The coaching focuses on alternative choices that might be made in pedagogy, didactics, resources, classroom management, and so on—instead of supposing that problems originate in the traits of a particular pupil. The guiding assumption is that a classroom of pupils will inevitably entail a mix of mental and physical traits, while an exciting challenge of teaching is precisely to meet pupils’ learning with optimally adjusted classroom practice even so. The value of this kind of approach was confirmed in empirical studies that assessed the role that educational consultation can play in resolving problems that arise between pupils, parents and educators (Sheridan, Kratochwill and Elliott, 1990; Elliott and Sheridan 1992), including such consultation providing a solid basis for standards of accountability that schools have for educating all pupils (Roach and Elliott, 2009).

DISCUSSION

We have argued that the rise in childhood disorders will in part be attributable to the widespread support there is in contemporary education praxis for biomedical views on children who are taken to deviate substantively from implicit norms set for standard (as opposed to special) educational effort. This routine sorting of children in the education system into supposedly ‘normal’ children and ‘special’ children (or children with special needs) has historical antecedents and has long made special education a growth sector (Dekker, 2009; Tomlinson, 2012). Yet with the rise of clinical psychiatry and diagnosis, this sorting mechanism has been given a new biomedical foundation and warrant, and given it entirely new growth potential. The symbiosis that has developed, between the psychiatric diagnosis of supposed childhood mental disorders and the sorting of children across regular and special education, has most likely contributed to inflating the numbers of children classified with mental disorders, as well as increased the amount of childhood psychotropic drug prescriptions in the last few decades.

Locating the problems that teachers have with educating some children in an expanding range of individual conditions may be considered progressive in clinical or medical terms, but the consequence of doing so is that children become the sole owners of what are in essence pedagogical issues and challenges in teaching. Diagnosing children with mental disorders inevitably involves a stigmatizing form of subjecting children to potentially lifelong treatment or management of internalized mental conditions. There is meantime little evidence that raising teacher's awareness of supposedly neuropsychiatric conditions in fact brings about more successful educational inclusion, and indeed regular school teachers generally remain weary of including children with more severe conditions in their classrooms (Pijl, 2010; Saloviita, 2020).

One way out of the far-reaching consequences of present high levels of psychiatric diagnosis of mental disorder in children is to explicitly recognize that education systems sort children by the level of special effort that teachers need to make in educating them. A first step in reversing the psychiatrization of children in education is therefore to recognize that teachers have special needs. Depending on the level of variation among pupils in a given classroom, teachers may need particular support in order to do inclusive education well. This acknowledges that teachers are likely to face special teaching problems that need then to be addressed with additional resources, effort or professional development. In a truly inclusive education system, no child has special educational needs. Instead, teachers are enabled to muster the special powers that they may sometimes need in order to support and nurture every child's capacities for learning equally, while valuing childhood diversity. Our proposal of shifting the attention in policy and discourse from pupils to teachers having special needs draws a principled pedagogical conclusion from an undesirable state of affairs: the increasing reification of biomedical knowledge is making individual pupils, rather than school communities, the stigmatized owners of problems that arise in education and the education system.

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The (Un)real Existence of ADHD—Criteria, Functions, and Forms of the Diagnostic Entity

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The contemporary conceptualization of Attention Deficit Hyperactivity Disorder (ADHD) as a complex, multifactorial neurodevelopmental disorder cannot be understood as such without a complex assemblage of political, economic, and cultural processes that deem the conceptualization to be valuable and useful. In this article we use the notion of psychiatrization as a lens through which to see parts of these processes that make up ADHD what it is. In the first part of the article, we critically assess the scientific basis of the ADHD diagnosis *via* examining its diagnostic criteria as presented in the current fifth edition of Diagnostic and Statistical Manual of Mental Disorders (DSM), the so called "Bible" of modern psychiatry. The second part of the article asks what is done with the ADHD diagnostic entity and with the idea that it represents a natural neurodevelopmental state within an individual—something an individual has—as represented in the DSM-5. Drawn from our previous research, we analyze how ADHD becomes real in discourse practice as a powerful semiotic mediator through analysis of the various functions and forms in which it takes shape in institutional, social, and individual levels. We conclude that the frequent changes in the diagnostic criteria of ADHD do not reflect any real scientific progress. Among other reasons, they change to match better the maneuvers of individuals when navigating an increasingly psychiatrized society in the search for recognition, support, category membership, immunity, sympathy, and sense of belonging.

Keywords: attention deficit hyperactivity disorder (ADHD), psychiatrization, diagnostic and statistical manual of mental disorders (DSM), diagnostic criteria, psychiatric nomenclature, discourse, semiotic mediator, consequences

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INTRODUCTION—PSYCHIATRIZATION AS A LENS TO UNDERSTANDING ADHD

The existence and realness of Attention-Deficit/Hyperactivity Disorder (ADHD) has been under ontological, epistemological, and axiological debate since the diagnosis was introduced in the second edition of Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1968 by the American Psychological Association (APA) (e.g., Laurence and McCallum, 1998). This article critically examines the contemporary notion of ADHD as a complex, multifactorial neurodevelopmental disorder. This notion represents the official understanding of the phenomenon.

National institutions (e.g., law, healthcare, welfare, education) globally share this approach to "discover" biomedical templates within which to place various behaviors, performance and functioning considered socially or academically—ultimately societally—disturbing or concerning (e.g., Chronis-Tuscano et al., 2010).

The "universalizing" approach that assumes ADHD to be a complex neurodevelopmental disorder while disregarding cultural meaning, beliefs, and practices for dealing with such behaviors is evident in most mainstream academic publications on the subject (for discussion, see Freedman, 2016; te Meerman et al., 2020). In addition, "International consensus statement on ADHD" (Barkley, 2002), the "Global consensus on ADHD/HKD" (Remschmidt and Global ADHD Working Group, 2005) and the more recently published "World Federation of ADHD International Consensus Statement: 208 Evidence-based conclusions about the disorder" (Faraone et al., 2021) written by groups of prominent researchers and clinicians are examples of top-down production and distribution of ideas about what ADHD is and how it should be regarded.

However, the official and hegemonic notion is not founded on natural facts grounded on science it purports to convey. ADHD cannot be understood as a complex neurodevelopmental disorder without a complex assemblage of political, economic and cultural processes that deem such a conceptualization to be valuable and useful. In this article we use the notion of psychiatrization as a lens through which to see parts of these processes that make up ADHD what it is. Psychiatrization refers here to a "process by which an ever-expanding assemblage of human life experiences have come to be observed, understood, enacted and acted upon through the language, theories, technologies and institutional practices of western biomedical psychiatry" (Coppock, 2020, p. 3). Psychiatrization includes both material (e.g., growth of psychiatric infrastructures, private or public research institutions, technological, pharmaceutical, or biomedical companies) and ideological aspects, such as defining or labeling certain conditions or behaviors as mental disorders (Beeker et al., 2020).

The premise of this paper is that ADHD, as it is contemporarily conceptualized, *exists* in an abstract space of *text* and becomes *real* in the concrete space of *practice* through various functions. Text refers to semiotics occurring in different forms of communication and interactions (Fairclough, 2004). The DSM is an example of a powerful and influential text. The DSM—and essentially its creator the American Psychiatric Association—plays a key role in "the global spread of psychiatric ways of being a person and how we all come to understand ourselves within this register" (Mills, 2014, p. 51). The DSM provides both the theory on and the language with which to communicate about human differences, guidelines for technologies of identification and naming of these differences (e.g., various rating scales), and directions for institutional and social practices to make use of the ideology of labeling.

How a diagnosis affects the lives of individuals has been identified as a research priority for those interested in the examination of psychiatrization (Beeker et al., 2021). The purpose of this article is to illustrate how pervasively psychiatrization manifests in our everyday lives by examining the criteria, functions and forms of ADHD diagnosis. The first part of this article contributes to this endeavor by critically assessing the scientific basis of the ADHD diagnosis *via* examining its diagnostic criteria as presented in the current fifth edition of DSM (American Psychiatric Association, 2013), the so called "Bible" of modern psychiatry, which forms the widely accepted official conceptualization of ADHD.

The second part focuses on the uses of the text by investigating what is done with the ADHD diagnostic entity[1] and with the idea that it represents a natural neurodevelopmental state within an individual in discourse practice. Discourse practice refers to processes of text production, distribution, and consumption in which sociocultural ideologies, beliefs, norms, and power relations are naturalized (Fairclough, 2004). We analyze how ADHD becomes real as a powerful semiotic mediator through analysis of the various functions and forms in which it takes shape in institutional, social and individual levels.

QUASI-SCIENTIFIC BASIS OF ADHD IN DSM-5

The DSM is regarded as western psychiatry's "bible" (Horwitz, 2021). From the publication of its third edition in 1980 and on, DSM committed to a "neo-Kraepelinian," cause-effect biomedical framework (Jacobs and Cohen, 2012). This framework embraces the assumptions that "psychiatry is a branch of medicine and treats people who are sick, there is a boundary between the normal and the sick, there are discrete mental illnesses, psychiatrists should concentrate on biological aspects of mental illnesses, and diagnostic criteria should be codified" (Jacobs and Cohen, 2012, p. 88). The publication of the manual's fifth edition (DSM-5; American Psychiatric Association, 2013) immediately provoked an unprecedented—both in size and intensity—criticism from within and outside psychiatry (e.g., Frances, 2013; Kirk et al., 2013; Timimi, 2013; Wakefield, 2013; Gambrill, 2014; Lacasse, 2014).

ADHD is defined in the DSM-5 as "a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development" (APA 2013, p. 59). DSM-5 represents a descriptive approach to diagnosis, that is using behavioral indicators, called symptoms, alone for the diagnosis without the necessity to understand or identify any presumed underlying causes or dynamics (Kirk et al., 2013). Indicators are then called "diagnostic criteria," and these criteria are the essence of descriptive diagnosis since they form the basis for the definitions of disorders and the scientific validity of the classification system (Kirk et al., 2015).

ADHD is listed in DSM-5 under "Neurodevelopmental Disorders" in spite of reviews showing that (a) genetic evidence on ADHD is inadequate (Travell and Visser, 2006; Gallo and

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[1] We use the term diagnostic entity as a reference to the plurality of meanings the ADHD concept is given in discourse practice, such as a condition, a disorder, a diagnosis, a trait, or a label. By using the term, we emphasize that although the DSM and alike classification manuals initially provide the language to communicate about human beings and lives, the language dynamically shapes human lives beyond the conceptual boundaries set in the manuals.

Posner, 2016) and diffused with ambiguous interpretations (Pittelli, 2002; Joseph, 2009; Pérez-Álvarez, 2017), (b) that no biological marker is diagnostic for ADHD (Thapar and Cooper, 2016) something that even DSM-5 authors themselves explicitly admit (American Psychiatric Association, 2013, p. 61), (c) the so-called "underlying mechanisms" remain unknown (Cortese, 2012; Matthews et al., 2013), and (d) no biological tests are available for its diagnosis (Thapar and Cooper, 2016). Moreover, DSM-5 authors implicitly acknowledge that the classification of ADHD as neurodevelopmental disorder is not well-founded: "[O]n the basis of patterns of symptoms, comorbidity, and shared risk factors, attention-deficit/hyperactivity disorder (ADHD) was placed with neurodevelopmental disorders, but the same data also supported strong arguments to place ADHD within disruptive, impulse-control, and conduct disorders" (American Psychiatric Association, 2013, p. 11).

In other words, there is no scientific evidence to support the claim that ADHD is as a condition within an individual—something individuals *have*, owing to which they *are* vulnerable to various risks the condition exposes them to. Asserting that ADHD is a neurodevelopmental disorder is a scientific conceit on one hand and reflects the DSM's political, cultural, and financial role in the psychiatrization of children's everyday lives on the other. ADHD diagnosis has expanded globally *via* institutions such as school (e.g., Hinshaw and Scheffler, 2014; Koutsoklenis et al., 2020), pharmaceutical industry, and western psychiatry along with the DSM (Conrad and Bergey, 2014), in all of which the psycho-medical discourse on deficit, disorder and disability is adopted and mobilized. In and through this discourse, ADHD exists as a neurobiological or neurodevelopmental condition within an individual caused by development processes of nature over which etiology individuals, society, or culture has no power.

ACCURACY OF ADHD DIAGNOSIS

We consider below some of the apparent challenges of ADHD diagnosis in relation to its accuracy. Adopting Kirk (2004, p. 255–256) definition we use the term *accuracy* "to refer to a bundle of questions about the clarity of definitions that distinguish one category from another, the conceptual coherence of these definitions, and the ability of users of the classification system to implement these distinctions consistently in practice." For our analysis we have used as a blueprint the criticism for descriptive diagnoses articulated by Kirk et al. (2013). Kirk et al. (2013, p. 164–174) refer to DSM criteria in general; we have specified and applied this criticism for the diagnostic criteria for ADHD and added two additional lines of criticism (i.e., "prescriptions of normality" and "conversion of value judgments into symptoms") to further fortify our argument regarding the inaccuracy of the DSM criteria for ADHD.

Ambiguity

The diagnostic criteria for ADHD in the DSM-5 are ambiguous. Ambiguity in the diagnostic criteria for ADHD is best exemplified in the language describing the frequency with which behaviors must occur to be considered as symptoms of the disorder. All eighteen diagnostic criteria begin with the descriptor "often" or "is often" (American Psychiatric Association, 2013, p. 59–60). However, no description or threshold for the frequency of the behaviors is provided in the manual. Consequently, who meets the criteria and subsequently who "has" ADHD is dependent on shared understandings of how much of a particular behavior is too much (Freedman and Honkasilta, 2017). Ambiguity is also evident in other instances, such as how much talking becomes "excessive" ("Often talks excessively," American Psychiatric Association, 2013, p. 60) or under which circumstances it is inappropriate for children to run or climb ("Often runs about or climbs in situations where it is inappropriate," American Psychiatric Association, 2013, p. 60)?

Those involved in the diagnostic procedure (clinicians, parents, teachers) make their own interpretations and judgements about the abovementioned issues, making the assessment biased toward subjective and cultural meaning making processes. For instance, race and ethnic background of children subjected to rating as well as of those utilizing the rating instruments affect how behaviors are interpreted as being "symptomatic" and "diagnosed" as manifesting a "disorder" (e.g., DuPaul et al., 2016; see also Bredström, 2019).

Redundancy

Aiming at enhancing the validity of diagnosis DSM-5 requires that disorders meet multiple criteria (Kirk et al., 2013). Providing lists that contain multiple criteria supposedly indicating different behaviors provides a sense of validity; but this is a false sense (Kirk et al., 2013). The diagnostic criteria for ADHD are 18 symptoms, nine of which are listed under the subsection "Inattention" and nine of which are listed under "Hyperactivity and Impulsivity." Six criteria must be met for "Inattention" and six for "Hyperactivity and Impulsivity" to use the diagnosis. However, there is an apparent redundancy in the formulation of the diagnostic criteria for ADHD; supposedly different criteria are much the same just with different wording (Kirk et al., 2013).

For "Inattention" the second criterion is "Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading)" (American Psychiatric Association, 2013, p. 59). This is restated in the fourth criterion which is "Often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily sidetracked)" and again in the sixth criterion "Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers)" (American Psychiatric Association, 2013, p. 59).

The redundancy occurs in the criteria for "Hyperactivity and Impulsivity" as well. More specifically, the first criterion is "Often fidgets with or taps hands or feet or squirms in seat" (American Psychiatric Association, 2013, p. 59) while the fifth is "Is often 'on the go,' acting as if 'driven by a motor' (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with)" (American Psychiatric Association, 2013, p. 60). In the same fashion, the seventh "Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation)," the eighth "Often has difficulty waiting his or her turn (e.g., while waiting in line)," and ninth criteria "Often interrupts or intrudes on others (e.g., butts into conversations, games, or activities; may start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing)" are all essentially referring to alike behaviors.

It is thus difficult to see how one subjected to assessment could manifest one of the criteria but not the others, particularly given that those engaged into interpreting and assigning meanings to behaviors through the diagnostic criteria interpretation frame are likely preconditioned to see the diagnostic criteria met for various reasons. This assertion will be further illustrated in the second part of this article.

Arbitrariness

Arbitrariness in the diagnostic criteria for ADHD is evident in two instances: (a) in the quantity of criteria required for the diagnosis, and (b) in the age of onset before which someone must display the behaviors described in the criteria. Regarding the quantity of the criteria, DSM-5 requires that at least six of the nine criteria for "Inattention" and at least six of the nine criteria for "Hyperactivity and Impulsivity" must be met for the diagnosis. The number of criteria required for a diagnosis of ADHD has been set arbitrarily in DSM-5. No scientific justification has been presented nor method used for deciding how many criteria should be required for any disorder in the manual (Davies, 2013; Kirk et al., 2013). Instead, their quantity has been established by consensual opinion among the DSM-5 Task Force members. Consensus ratifies the absence of scientific evidence; if evidence was available consensus would not be necessary (Pérez-Álvarez, 2017).

Arbitrariness is also evident in setting the age of onset of symptoms. The age of onset of symptoms increased from "before 7 years" in DSM IV-TR (American Psychiatric Association, 2000) to "before 12 years" in DSM-5 (American Psychiatric Association, 2013). Reviewing the available research evidence, Sanders et al. (2019, p. 6) concluded that changes to the age of the onset criterion "were based on research that was judged to be at high risk of bias and/or to have poor applicability." This change widened the definition of ADHD and consequently the number of children who can be included in the increased reservoir of potentially diagnosable ADHD cases (see, for a review, Kazda et al., 2021).

In conclusion, like most psychiatric classifications, ADHD is premised on an arbitrary consensus among a small psychiatric community behind the DSM manual rather than on any new scientific breakthroughs. In other words, "psychiatrists do not prove things but *decide* things: they *decide* what is disordered and what is not, *decide* where to draw the threshold between normality and abnormality, *decide* that biological causes and treatments are most critical in understanding and managing emotional distress" (Davies, 2013, p. 181, original emphases).

Prescriptions of Normality

Disorders cannot be defined in the absence of social values and notions of normality (Horwitz and Wakefield, 2012). As Bowden (2014, p. 434) points out in his paper on sociological accounts of disorder, "[i]t is not that objective physical states are identifiable as disorder, only then to provoke moral quandaries, or then translated into 'lived experience.' Rather, any demarcation of behavior as disorder is meaningful only because of a normative context." Hence, ascriptions of disorder essentially implicate value judgments about behaviors that are undesirable. Certain behaviors are regarded as rule-breaking and thus undesirable and deviant, and it is only through this devaluation that they can be characterized as symptoms of a disorder.

The ADHD diagnostic criteria are essentially lists of symptoms that are the contraries of socially valued norms (Freedman and Honkasilta, 2017). The "normal child," all-pervading the manual, exemplifies the preferable behavior which in turn becomes a prescription of how children should play (e.g., "Often unable to play or engage in leisure activities quietly", American Psychiatric Association, 2013, p. 60), when to remain seated (e.g., "Often leaves seat in situations when remaining seated is expected", American Psychiatric Association, 2013, p. 60), what to pay attention to ("Is often easily distracted by extraneous stimuli," American Psychiatric Association, 2013, p. 59) and how much to talk (e.g. "Often talks excessively," American Psychiatric Association, 2013, p. 60). Children who aberrate from these prescribed "normal" behaviors are at risk for a "dangerous development" in which their actions not only threaten their social and educational future but also the related cultural values (Bailey, 2010, p. 584; Freedman and Honkasilta, 2017).

At this point, we think that a brief discussion on embodiment related to ADHD is in order before moving on. We are by no means to deprecate or ignore the embodied experiences by individuals, nor difficulties in everyday lives associated with ADHD in general. Neurobiological and psychological traits manifest in various embodied ways. For instance, the urge to be on the move or difficulty in sustaining attention are potentially experienced as emotions of restlessness or anxiousness. Physical modalities associated with ADHD and rooted in human physiology are however unlikely to be negatively experienced without it being associated with a certain degree of commitment to contextual sociocultural modal expectations regarding behavior and performance by self (i.e., internalized modal expectations), others (i.e., imposed modal expectations), or institutions (i.e., institutionalized modal expectations). Thus, when it comes to behavior, performance, or functioning associated with the ADHD diagnosis, it is the mismatch between expectations and capabilities to meet them that fortify their pathological nature over the normal variation of human behavior, performance and functioning, and name their moral and ethical outcomes. Embodied experiences are given contextual meanings, relevance, and significance in social interactions vis-à-vis social and cultural expectations and requirements that DSM translates into language of individualistic psycho-medical models of deficit, disorder, and disability.

Conversion of Value Judgments Into Symptoms

Ascriptions of disorder essentially implicate value judgments about behaviors that are undesirable (Horwitz and Wakefield, 2012; Bowden, 2014). Certain behaviors are regarded as rule-breaking and thus undesirable and deviant, and it is only through this devaluation that they can be characterized as symptoms of a disorder. The ADHD diagnosis directly embeds social values. This is evident in the listing of "symptoms" that are the contraries of socially valued norms (Hawthorne, 2010). The diagnostic criteria "Often talks excessively" (American Psychiatric Association, 2013, p. 60), "Often interrupts or intrudes on others" (American Psychiatric Association, 2013, p. 60) and "Often blurts out an answer before a question has been completed" (American Psychiatric Association, 2013, p. 60) concern the social value of *social intelligence*. Certain behaviors are more likely to be interpreted by other "normal" individuals as rude or intruding. The actual criterion being used here is the annoyance threshold of the observer; observed behavior is dependent to the emotion of the observer, and thus is subject to be reconstructed as a symptom of the one being observed (Freedman and Honkasilta, 2017).

Inadequate Attention to Context and Agency

DSM-5 portrays an ethnocentric (Bredström, 2019) and "an extraordinarily sanitized, asocial view of the human condition" (Jacobs and Cohen, 2012, p. 90). The diagnostic rationale of the DSM-5 for ADHD is subject to the *fundamental attribution error*. The fundamental attribution error suggests that observers attribute other people's behavior primarily to dispositional (internal) causes, rather than to situational (external) causes (Ross, 1977). As Kirk et al. (2013) explain, "descriptive psychiatry requires the implausible belief that the meaning and causes of observable behaviors can be understood and used as symptoms of *mental disorder* without paying attention to the social context of the behaviors themselves, and of course the meaning of the behaviors to the person and those who observe the person" (p. 168). For example, behaviors such as "often fidgets with or taps hands or feet or squirms in seat" and "often talks excessively" (American Psychiatric Association, 2013, p. 60) are considered as stemming from internal dysfunction (and subsequently are symptomatic) rather than as natural responses to stressful situations at home or at school. In a contradictory manner, the DSM-5 includes an ambiguous statement regarding the role of social context in the behavior of children. In a remark made in the "Diagnostic Features" section, it is stated that "signs of the disorder may be minimal or absent when the individual is receiving frequent rewards for appropriate behavior, is under close supervision, is in a novel setting, is engaged in especially interesting activities, has consistent external stimulation (e.g., *via* electronic screens), or is interacting in one-on-one situations (e.g., the clinician's office)" (American Psychiatric Association, 2013, p. 61). The role of social context is indeed acknowledged in this statement. It is apparent that this statement contradicts the conceptualization of ADHD provided in the manual by undermining its existence as neurodevelopmental disorder; how could frequent rewards and adequate attention make a neurodevelopmental disorder disappear? (Breggin, 1999).

Furthermore, in depicting certain ordinary behaviors as symptoms of mental disease, DSM-5 simultaneously also commits *de-agentilization*. De-agentilization is the tendency for representing actions and reactions "as brought about in ways that are impermeable to human agency—through natural forces, unconscious processes and so on" (van Leeuwen, 2016, p. 149). Several such examples appear in the diagnostic criteria for ADHD in which children are depicted as if they do not possess any intentionality or free-will with regards to their actions (Freedman and Honkasilta, 2017). For example, DSM-5 lists the behaviors "Often unable to play or engage in leisure activities quietly" and "Often blurts out an answer before a question has been completed (e.g., completes people's sentences; cannot wait for turn in conversation)" (American Psychiatric Association, 2013, p. 60). In the abovementioned examples, DSM-5 authors depict children as someone who is not making a conscious decision to stop one activity in favor of another or for any other reason. This is reinforced through the use of the dynamic modal verbs "unable" and "cannot" which emphasize that the observed actions are not the result of conscious decision-making but passive pathological responses to external stimuli resulting from the child's inability to function properly (Freedman and Honkasilta, 2017).

Diversity of Those Diagnosed With ADHD

The population of children diagnosed with ADHD is highly diverse and this makes ADHD an overly heterogeneous diagnostic category. This diversity is best exemplified in the high rates of comorbidity (i.e., meeting the criteria for more than one psychiatric disorder) that characterizes those diagnosed with ADHD. Authors of DSM-5 explicitly acknowledge that comorbidity is a frequent phenomenon in relation to the ADHD diagnosis by stating that "in clinical settings, comorbid disorders are frequent in individuals whose symptoms meet criteria for ADHD" (American Psychiatric Association, 2013, p. 65). Danielson et al. (2018) used data form the National Survey of Children's Health to estimate the US national-wide prevalence of parent-reported ADHD diagnosis. They found that, as of 2016, nearly two-thirds (63.8%) of children with current diagnosis of ADHD had at least one current co-occurring condition. There is a wealth of research documenting that ADHD is diagnosed with a wide range of other psychiatric disorders (e.g., anxiety disorder, bipolar disorder) or disabilities (e.g., intellectual disability, learning disabilities) (see **Table 1**).

Apart from "comorbidity" with other disorders, the population of children diagnosed with ADHD is considerably diverse in terms of neuropsychological profiles. This is confirmed both from qualitative neuropsychological assessments (e.g., Solovieva and Rojas, 2014, 2015) and from neuropsychological assessments that employ standardized, quantifiable measures (e.g., Kofler et al., 2019; DeRonda et al., 2021). Moreover, children diagnosed with ADHD are substantially diverse pertaining to their "symptom profiles" and "symptom trajectories" (Karalunas and Nigg, 2019). This is to be expected since the ADHD

TABLE 1 | Examples of ADHD "co-morbidity" (in alphabetical order).

"Co-morbid" condition	Sources
Anxiety disorders	Danielson et al., 2018; D'Agati et al., 2019
Autism	Antshel et al., 2016; Danielson et al., 2018
Bipolar disorder	Marangoni et al., 2015
Conduct disorder	Jensen and Steinhausen, 2015
Depression	Danielson et al., 2018
Disruptive mood dysregulation disorder	Copeland et al., 2013; Bruno et al., 2019
Eating disorders	Bleck et al., 2015; Ziobrowski et al., 2018
Intellectual disability	Ahuja et al., 2013; Jensen and Steinhausen, 2015
Intermittent explosive disorder	McLaughlin et al., 2012
Learning disabilities	Germano et al., 2010; DuPaul et al., 2013
Obsessive-Compulsive disorder	Abramovitch et al., 2015; Çelebi et al., 2020
Oppositional defiant disorder	Connor and Doerfler, 2008; Reale et al., 2017
Sleep disorder	Reale et al., 2017
Specific developmental disorders of motor development	Jensen and Steinhausen, 2015

diagnostic category includes three sub-categories (American Psychiatric Association, 2013, p. 60):

> 314.01 (F90.2) Combined presentation: If both Criterion A1 (inattention) and Criterion A2 (hyperactivity-impulsivity) are met for the past 6 months.
>
> 314.00 (F90.0) Predominantly inattentive presentation: If Criterion A1 (inattention) is met but Criterion A2 (hyperactivity-impulsivity) is not met for the past 6 months.
>
> 314.01 (F90.1) Predominantly hyperactive/impulsive presentation: If Criterion A2 (hyperactivity- impulsivity) is met and Criterion A1 (inattention) is not met for the past 6 months.

That is to say, children diagnosed with "Predominantly inattentive presentation" may not share common "symptoms" with children diagnosed with "Predominantly hyperactive/impulsive presentation."

Description Is Not Explanation

Descriptive diagnoses do not have any explanatory power. Instead, they are prone to the Begging the Question Fallacy, that is circular reasoning (Tait, 2009). Children have a disorder because they present the behaviors which define it: "The child often has difficulty sustaining attention in tasks or play activities because she has ADHD and she has ADHD because she does not sustain her attention in tasks or play activities." As Pérez-Álvarez (2017, p. 2) notes "the symptoms are the guarantee of the diagnostic category, which in turn is invoked to explain the symptoms in an endless loop."

Tautology is masqueraded as scientific explanation (Kirk et al., 2013). Subscribing to the idea that descriptive diagnoses have the power to explain behaviors creates a sort of tunnel vision. When behaviors related to inattention, impulsiveness and hyperkinesis are immediately connected with the ADHD diagnosis, other factors that are involved in the development of such behaviors may be ignored (Timimi, 2017). Examples of such factors are as diverse as child maltreatment (Ouyang et al., 2008), parental long-term unemployment (Christoffersen, 2020), and mobile phone use (Byun et al., 2013).

HOW DOES ADHD BECOME REAL? FUNCTIONS AND FORMS OF THE DIAGNOSTIC ENTITY

The idea that ADHD represents a natural neurodevelopmental state within an individual structures institutional and social practices. The DSM is an example of a top-down process providing an interpretation frame and language through which human behaviors can be translated to neuro-governed value-neutral symptoms irrespective of history and culture. Each time the DSM is revised, so is the interpretation frame redone, adjusted or maintained, governing thus how human behaviors should be perceived. The hegemonic position of contemporary conceptualization of ADHD as presented in the DSM also results from a bottom-up process deriving from people's intentional, dynamic, and situationally sensitive uses of psychiatric diagnoses as a gateway for navigating institutions and everyday interactions.

Thus, no matter how influential the idea of ADHD as a natural state within an individual is (i.e., text), it only materializes if recognized as such in practices of institutions (e.g., law, healthcare, welfare, education, and parenting), pertinent professionals (clinicians, physicians, educators, social workers, etc.), or laypeople (e.g., family members, peers, or the one being diagnosed). The idea of ADHD as a complex, multifactorial neurodevelopmental disorder becomes real *via* performance or enaction in material interactions with ideological conventions and power relations, with agents empowered to push these ideologies to action (e.g., clinicians, teachers, parents, interest groups) and with the ones being diagnosed. Meanings and ideas originate in action but also (de)legitimize the forms of action and, thus, shape action as well as how it should be perceived. ADHD is a semiotic mediator; a sign that acts as catalyst for the processes of human acting, feeling, and thinking (Brinkmann, 2014; Valsiner, 2018).

To better understand how these processes work, we will next focus on meanings given to the ADHD diagnostic entity and their functions deployed through cultivating psycho-medical discourse of ADHD in institutional and social practices. Drawing from our previous research on how identities, agencies, and moral responsibility are negotiated in relation to the ideas about ADHD (Honkasilta et al., 2015, 2016; Honkasilta and Vehkakoski, 2019) and medication use (see Honkasilta and Vehkakoski, 2017) as well as how the diagnosis impacts social and educational practices (see, Koutsoklenis and Gaitanidis, 2017; Koutsoklenis, 2020; Koutsoklenis et al., 2020), we have identified four functions and nine specific forms of the ADHD diagnosis as a semiotic mediator in the literature. Below, we present and analyze each of them and provide examples drawn from empirical studies (see **Table 2** for a summary).

ADHD as a Neurodevelopmental State

Being primarily a (neuro)psychiatric concept, ADHD represents a natural neurodevelopmental state within an individual—something individual has. DSM and alike "identification" manuals, law and national care guidelines applying the text of these manuals, and international consensus statements cultivating and strengthening the text of these manuals are examples of top-down processes through which the idea that ADHD represents a (complex) neurodevelopmental state become naturalized.

As a bottom-up process, this naturalization typically happens in interactions between and among school representatives and parents, in which the psycho-medical discourse of ADHD is distributed as an account for school failure resulting from a naturally occurring deficit in brain functioning (e.g., Hjörne and Säljö, 2004, 2014a,b; Hjörne, 2005). Recognizing the neurodevelopmental condition within an individual functions as an explanation to experienced or perceived problems related to behaviors, performance, and functioning in everyday life.

ADHD as a Psychiatric Disorder

The idea that that behaviors, performance and functioning are explainable by neurobiological developmental deficits become legitimized in *institutional practice*. Institutional practice refers to actions and meaning-making processes within institutions by authorities entitled with power to "author" the kind of recognition in question (Gee, 2000). Research by Tegtmejer et al. (2018) of meetings that took place in a Danish psychiatric clinic to which children suspected of having ADHD were referred from primary schools provides a unique example of how psycho-medical discourse guides institutional practices, in this case multi professional practices between school and psychiatric clinic. Their analysis points out to a cumulative negotiation process through which perceived problems at school are decontextualized from their social origins, individualized as child characteristics, and re-contextualized as symptomatic manifestation of a neurological condition leading to a diagnosed disorder (Tegtmejer et al., 2018, p. 10):

> Psychiatrist: If we give it a 90.1 (...) Is that not a fair description of the difficulties at hand?
>
> Psychiatric professional: Yes, I think it is. And what are you thinking in relation to treatment?
>
> Psychiatrist: I think we should give her some medicine.
>
> Psychiatric professional: Yes.
>
> Psychiatrist: They have already provided a lot of support, placement in a special educational unit, structure, and a family consultant at home.
>
> Psychiatric professional: Yes. Psychiatrist: It is extensive support. (...) And of course, we also need to offer the parents an ADHD parenting course (Anne's case, team conference, August 2016).

ADHD becomes real as a psychiatric disorder treatable with medication based on information communicated from various professionals instead of *via* a thorough assessment of the adequacy, quality and execution of the means of support provided at home and school, for example. Diagnosis of ADHD is an institutional legitimization for an alleged condition, serving as a means to communicate between authorities and institutions (e.g., home, school, psychiatric clinic) about the veracity of needed professional support. Institutional practice transforms ADHD from a natural state to an institutionally recognized position: Not only do individuals "have" the condition, now they also have the diagnosis, which in turn legally entitles them to societal and institutional recognition of certain kinds.

Diagnosing ADHD followed by special need education resolution at school is a typical sequence of events in institutional practice (e.g., Koutsoklenis, 2020). When problems associated with ADHD are recognized as a valid psychiatric disorder a promise is entailed of them being taken seriously and responded respectfully in institutional and social practice. However, organizing practice on the basis of the diagnosis has doubtful effectiveness (Koutsoklenis and Gaitanidis, 2017; Timimi, 2017).

ADHD as an Instrument of Institutional Governance

It would be naïve to assert that diagnosing ADHD is a somewhat logical trajectory of identifying biological markers of impairment in order to compensate them by remedial social practices. Instead, it has been extensively and well-pointed out by how exclusive education policies leave educators (parents, teachers) little choice but find diagnostic categories for "disorderly" students (e.g., Hinshaw and Scheffler, 2014). For example, in the USA laws and policies related to school accountability and the push for performance give schools the incentive to direct parents toward seeking diagnoses in order to attract resources to schools to raise students' test scores, and to "exempt a low achieving youth from lowering the district's overall achievement ranking" (Hinshaw and Scheffler, 2014, p. 79).

ADHD is an instrument of institutional governance resulting in a top-down process of distributing and directing educational, pedagogical, healthcare, welfare and institutional, and societal resources according to information communicated through the diagnosis. In other words, diagnosis is a prerequisite for a range of support services, such as special need education, parental training, or medication.

ADHD as a Legal Entity

Since the diagnosis provides evidence of a legally recognized disorder, ADHD is simultaneously mobilized as a legal entity leading to an entitlement to receive goods, services and treatments by laypeople. Apart from societal distribution of support, in many countries, remedial or special educational support at schools is diagnosis bound. It is then of little surprise that parents actively seek a diagnosis for their children so that their so-called "special needs" verified by the diagnosis will be adequately pedagogically met at schools (Honkasilta et al., 2015). This is when the various neurocognitive theories of ADHD, such

TABLE 2 | ADHD diagnostic entity: Its functions, forms, and objects under negotiation.

Function of the diagnostic entity (What is done with ADHD?)	Specific form (What is ADHD?)	Object under negotiation (Why ADHD takes such a form?)
Explanation	1. Neurobiological/-developmental condition	Recognition for the veracity of experienced problems; diagnostic entity is expected to explain unfavorable behavior, performance, and/or functioning
	2. Neuropsychiatric disorder	Recognition of need for support; without adequate support ADHD potentially affects person's life trajectory negatively
Entitlement	3. Instrument of governance top-down	Resource distribution; diagnosis as a means to direct educational, pedagogical, healthcare, welfare, and alike institutional resources
	4. Legal entity bottom-up	Right for support and treatment; diagnosis denotes institutionally recognized medical disorder
Disclaimer	5. Emancipation from legal liability	Immunity; discharge of culpability and/or liability owing to the nature of deficit, disorder, impairment, and/or disability
	6. Emancipation from moral liability	Freedom of responsibility; discharge of blame, shame and guilt owing to the nature of deficit, disorder, impairment, and/or disability
Identifier	7. Instrument of humanizing	Sympathy, empathy and understanding; diagnostic entity as a basis for constructive interaction and/or collaboration
	8. Instrument of empowerment	Self-worth; being perceived in a certain way as a certain kind
	9. Identity category	Belonging; attachment to or detachment from the membership in ADHD category

as executive functioning and inhibition theories, are expected to come to play so that the learning environment along with pedagogies and didactics are altered to make it easier for student to behave, perform or function in accordance with social and academic expectations.

ADHD as Emancipation From Legal Liability

Tait (2005) provides another example of how ADHD came to exist and serve certain functions in institutional practice, namely emancipation from legal liability. He introduces a case from Wisconsin USA, in which a student with his two accomplices caused $40,000 of damage to two elementary schools. During the hearing into his actions, as a result of the disagreement of the school district's psychologist the boy's mother acquired a private psychologist's statement that he might have ADHD. The case ended up into court and resulted in the student winning and avoiding expulsion from his school because he was recognized as being disabled. Thus, both the private psychologist's statement and subsequent adjudication reasserted that the son's actions were caused by a compulsive medical condition that overruled the legal accountability of his actions.

The ADHD label functions here as a disclaimer discharging the son from legal liability. Had the mother been unaware of how to mobilize psycho-medical discourse in this manner, her son would have been recognized as acting due to maliciousness and expelled, alike his two accomplices.

ADHD as Emancipation From Moral Liability

This above example of so-called diagnostic shopping is a powerful demonstration of how mobilizing psycho-medical discourse and a (pseudo)medical diagnosis functions within intertwined spaces of institutional and social practice. Not only did the ADHD label discharge the son from legal but also from moral liability for his actions. In addition, the mother fended off potential blame of poor parenting by becoming the guardian of a disabled son. The psycho-medical discourse is harnessed to counter normative assumptions and judgments regarding "normal" development, behavior, performance, functioning, parenting, teaching, and so on—broadly put, cultural blame. In and through this discourse, ADHD diagnosis is mobilized as an emancipation of moral liability, or as Reid and Maag (1997) conclude, a label of forgiveness, carrying psychological meanings.

For parents, a child's diagnosis absolves the culture of blame of what may be seen as poor parenting, since asserting that a child "suffers" from a neurobiological disorder is not as delicate a matter as asserting that the child manifests unwanted ADHD-like symptoms in response to an unsteady home life (e.g., Frigerio and Montali, 2016; Wong et al., 2018). The diagnosis eases parents from self-blame or guilt against conventional beliefs of good or bad parenting (e.g., Frigerio et al., 2013; Dauman et al., 2019) as well as protecting them from being blamed, shamed and held accountable for their child's doings in interaction between home and education institutions (e.g., Carpenter and Emerald, 2009; Honkasilta et al., 2015; Honkasilta and Vehkakoski, 2019). The diagnosis thus functions as a disclaimer for both parents and their diagnosed children: child is not the problem nor does the child have a problem, the problem lays *within* the child.

The ways diagnosed children and youth voice their experiences and account for their behaviors is likely to entail intertextuality with discourse of their parents, teachers and mental health professionals they have direct or indirect access to, as illustrated below with a shortened data excerpt from first author's research on how diagnosed youth account their moral responsibility associated to the diagnosis (Honkasilta et al., 2016, 251):

> Pete: my mum gave him [teacher] [. . .] some sort of book that explained about ADHD what it actually is and stuff [. . .] and he learned a bit about it [. . .] and started learning to give a bit of slack [. . .] he sort of like understood me a bit better and why I'm just sometimes the way I am [. . .] generally being a bit sort of like being deliberately annoying and messing about and stuff he kind of understood like where that might come from.

Neurobiological or diagnostic explanations are used to minimize own responsibility for behaviors, providing thus means to excuse oneself from demanding self-control as well as to explain and neutralize behaviors in face-to-face interaction (Travell and Visser, 2006; Singh, 2011; Berger, 2015; Honkasilta et al., 2016). Diagnosis thus functions as a moral disclaimer and immunity for blame, guilt or liability for those diagnosed.

ADHD diagnosis functions as a disclaimer for teachers and education institutions as well. Ethnographic research on early childhood education (Bailey, 2014) and primary schooling (Shallaby, 2017) reveal how teachers' reactions to a student's maladaptive classroom behavior constructs a social reality in which a certain malevolence assumed as being inherent cannot be nurtured at school or by teachers (e.g., the student "has" ADHD). On one hand, schools promote student diagnoses to identify and nurture their "special needs," yet they can simultaneously distance themselves from the responsibility of adequately meeting the need. The diagnosis serves as a rhetorical device that creates a common understanding of school difficulties for school staff, parents, and other actors, and simultaneously as a legitimate proof that these difficulties lay within the child, not the social environment and its everyday practices (e.g., Hjörne and Säljö, 2004).

ADHD as an Instrument of Humanizing

The data excerpt presented above also illustrates another form and function the ADHD diagnostic entity takes when mobilized in social interaction in addition to moral excuse. It is an instrument of humanizing functioning as a means to evoke sympathy, empathy and/or understanding for lived experiences and experienced challenges, challenging life situations and individual traits deemed deviant. The idea of humanizing through labeling of deviance or difference is to wipe the slate clean for constructive collaboration informed by psycho-medical discourse of ADHD.

Parents seek a diagnosis for their children not only to advocate for their children's so-called remedial or special needs being recognized and pedagogically supported at schools, but also as a response to perceiving their children as being misjudged and inadequately socioemotionally supported (Carpenter and Emerald, 2009; Bailey, 2014; Honkasilta et al., 2015). Furthermore, the humanizing function and how it interplays with that of moral emancipation from blame or guilt also extends to parents' negotiating an alternative form of recognition for themselves, as demonstrated in the excerpt (below) from a study conducted by the first author on meanings given to the ADHD diagnosis in a family narrative of a young person diagnosed as "having" ADHD (Honkasilta and Vehkakoski, 2019, p. 9):

> If teachers had knowledge about ADHD their prejudice wouldn't be so harsh "cause they would adopt a different attitude (–) because teacher's initial stance is that there has to be something wrong with the family because the child behaves like (. . .) it just showed how much they lack knowledge (Mother).
>
> It was quite a disappointment that they [teachers and principals] were of the opinion that this doesn't exist, ADHD doesn't exist, that only poorly behaving kids with behavioral disorders exist, and it is caused by conditions at home (Father).

Diagnosis is expected to reframe and change the way child and parents are viewed, regarded and treated by others, and translate psycho-medical discourse into pedagogies that promote learning and positive self-image; to direct the focus from behaviors and performance that may be of concern to an individual characterized by neurodiversity. With this new interpretation frame then, an ADHD diagnosis functions as a means to normalize the parents as well as the child, who can now establish their moral status as competent educators and caregivers through received/internalized emotional reprieve from guilt and blame (Schubert et al., 2009; Singh, 2011; Frigerio and Montali, 2016; Wong et al., 2018; Honkasilta and Vehkakoski, 2019).

ADHD as an Instrument of Empowerment

Along with normalizing how individuals are viewed and treated by others (i.e., humanizing), the diagnosis also entails a promise for empathetically receiving and treating oneself. Hence, the diagnosis also takes form as an instrument of empowerment, serving as a means to come to terms with the idea of ADHD as an individual trait and characteristic—with the neurodiverse self/individual—and embrace it as such. This is illustrated below by excerpts from Gajaria et al. (2011) research on how youth self-identified as "having" ADHD view themselves in Facebook peer-group postings.

> "ADHD is a great Personality enhancer!! I think we are all blessed in that field!!" (ibid., p. 17).
>
> "I feel sorry for people who don't have ADD. Seriously, I think we have waaaay more fun!" (ibid., p. 18).

Such accounts on ADHD-selves rely on the essentialist idea of self-discovery (see Levy, 2011). ADHD is portrayed as an embodiment of certain ways of being, experiencing and doing—interacting with social environments. Harnessing psycho-medical discourse of ADHD as part of personal, and beyond dispute, social narratives provide a rationale for making sense of lived experiences and selves, language to communicate these experiences and advocate for understanding and acceptance, and subjectivities with liberty to express one's ADHD as part of self. Metaphorically put, break the chains of blame, shame, and guilt and re-discover oneself.

The diagnostic entity empowers the claiming of ownership in ways subjectivities are recognized in social interactions. It is noteworthy that this function is not limited to subjectivities of those diagnosed. Instead, for parents of a diagnosed child the empowering nature of the diagnosis may materialize in a form of claiming strong advocacy and expertise in the diagnosed child's schooling, after having gained a more in-depth understanding of the claimed condition, the manifestation of its so-called symptoms, and means of support (e.g., Frigerio et al., 2013; Honkasilta et al., 2015; Honkasilta and Vehkakoski, 2019). Internalization of psycho-medical discourse of ADHD can thus make acknowledging and welcoming parents' knowledge, expertise, and agency possible in multisectoral collaboration with professionals and equalize the power relations (Honkasilta and Vehkakoski, 2019). In this regard, Frigerio et al. (2013, p. 584) conclude in their analysis of mutual blame centering on questions of compliance, recognition of authority and morality in discourses of mental health professionals, teachers and parents, that "[t]hrough the blame game, adults negotiate their own and others' subjectivity in ways that simultaneously (re)produce power relationships and resistance efforts."

Ironically then, events in which school staff overtly suggest the initiation of a diagnosis process while parents being more hesitant or reluctant about assessing, diagnosing, and thus categorizing the child as "having" ADHD (e.g., Hjörne and Säljö, 2004, 2014a,b; Hjörne, 2005) can be illustrative of how ADHD is used as an instrument of empowerment by school staff as well. As Hjörne (2005) points out in her school ethnographic research, assessment of ADHD is implied with the idea that the diagnosis could strengthen the parents' role as parents as well as teachers' roles as teachers, since the diagnosis would bring forth a sense of security and clarity regarding what to do with a child.

ADHD as an Identity Category

All previously presented forms and their functions negotiated in institutional, social and individual levels rest on the dynamic process of recognizing those subjected to labeling as certain kinds. Thus, ADHD is an identity category that creates and fortifies category memberships of *us* and *them*/*others*. Gee (2000) conceptualizes four perspectives and sources of identities—nature, institution, discourse and affinity—each with a distinct process of recognition of what kind (of a person) one is: development, authorization, dialogue and shared endeavors and practices. Although interrelated and eventually bound together in discourse practice, this division is illustrative of how the ADHD label is confined to identities of those categorized.

The nature perspective on ADHD identities is consistent with the official and hegemonic discourse on ADHD: it is a fixed internal neurodevelopmental state affecting behaviors, performance and functioning. Biological states (e.g., blood relation, cancer) are not meaningful parts of our identities outright unless they are recognized as such in portraying what kind of a person one is by self and/or others. Natural states gain force as identities through discourse in institutional (e.g., diagnosis-bound support distribution) and social practices (e.g., internet peer-groups).

Once officially diagnosed, the hypothesized natural state becomes legitimized by institutional authorities. Now the nature identity is strengthened and paired with the imposed institutional identity, as the one diagnosed becomes subjected to certain level of institutional and social means of monitoring, support and/or treatments. Since diagnostic entity ADHD functions as a means to be emancipated from legal and moral liability as well as to cultivate sympathy and empathy it is unlikely for diagnosed children to avoid forming their identities in relation to ADHD in one way or another after being diagnosed. On the other hand, adults diagnosed in adulthood will have likely started monitoring themselves according to the psycho-medical discourse of ADHD prior to official diagnosing, now receiving a pathway to re-creating themselves empowered by authorities (i.e., ADHD as an instrument of empowerment). The nature and institution identities thus mutually support and sustain each other.

The third perspective on ADHD identities is discourse (Gee, 2000), as ADHD gains recognition in dialogue among people. Whereas, institutions must rely on discursive practices to construct and sustain ADHD as nature and institution identities, ADHD identities can also be constructed and sustained through dialogue between people without them being sanctioned and sustained by clinical institutions and authorities. The official discourse on ADHD formed in the DSM and alike manuals has globalized our perceptions of behaviors, performance, functioning and disability. It seems safe to state that once educators such as parents and teachers get hold of the psycho-medical discourse of ADHD as an explanation for lived experiences of and with the child, it starts forming the ways child's behaviors are recognized even before or without official diagnosis, thus imposing ADHD as nature identity. This is seen in practice when parents advocate diagnosing their children or at least recognizing their troubles in school as ADHD symptoms and expect schools to join this endeavor, or vice-versa.

In this regard, Tomlinson (2015) has argued that in England, the expansion of ADHD among other learning disabilities (e.g., dyslexia, autism) derived particularly from middle-class parents prepared to litigate to receive adequate special education services at schools because their children were struggling to succeed in competitive learning environments. Families' active attempts to have their children recognized as "learning disabled" to gain remedial support is an example of parents' *achieving* a certain kind of ADHD discourse identity for the child. Parents tend to *receive diagnosis* for their children and recognitions for certain kinds that follow. Children on the other hand play no active role in the process. They are *diagnosed,* and the basis for the ADHD discourse identities is *ascribed* to them.

The mobilization of ADHD-related stereotypes and lay diagnoses, or the act of lay or self-diagnosing are other examples of forming discursive ADHD identities without them being warranted by institutional authorities. Discursive identities are dynamic and enable detachment from the official psycho-medical model of deficit, disorder, and disability by reconstructing of what ADHD as an individual trait is about. Contemporary western zeitgeist is characterized with new emerging discourses with an aim at changing the ways people "with" ADHD are recognized. Take the empowering nature of the diagnostic entity as an example. It resonates with the claims of a social movement called the neurodiversity movement, originally coined by and for people labeled with what is currently described as the autism spectrum (For a critical account, see e.g., Ortega, 2009; Runswick-Cole, 2014). Mobilizing neuroscientific metaphors about "differently wired brains" that differentiates *them* from majority of people with so-called "neurotypical brains," the movement advocates that neurobiological differences are part of natural variation among the human population, hence, "neurodiverse people" such as those "with" ADHD are not to be cured nor treated but rather recognized as part of human specificity like sex or race.

Academia has further adopted this discourse and harnessed it to rebrand traits associated with ADHD, for instance, as an entrepreneurial mindset (Moore et al., 2021) or character strengths and virtues (Sedgwick et al., 2019). Similarly, a quick online search illustrates that a range of advocacy groups has harnessed the neuroscientific discourse to create entrepreneurial ADHD discursive identities with headlines such as "Why hiring upside down thinkers is a competitive advantage." The auspicious attempt here is to change the narrative and interpretation frames from disorder subject to rehabilitation and treatment to a difference worth embracing.

This brings us to the last perspective on ADHD identities, the affinity identities (Gee, 2000). The recognition of affinity identities stem from the distinctive practices of a group of people, an affinity group, that shares allegiance to, access to, and participation in specific endeavors or social practices that create and sustain group affiliations. One does not need to own ADHD as part of natural or institutional identity to acquire ADHD as an affinity identity, that is, partly constitutive of the "kind of person" they are, nor does ADHD diagnosis lead to acquiring a meaningful affinity identity outright. Take parents, clinicians, authors, scholars, and (other) advocates with or without the diagnosis as an example. For them ADHD can become an affiliation, a matter of participating into a common cause, through actively sharing inside information or experiences on ADHD, or advocating for policies and changes in practices, values and attitudes to improve lives of those "with" ADHD.

Scholars representing different disciplines and paradigms, and perhaps sharing ADHD as their affinity identity, play their role in creating and strengthening the set of available ADHD discursive identities by communicating about the phenomenon as if it was an objective natural state, not a value-laden social category. However, the ADHD diagnosis does not project a value-neutral self-image for those so-labeled. Although a label may provide resources to understand oneself (empowerment) and make oneself understandable (humanize), it simultaneously distances one from "normalcy" and imposes stigma (e.g., Laws and Davies, 2000; Honkasilta et al., 2016; Wong et al., 2018; Honkasilta and Vehkakoski, 2019).

Not recognizing ADHD as a social category yet communicating about it as such [e.g., "people with ADHD (symptoms)," "neurodiverse people"] widens the gap between *us* and *them* rather than bridges it and closes the arbitrary boundaries of "normalcy" rather than opens them (see Runswick-Cole, 2014). The discourse cultivates empathy and respect for human diversity through labeling and categorizing difference. It normalizes the ableist status quo favoring and privileging assumed "neurotypicals."

CONCLUDING REMARKS ON HOW ADHD EXIST: THE CONSEQUENCES OF ADHD

The philosopher of science Hacking (2006) notes that human sciences, such as psychology, psychiatry, and to some extent clinical medicine, create kinds of people that in a certain sense did not exist before they were "identified." This is what he calls "making up people." The engines used in these sciences, such as statistical analyses and the striving to recognize hidden medical, biological, or genetic causes for problems that beset classes of people, are not only engines of discovery but simultaneously, and fundamentally, engines for making up people of certain kinds.

In this article we have demonstrated how making up "ADHD-people" takes shape as both top-down and bottom-up processes through discourse, institutional and social practices. We started off by problematizing the mainstream notion of western clinical psychiatry, exemplified in the DSM. The ontology of the claim about ADHD existing and being a real disorder lies not in nature nor does its epistemology point to clinical practices successfully "identifying" the condition. The onto-epistemological premises of ADHD are rather founded on pragmatism and utilitarianism (Tait, 2005; Sjöberg, 2019); on the idea that neurodevelopmental interpretation frame for behaviors, performance and functioning joined with psychiatric diagnoses are useful or even necessary in structuring institutional, social and (intra)personal lives and making sense of related everyday struggles.

For this reason, we reckon that the frequent changes in the diagnostic criteria of ADHD do not reflect any real scientific progress. Among other reasons, they change to match better the maneuvers of individuals when navigating an increasingly psychiatrized society in the search for recognition, support, category membership, immunity, sympathy, and sense of belonging. Psychiatric diagnoses produce a "looping effect" of human kinds (Hacking, 1995). This refers to a process where "people classified in a certain way tend to conform to or grow into the ways that they are described; but they also evolve in their own ways, so that the classifications and descriptions have to be constantly revised" (Hacking, 1995, p. 21).

The act of naming and making sense of behaviors, experiences, or persons through psychiatric nomenclature such as ADHD is a moral goal-oriented discursive practice with actual consequences for those subjected to it. We have illustrated that ADHD diagnosis has various functions that take specific forms related to specific objects that are negotiated. Fighting for legal rights or for discharge from liability, explaining behaviors, performance and functioning, allocating, planning, and implementing means of supports and treatments, involving parents in school, and cultivating sympathy, empathy and valued identities and agency are built on the idea of an ADHD as a valid neurobiological entity within an individual. These negotiation processes with the diagnostic entity have institutional (e.g., entitlement for/distribution of support), social (e.g., support practices, sympathy, empathy, stigmatization), and psychological (e.g., moral relief, empathy, empowerment, stigmatization) consequences.

Psycho-medical discourse of ADHD forms the object of which it speaks, that is the person "with" ADHD and various traits associated with the label. It directs focus on individuals—*them*—and guides the kinds of action that should be targeted for *us* to intervene positively in their lives and potential life trajectories. The well-meaning discourse also forms the subject of which it speaks, such as a patient, a sufferer of a disorder, (a parent of) a person "with" ADHD or an achieved entrepreneur. It enables a subject's maneuvering within the discourse for achieving certain kinds of recognition while simultaneously limiting subjects' access to other discourses (van Dijk, 1996).

To conclude, diagnosis does not represent *having* or *being* ADHD but *becoming* and *performing* ADHD through deploying psycho-medical discourse provided in the DSM. The diagnostic label is a sociocultural means of making meaning of embodied, material, and social experiences that may conflict with social contexts, and a means of communicating about these experiences and reacting to them in societal, institutional, social, and individual levels. ADHD is better understood as a social category that eliminates human diversity and enforces the standard model of what an individual should behave and be like in order to navigate within the cultural boundaries of normalcy and be a productive citizen.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article, further inquiries can be directed to the corresponding author/s.

AUTHOR CONTRIBUTIONS

JH was in charge of the second part of the article and the analysis of the forms and functions of the diagnostic entity. AK was in charge of the first part of the article focusing on critical assessment of the diagnostic criteria presented in the DSM-5. Both authors contributed to the article and approved the submitted version.

REFERENCES

Abramovitch, A., Dar, R., Mittelman, A., and Wilhelm, S. (2015). Comorbidity between attention deficit/hyperactivity disorder and obsessive-compulsive disorder across the lifespan: a systematic and critical review. *Harv. Rev. Psychiatry* 23, 245–262. doi: 10.1097/HRP.0000000000000050

Ahuja, A., Martin, J., Langley, K., and Thapar, A. (2013). Intellectual disability in children with attention deficit hyperactivity disorder. *J. Pediatr.* 163, 890–895.e1. doi: 10.1016/j.jpeds.2013.02.043

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders, 4th edn, Text Revision)*. Washington, DC: American Psychiatric Association.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders. 5th edn.* Washington, DC: American Psychiatric Publishing.

Antshel, K. M., Zhang-James, Y., Wagner, K. E., Ledesma, A., and Faraone, S. V. (2016). An update on the comorbidity of ADHD and ASD: a focus on clinical management. *Expert Rev. Neurother.* 16, 279–293. doi: 10.1586/14737175.2016.1146591

Bailey, S. (2010). The DSM and the dangerous school child. *Int. J. Incl. Educ*. 14, 581–592. doi: 10.1080/13603110802527961

Bailey, S. (2014). *Exploring ADHD: An Ethnography of Disorder in Early Childhood*. London: Taylor & Francis.

Barkley, R. A. (2002). International Consensus Statement on ADHD. *Clin. Child Fam. Psychol. Rev.* 5, 89–111.

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12, 645556. doi: 10.3389/fpsyt.2021.645556

Beeker, T., Witeska-Młynarczyk, A., te Meerman, S., and Mills, C. (2020). Psychiatrization of, with and by children: drawing a complex picture. *Glob. Stud. Child*. 10, 12–25. doi: 10.1177/2043610619890074

Berger, N. P. (2015). The creative use of the adhd diagnosis in probationers' self-narratives. *J. Scand. Stud. Criminol. Crime Prev.* 16, 122–139. doi: 10.1080/14043858.2015.1024945

Bleck, J. R., DeBate, R. D., and Olivardia, R. (2015). The comorbidity of ADHD and eating disorders in a nationally representative sample. *J. Behav. Health Serv. Res.* 42, 437–451. doi: 10.1007/s11414-014-9422-y

Bowden, G. (2014). The merit of sociological accounts of disorder: the Attention-Deficit Hyperactivity Disorder case. *Health*. 18, 422–438. doi: 10.1177/1363459313507585

Bredström, A. (2019). Culture and context in mental health diagnosing: scrutinizing the DSM-5 revision. *J. Med. Humanit*. 40, 347–363. doi: 10.1007/s10912-017-9501-1

Breggin, P. (1999). Psychostimulants in the treatment of children diagnosed with ADHD: risks and mechanism of action. *Int. J. Risk Saf. Med.* 12, 3–35.

Brinkmann, S. (2014). Psychiatric diagnoses as semiotic mediators: the case of ADHD. *Nordic Psychol.* 66, 121–134. doi: 10.1080/19012276.2014.926227

Bruno, A., Celebre, L., Torre, G., Pandolfo, G., Mento, C., Cedro, C., et al. (2019). Focus on disruptive mood dysregulation disorder: a review of the literature. *Psychiatry Res.* 279, 323–330. doi: 10.1016/j.psychres.2019.05.043

Byun, Y.-H., Ha, M., Kwon, H.-J., Hong, Y.-C., Leem, J.-H., et al. (2013). Mobile phone use, blood lead levels, and attention deficit hyperactivity symptoms in children: a longitudinal study. *PLoS ONE* 8, e0059742. doi: 10.1371/journal.pone.0059742

Carpenter, L., and Emerald, E. (2009). *Stories From the Margin: Mothering a Child With ADHD or ASD*. Teneriffe, QLD: Post Pressed.

Çelebi, F., Koyuncu, A., Ertekin, E., Alyanak, B., and Tükel, R. (2020). The features of comorbidity of childhood ADHD in patients with obsessive compulsive disorder. *J. Attent. Disord.* 24, 973–980. doi: 10.1177/1087054716669228

Christoffersen, M. N. (2020). Sexual crime against schoolchildren with disabilities: a Nationwide Prospective Birth Cohort Study. *J. Interpersonal Violence*. 088626052093444. doi: 10.1177/0886260520934442

Chronis-Tuscano, A., Monila, B., Pelham, W., Applegate, B., Dahlke, A., Overmyer, M., et al. (2010). Very early predictors of adolescent depression and suicide attempts in children with attention-deficit/hyperactivity disorder. *Arch. Gen. Psychiatry* 67, 1044–1051. doi: 10.1001/archgenpsychiatry.2010.127

Connor, D. F., and Doerfler, L. A. (2008). ADHD with comorbid oppositional defiant disorder or conduct disorder: discrete or nondistinct disruptive behavior disorders? *J. Atten. Disord.* 12, 126–134. doi: 10.1177/1087054707308486

Conrad, P., and Bergey, M. R. (2014). The impending globalization of ADHD: notes on the expansion and growth of a medicalized disorder. *Soc Sci Med*. 122, 31–43. doi: 10.1016/j.socscimed.2014.10.019

Copeland, W. E., Angold, A., Costello, E. J., and Egger, H. (2013). Prevalence, comorbidity, and correlates of DSM-5 proposed disruptive mood dysregulation disorder. *Am. J. Psychiatry* 170, 173–179. doi: 10.1176/appi.ajp.2012.12010132

Coppock, V. (2020). Psychiatrised childhoods. *Glob. Stud. Childh.* 10, 3–11. doi: 10.1177/2043610620901361

Cortese, S. (2012). The neurobiology and genetics of attention-deficit/hyperactivitydisorder (ADHD): what every clinician should know. *Eur. J. Paediatr. Neurol.* 16, 422–433. doi: 10.1016/j.ejpn.2012.01.009

D'Agati, E., Curatolo, P., and Mazzone, L. (2019). Comorbidity between ADHD and anxiety disorders across the lifespan. *Int. J. Psychiatry Clin. Pract*. 23, 238–244. doi: 10.1080/13651501.2019.1628277

Danielson, M. L., Bitsko, R. H., Ghandour, R. M., Holbrook, J. R., Kogan, M. D., and Blumberg, S. J. (2018). Prevalence of parent-reported ADHD diagnosis and associated treatment among U.S. children and adolescents, 2016. *J. Clin. Child Adolesc. Psychol.* 47, 199–212. doi: 10.1080/15374416.2017.1417860

Dauman, N., Haza, M., and Erlandsson, S. I. (2019). Liberating parents from guilt: a grounded theory study of parents' internet communities for the recognition of ADHD. *Int. J. Qual. Stud. Health Welbeing*. 14, 1564520. doi: 10.1080/17482631.2018.1564520

Davies, J. (2013). *Cracked. The Unhappy Truth About Psychiatry*. New York, NY: Pegasus Books.

DeRonda, A., Zhao, Y., Seymour, K. E., Mostofsky, S. H., and Rosch, K. S. (2021). Distinct patterns of impaired cognitive control among boys and girls with ADHD across development. *Res. Child Adolesc. Psychopathol.* 49, 835–848. doi: 10.1007/s10802-021-00792-2

DuPaul, G. J., Gormley, M. J., and Laracy, S. D. (2013). Comorbidity of LD and ADHD: implications of DSM-5 for assessment and treatment. *J. Learn. Disabil.* 46, 43–51. doi: 10.1177/0022219412464351

DuPaul, G. J., Reid, R., Anastopoulos, A. D., Lambert, M. C., Watkins, M. W., and Power, T. J. (2016). Parent and teacher ratings of attention-deficit/hyperactivity disorder symptoms: factor structure and normative data. *Psychol. Assess.* 28, 214–225. doi: 10.1037/pas0000166

Fairclough, N. (2004). "Semiotic aspects of social transformation and learning," in *An Introduction to Critical Discourse Analysis in Education*, ed R. Rogers (Mahwah, NJ: Lawrence Erlbaum Associates), 225–236.

Faraone, S. V., Banaschewski, T., Coghill, D., Zheng, Y., Biederman, J., Bellgrove, M. A., et al. (2021). The world federation of ADHD international consensus statement: 208 evidence-based conclusions about the disorder. *Neurosci. Biobehav. Rev*. 128, 789–818. doi: 10.1016/j.neubiorev.2021.01.022

Frances, A. (2013). *Essentials of Psychiatric Diagnosis: Responding to the Challenge of DSM-5*. New York, NY: Guilford.

Freedman, J. E. (2016). An analysis of the discourses on attention deficit hyperactivity disorder (ADHD) in US special education textbooks, with implications for inclusive education. *Int. J. Inclus. Educ*. 20, 32–51. doi: 10.1080/13603116.2015.1073375

Freedman, J. E., and Honkasilta, J. (2017). Dictating the boundaries of Ab/normality: a critical discourse analysis of the diagnostic criteria for attention deficit hyperactivity disorder and hyperkinetic disorder. *Disabil. Soc*. 32, 565–588. doi: 10.1080/09687599.2017.1296819

Frigerio, A., and Montali, L. (2016). An ethnographic-discursive approach to parental self-help groups: the case of ADHD. *Qual. Health Res.* 26, 935–950, doi: 10.1177/1049732315586553

Frigerio, A., Montali, L., and Fine, M. (2013). Attention deficit/hyperactivity disorder blame game: a study on the positioning of professionals, teachers and parents. *Health* 17, 584–604. doi: 10.1177/1363459312472083

Gajaria, A., Yeung, E., Goodale, T., and Charach, A. (2011). Beliefs about attention-deficit/hyperactivity disorder and response to stereotypes: youth postings in facebook groups. *J. Adolesc. Health* 49, 15–20. doi: 10.1016/j.jadohealth.2010.09.004

Gallo, E. F., and Posner, J. (2016). Moving towards causality in attention-deficit hyperactivity disorder: overview of neural and genetic mechanisms. *Lancet Psychiatry* 3, 555–567. doi: 10.1016/S2215-0366(16)00096-1

Gambrill, E. (2014). The diagnostic and statistical manual of mental disorders as a major form of dehumanization in the modern world. *Res. Soc. Work Pract*. 24, 13–36. doi: 10.1177/1049731513499411

Gee, J. P. (2000). Identity as an analytic lens for research in education. *Rev. Res. Educ*. 25, 99–125. doi: 10.2307/1167322

Germano, E., Gagliano, A., and Curatolo, P. (2010). Comorbidity of ADHD and dyslexia. *Dev. Neuropsychol*. 35, 475–493. doi: 10.1080/87565641.2010.494748

Hacking, I. (1995). *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. Princeton, NJ: Princeton University Press. doi: 10.1515/9781400821686

Hacking, I. (2006). Making up people. *Lond. Rev. Books* 28. Available online at: https://www.lrb.co.uk/the-paper/v28/n16/ian-hacking/making-up-people

Hawthorne, S. (2010). Embedding values: how science and society jointly valence a concept-the case of ADHD. *Stud. Hist. Philos. Sci. Part C* 41, 21–31. doi: 10.1016/j.shpsc.2009.12.00

Hinshaw, S. P., and Scheffler, R. M. (2014). *The ADHD Explosion: Myths, Medication, Money, and Today's Push for Performance*. Oxford: Oxford University press.

Hjörne, E. (2005). Negotiating the 'problem-child' in school. Child identity, parenting and institutional agendas. *Qual. Soc. Work* 4, 489–507. doi: 10.1177/1473325005058648

Hjörne, E., and Säljö, R. (2004). "There is something about Julia": symptoms, categories, and the process of invoking attention deficit hyperactivity disorder in the Swedish school: a case study. *J. Lang. Identity Educ*. 3, 1–24. doi: 10.1207/s15327701jlie0301_1

Hjörne, E., and Säljö, R. (2014a). Analysing and preventing school failure: exploring the role of multi-professionality in pupil health team meetings. *Int. J. Educ. Res.* 63, 5–14. doi: 10.1016/j.ijer.2012.09.005

Hjörne, E., and Säljö, R. (2014b). Defining student diversity: categorizing and processes of marginalization in Swedish schools. *Emot. Behav. Diffic*. 19, 251–265. doi: 10.1080/13632752.2014.883781

Honkasilta, J., and Vehkakoski, T. (2017). Autenttisuutta lääkitsemässä vai lääkitsemällä? adhd-lääkitykselle annetut merkitykset nuorten identiteettien muokkaajana. (in Finnish) [Medicating authenticity or authenticity through medication? Meanings given to ADHD medication as a means to construct identities of young people]. *Nuorisotutkimus* 35, 21–34. Available online at: http://hdl.handle.net/10138/234770

Honkasilta, J., and Vehkakoski, T. (2019). The premise, promise and disillusion of the ADHD categorisation – family narrative about the child's broken school trajectory. *Emot. Behav. Diffic*. 24, 273–286. doi: 10.1080/13632752.2019.1609269

Honkasilta, J., Vehkakoski, T., and Vehmas, S. (2015). Power struggle, submission and partnership: agency constructions of mothers of children with ADHD diagnosis in their narrated school involvement. *Scand. J. Educ. Res*. 59, 674–690. doi: 10.1080/00313831.2014.965794

Honkasilta, J., Vehmas, S., and Vehkakoski, T. (2016). Self-pathologizing, selfcondemning, self-liberating: youths' accounts of their ADHD-related behavior. *Soc. Sci. Med*. 150, 248–255. doi: 10.1016/j.socscimed.2015.12.030

Horwitz, A. V. (2021). *DSM: A History of Psychiatry's Bible*. Baltimore, MD: Johns Hopkins University Press.

Horwitz, A. V., and Wakefield, J. C. (2012). *All We Have to Fear: Psychiatry's Transformation of Natural Anxieties into Mental Disorders*. New York, NY: Oxford University Press.

Jacobs, D. H., and Cohen, D. (2012). The end of neo-kraepelinism. *Ethic. Hum. Psychol. Psychiatry* 14, 87–90. doi: 10.1891/1559-4343.14.2.87

Jensen, C. M., and Steinhausen, H. C. (2015). Comorbid mental disorders in children and adolescents with attention-deficit/hyperactivity disorder in a large nationwide study. *Atten. Defic. Hyperact. Disord.* 7, 27–38. doi: 10.1007/s12402-014-0142-1

Joseph, J. (2009). "ADHD and genetics: a consensus reconsidered," in *Rethinking ADHD: From Brain to Culture*, eds J. Leo, and S. Timimi (London: Palgrave MacMillan), 58–91. doi: 10.1007/978-1-137-02058-1_3

Karalunas, S. L., and Nigg, J. T. (2019). Heterogeneity and subtyping in attention-deficit/ hyperactivity disorder—considerations for emerging research using person-centered computational approaches. *Biol. Psychiatry* 88, 103–110. doi: 10.1016/j.biopsych.2019.11.002

Kazda, L., Bell, K., Thomas, R., McGeechan, K., Sims, R., and Barratt, A. (2021). Overdiagnosis of attention-deficit/hyperactivity disorder in children and adolescents: a systematic scoping review. *JAMA Netw Open*. 4, e215335. doi: 10.1001/jamanetworkopen.2021.5335

Kirk, S. (2004). Are children's DSM diagnoses accurate? *Brief Treat Crisis Interv*. 4, 255–270. doi: 10.1093/brief-treatment/mhh022

Kirk, S. A., Cohen, D., and Gomory, T. (2015). "DSM-5: the delayed demise of descriptive diagnosis," in *The DSM-5 in Perspective: Philosophical Reflections of the Psychiatric Babel*, eds S. Demazeux and P. Singy (London: Springer), 63–81. doi: 10.1007/978-94-017-9765-8_4

Kirk, S. A., Gomory, T., and Cohen, D. (2013). *Mad Science: Psychiatric Coercion, Diagnosis, and Drugs*. New Brunswick, NJ: Transaction.

Kofler, M. J., Irwin, L. N., Soto, E. F., Groves, N. B., Harmon, S. L., and Sarver, D. E. (2019). Executive functioning heterogeneity in pediatric ADHD. *J. Abnorm. Child Psychol.* 47, 273–286. doi: 10.1007/s10802-018-0438-2

Koutsoklenis, A. (2020). Functions of the ADHD diagnosis in educational contexts. *Metalogos* 36, 1–10. Available online at: https://www.metalogos-systemic-therapy-journal.eu/gr/issue/article/36-13

Koutsoklenis, A., and Gaitanidis, A. (2017). Interrogating the effectiveness of educational practices: a critique of evidence-based psychosocial treatments for children diagnosed with attention-deficit/hyperactivity disorder. *Front. Educ.* 2, 11. doi: 10.3389/feduc.2017.00011

Koutsoklenis, A., Honkasilta, J., and Brunila, K. (2020). Reviewing and reframing the influence of relative age on ADHD diagnosis: beyond individual psycho(patho)logy. *Pedagogy Cult. Soc.* 28, 165–181. doi: 10.1080/14681366.2019.1624599

Lacasse, J. (2014). After DSM-5: a critical mental health research agenda for the 21st century. *Res. Soc. Work Pract.* 24, 5–10. doi: 10.1177/1049731513510048

Laurence, J., and McCallum, D. (1998). The myth-or-reality of attention-deficit disorder: a genealogical approach. *Discourse Stud. Cult. Polit. Educ.* 19, 183–200. doi: 10.1080/0159630980190204

Laws, C., and Davies, B. (2000). Poststructuralist theory in practice: working with 'behaviourally disturbed' children. *Int. J. Qualit. Stud. Educ.* 13, 205–221. doi: 10.1080/09518390050019631

Levy, N. (2011). Enhancing authenticity. *J. Appl. Philos.* 28, 308–318. doi: 10.1111/j.1468-5930.2011.00532.x

Marangoni, C., De Chiara, L., and Faedda, G. L. (2015). Bipolar disorder and ADHD: comorbidity and diagnostic distinctions. *Curr. Psychiatry Rep.* 17, 67. doi: 10.1007/s11920-015-0604-y

Matthews, M., Nigg, J. T., and Fair, A. (2013). Attention deficit hyperactivity disorder. *Curr. Topics Behav. Neurosci.* 16, 235–266. doi: 10.1007/978-3-662-45758-0_249

McLaughlin, K. A., Green, J. G., Hwang, I., Sampson, N. A., Zaslavsky, A. M., and Kessler, R. C. (2012). Intermittent explosive disorder in the national comorbidity survey replication adolescent supplement. *Arch. Gen. Psychiatry* 69, 1131–9. doi: 10.1001/archgenpsychiatry.2012.592

Mills, C. (2014). *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*. London: Routledge. doi: 10.4324/9780203796757

Moore, C. B., McIntyre, N. H., and Lanivich, S. E. (2021). ADHD- related neurodiversity and the entrepreneurial mindset. *Entrepreneur. Theory Pract.* 45, 64–91. doi: 10.1177/1042258719890986

Ortega, F. (2009). The cerebral subject and the challenge of neurodiversity. *Biosocieties* 4, 425–445. doi: 10.1017/S1745855209990287

Ouyang, L., Fang, X., Mercy, J., Perou, R., and Grosse, S. D. (2008). Attention-Deficit/hyperactivity disorder symptoms and child maltreatment: a population-based study. *J. Pediatr.* 153, 851–856. doi: 10.1016/j.jpeds.2008.06.002

Pérez-Álvarez, M. (2017). The four causes of ADHD: aristotle in the classroom. *Front. Psychol.* 8, 928. doi: 10.3389/fpsyg.2017.00928

Pittelli, S. J. (2002). Meta-analysis and psychiatric genetics [letter to editor]. *Am. J. Psychiatry* 159, 496–497. doi: 10.1176/appi.ajp.159.3.496

Reale, L., Bartoli, B., Cartabia, M., Zanetti, M., Costantino, M. A., Canevini, M. P., et al. (2017). Comorbidity prevalence and treatment outcome in children and adolescents with ADHD. *Eur. Child Adolesc. Psychiatry* 26, 1443–1457. doi: 10.1007/s00787-017-1005-z

Reid, R., and Maag, J. (1997). Attention deficit hyperactivity disorder: over here, over there. *Educ. Child Psychol.* 14, 10–20.

Remschmidt, H., and Global ADHD Working Group (2005). Global consensus on ADHD/HKD. *Euro. J. Child Adolesc. Psychiatry* 14, 127–137. doi: 10.1007/s00787-005-0439-x

Ross, L. D. (1977). "The intuitive psychologist and his shortcomings: distortions in the attribution process," in *Advances in Experimental Social Psychology, Vol. 10*, ed L. Berkowitz (New York, NY: Academic Press), 174–221. doi: 10.1016/S0065-2601(08)60357-3

Runswick-Cole, K. (2014). 'Us' and 'them': the limits and possibilities of a 'politics of neurodiversity' in neoliberal times. *Disabil. Soc.* 29, 1117–1129. doi: 10.1080/09687599.2014.910107

Sanders, S., Thomas, R., Glasziou, P., and Doust, J. (2019). A review of changes to the attention deficit/hyperactivity disorder age of onset criterion using the checklist for modifying disease definitions. *BMC Psychiatry* 19, 357. doi: 10.1186/s12888-019-2337-7

Schubert, S. J., Hansen, S., Dyer, K. R., and Rapley, M. (2009). 'ADHD patient' or 'illicit drug user'? Managing medico-moral membership categories in drug dependence services. *Discourse Soc.* 20, 499–516. doi: 10.1177/0957926509104025

Sedgwick, J. A., Merwood, A., and Asherson, P. (2019). The positive aspects of attention deficit hyperactivity disorder: a qualitative investigation of successful adults with ADHD. *ADHD Atten. Def. Hyp. Disord.* 11, 241–253 doi: 10.1007/s12402-018-0277-6

Shallaby, C. (2017). *Troublemakers. Lessons in Freedom From Young Children at School*. New York, NY: The New Press.

Singh, I. (2011). A disorder of anger and aggression: children's perspectives on attention deficit/hyperactivity disorder in the UK. *Soc. Sci. Med.* 73, 889–896. doi: 10.1016/j.socscimed.2011.03.049

Sjöberg, M. N. (2019). Reconstructing truth, deconstructing ADHD: badiou, onto-epistemological violence and the diagnosis of ADHD. *Crit. Stud. Educ.* 62, 243–257. doi: 10.1080/17508487.2019.1620818

Solovieva, Y., and Rojas, L. Q. (2014). Syndromic analysis of ADHD at preschool age according to A.R. Luria concept. *Psychol. Neurosci.* 7, 443–452. doi: 10.3922/j.psns.2014.4.03

Solovieva, Y., and Rojas, L. Q. (2015). Qualitative syndrome analysis by neuropsychological assessment in preschoolers with attention deficit disorder with hyperactivity. *Psychol. Russ.* 3, 112–123. doi: 10.11621/pir.2015.0309

Tait, G. (2005). The ADHD debate and the philosophy of truth. *Int. J. Inclus. Educ.* 9, 17–38, doi: 10.1080/1360311042000299775

Tait, G. (2009). The logic of ADHD: a brief review of fallacious reasoning. *Stud. Philo. Educ.* 28, 239–254. doi: 10.1007/s11217-008-9114-2

te Meerman, S., Batstra, L., Freedman, J. E., Hoekstra, R., and Grietens, H. (2020). ADHD and brain anatomy: what do academic textbooks used in the Netherlands tell students? *Child. Soc.* 34, 136–150. doi: 10.1111/chso.12362

Tegtmejer, T., Hjörne, E., and Säljö, R. (2018). Diagnosing ADHD in Danish primary school children: a case study of the institutional categorization of emotional and behavioural difficulties. *Emot. Behav. Diffic.* 23, 127–140. doi: 10.1080/13632752.2017.1383685

Thapar, A., and Cooper, M. (2016). Attention deficit hyperactivity disorder. *Lancet* 387, 1240–1250. doi: 10.1016/S0140-6736(15)00238-X

Timimi, S. (2013). No more psychiatric labels: campaign to abolish psychiatric diagnostic systems such as ICD and DSM (CAPSID). *Self Soc.* 40, 6–14. doi: 10.1080/03060497.2013.11084297

Timimi, S. (2017). Non-diagnostic based approaches to helping children who could be labelled ADHD and their families. *Int. J. Qual. Stud. Health Wellbeing* 12, 1298270. doi: 10.1080/17482631.2017.1298270

Tomlinson, S. (2015). Is a sociology of special and inclusive education possible? Educ. *Rev.* 67, 273–281. doi: 10.1080/00131911.2015.1021764

Travell, C., and Visser, J. (2006). 'ADHD does bad stuff to you': young people's and parents' experiences and perceptions of attention deficit hyperactivity disorder (ADHD). *Emot. Behav. Diffic.* 11, 205–216. doi: 10.1080/13632750600833924

Valsiner, J. (2018). "The human psyche on the border of irreversible time: forward-oriented semiosis," in *Beyond the Mind: Cultural Dynamics of the Psyche* ed G. Marsico (Charlotte: Information Age Publishing), 503–532.

van Dijk, T. A. (1996). "Discourse, power, and access," in *Text and Practices: Reading in Critical Discourse Analysis*, eds R. C. Caldas-Coulthard, and M. Coulthard (London: Routledge & Kegan Paul), 84–104.

van Leeuwen, T. (2016). "Discourse as the recontextualization of social practice - a guide," in *Methods for Critical Discourse Analysis*, eds R. Wodak, and M. Meyer (London: Sage), 144–161.

Wakefield, J. C. (2013). DSM-5: an overview of changes and controversies. *Clin. Soc. Work J.* 41, 139–154. doi: 10.1007/s10615-013-0445-2

Wong, I. Y. T., Hawes, D. J., Clarke, S., Kohn, M. R., and Dar-Nimrod, I. (2018). Perceptions of ADHD among diagnosed children and their parents: a systematic review using the common-sense model of illness representations. *Clin. Child Fam. Psychol. Rev.* 21, 57–93. doi: 10.1007/s10567-017-0245-2

Ziobrowski, H., Brewerton, T. D., and Duncan, A. E. (2018). Associations between ADHD and eating disorders in relation to comorbid psychiatric disorders in a nationally representative sample. *Psychiatry Res*. 260, 53–59. doi: 10.1016/j.psychres.2017.11.026

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Sick or Sad? A Qualitative Study on How Dutch GPs Deal With Sadness Complaints Among Young Adults

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Feelings of sadness among young adults related to a certain phase of life or to societal factors run the risk of being interpreted as an individual medical problem. Therefore, healthcare professionals should more often widen their perspective and consider de-medicalization as being part of their professional responsibility too. This article presents results from a qualitative interview conducted with 13 GPs in different phases of their career to get more insight into the way they deal with complaints of sadness among young adults. All participants acted proactively but in different ways. Based on the interviews, a typology of three types of general practitioners has been created: the fast referrer, the expert, and the societal GP. There seems to be a paradox in the way GPs think about de-medicalization on a macro level and the way they act on a micro level. Elaborating on Parsons'(1951) classical concept of the sick role, this study introduces the term semi-legitimized sick role to clarify this paradox. The third type, "the societal GP", appears to be the most able to show a more multifactorial view on complaints of sadness. Therefore, this type connects the most to a course of de-medicalization.

Keywords: general practitioner, depression, sick role, young adult, medicalisation

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INTRODUCTION

According to the World Health Organization, unipolar depressive disorders were ranked as the third leading cause of the global burden of disease in 2004 and is expected to move into first place by 2030 (Lépine and Briley, 2011).

The medicalization critique argues that the rise of depression globally exemplifies a process whereby a problem of living—indicating social origins and social contradictions—comes to be redefined as a problem of individual biology. The conceptual framework of medicalization has been mainly coined by social scientists, among them Peter Conrad (1992) who defined medicalization as: "Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it" (p. 211). Critics like Illich (1975) who also take this view have argued that the biologization of depression constitutes a fundamental assault on the self, which, in the guise of a quick cure *via* the prescription of antidepressants, silences people's dissent and diminishes their capacity to reflect upon the social and political roots of their affliction (Kitanaka, 2011). Another line of criticism asserts that the medicalization of depression has brought to North America a "loss of sadness" (Horwitz and Wakefield, 2007), whereby people are losing their capacity for tolerance, patience, suffering, and grief. Noting how emotional life is being transformed by the act of taking "happy pills," some scholars suggest that this form of medicalization is creating moral anxiety—seen as impoverishing the cultural resources with which people have traditionally confronted the hardships of life (Chambers and Elliot, 2004). Parens (2013) also stressed that as medicine focuses on changing individuals' bodies to reduce suffering, its increasing influence steals attention and resources away from changing the social structures and expectations that can produce such suffering in the first place. The abovementioned examples and effects of the concept of medicalization shares features with the concept of psychiatrization defined by Beeker et al. (2021) as a complex process of interaction between individuals, society, and psychiatry. In order to effectively criticize the medicalization and psychiatrization of a problem Kaczmarek (2019) indicates, one needs to find an alternative explanation and a solution that would be more adequate and helpful in a given situation.

Over the past decades, sociologists have shown that the medical profession is only one of the many engines driving the complex process of medicalization (Conrad, 2005). However, physicians do play an important role regarding this subject. After all, if someone is convinced that he or she is having a medical problem that a physician can solve, the physician has the authority to prove the opposite, consult other professionals or change the course (RvS, 2017). Next to individual factors, social factors may contribute to a higher risk of sadness complaints among young adults (RvS, 2017). The Dutch National Institute for Public Health and the Environment (Rijksinstituut voor Volksgezondheid en Milieu) (RIVM, 2018) emphasizes the pressure to perform that young adults could experience. There seems to be a tendency to want and meet high standards, for example, on social media (RvS, 2017). On the other hand, the fact that (young) people sometimes feel lost and insecure in their search for meaning, identity, and purpose in life is less accepted as "normal" nowadays (RvS 2017). In their reports, the Dutch Council for Health and Society (RvS, 2017) and The Health Council of the Netherlands (RIVM, 2018) warn against the overmedicalization in cases of complaints of sadness. They argue that healthcare professionals should more often widen their perspective and consider de-medicalization as being part of their professional responsibility too.

In the healthcare system in the Netherlands, the General Practitioner (GP) plays the role of the gatekeeper. That is why the GP is in most cases consulted first when people are dealing with complaints of sadness among other things. As primary care provides highly accessible services and secondary care is relatively expensive, recent changes in the Dutch healthcare system were aimed at a more eminent role for mental healthcare by general practitioners. Since January 2014, according to new referral criteria, patients with mild psychological symptoms or social problems should all be treated within general practices (Magnée et al., 2017). To accommodate GPs in their larger role in providing mental health care, from 2008, the Practice Nurse Mental Health (PN-MH) has been introduced in general practices. In order to encourage the shift from secondary to primary mental health care and to save costs, the Ministry of Health, Welfare and Sports decided to provide more financial means in 2012, 2013, and 2014 to stimulate the deployment of the PN-MH in general practices. The PN-MH provides support in general practice care to all patients with psychological, psychosocial, or psychosomatic symptoms, while working under the supervision of the GP (Trimbos-institute, 2014). The role of the PN-MH is rather new but a function and competence profile describes that the tasks of the PN-MH often include diagnostic clarification, screening, referring to other mental health caregivers and providing accessible mental health consultation and brief advice or short-term treatment based on motivational interviewing or psycho-education for patients with early signs of psychological disorders or social problems. As the PN-MH provides mental health consultation and brief advice or short-term treatment within general practice, the PN-MH can be easily reached and patients can be easily referred (i.e., low-threshold service) (Abidi et al., 2019). Research of Verhaak et al., 2013 shows that more patients with psychological problems or symptoms such as anxiety or depression are seeking treatment within general practice: in the first 6 months of 2014, there was a 21% increase in consultations for psychological diagnoses compared to the first 6 months of 2013. Furthermore, Magnée et al., 2017 show in their research that the introduction of the PN-MH has not decreased antidepressant prescriptions, but that it may have a postponing effect. Eventually, based on the results of the study of Abidi et al. (2019), it seems that the PN-MH does not contribute to increased chronic or acute alcohol abuse diagnoses. How the introduction of the PN-MH specifically can be placed in the broader light of medicalization and psychiatrization could be investigated in further other research.

In the Netherlands, 9% of the young adults were, in their own words, dealing with depression in 2017 (Cbs Statline, 2017). Considering the important role of the GP regarding these complaints and the risk of them being (over) medicalized**,** the aim of this study is to get more insight into the way general practitioners deal with this task in relation to the complaints of sadness among young adults, how those complaints are viewed by them, and how they are influenced by societal, personal, and professional factors and patient characteristics.

DATA AND METHODS

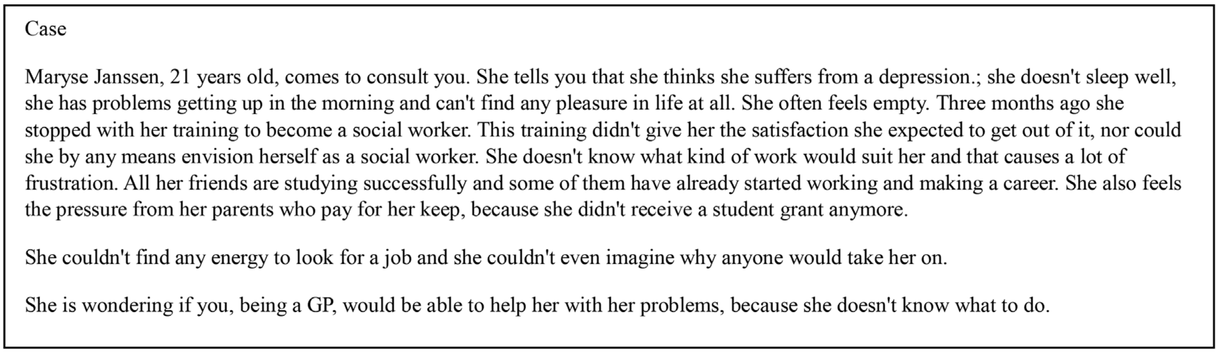
Participants

To obtain more knowledge on how the change in the Dutch healthcare system in 2014 and years of work experience impact the GPs' way of working when it comes to dealing with complaints of sadness, stratified sampling was used to select three specific groups of participants. A Dutch GP has received 3 years of specialist training after the basic 6 years of medical education. The first group were the alumni general practitioners, who finished their general practice after 2014 (abbreviated in **Table 1** as A), the second group were the more advanced general practitioners (abbreviated in **Table 1** as GP), and the third group were the general practitioners in training (abbreviated in **Table 1** as GP-T).

To recruit the more advanced GPs, an invitation was delivered at their workplace, but because of the limited response of one

TABLE 1 | Participants characteristics.

(Group) nr	A1	A2	A3	A4	A5	GP1	GP2	GP3	GP4	GP5	GP-T1	GP-T2	GP-T3
Gender	Male	Female	Female	Female	Female	Male	Female	Male	Male	Female	Male	Male	Female
Work-experience as GP (in years)	2	2	3	2	1	20	16	18	26	6	—	—	—



Case

Maryse Janssen, 21 years old, comes to consult you. She tells you that she thinks she suffers from a depression.; she doesn't sleep well, she has problems getting up in the morning and can't find any pleasure in life at all. She often feels empty. Three months ago she stopped with her training to become a social worker. This training didn't give her the satisfaction she expected to get out of it, nor could she by any means envision herself as a social worker. She doesn't know what kind of work would suit her and that causes a lot of frustration. All her friends are studying successfully and some of them have already started working and making a career. She also feels the pressure from her parents who pay for her keep, because she didn't receive a student grant anymore.

She couldn't find any energy to look for a job and she couldn't even imagine why anyone would take her on.

She is wondering if you, being a GP, would be able to help her with her problems, because she doesn't know what to do.

FIGURE 1 | Vignette "Maryse".

reply, snowball purposive sampling was used to recruit the rest of the more advanced participants (GP). The other two groups, general practitioners in training (GP-T) and the alumni general practitioners (A), were recruited *via* the database Department of General practice of the University Medical Centre Groningen (UMCG). An invitation to participate was e-mailed to all alumni GPs who graduated in or after 2014 and to GPs who were in their third year of training. The e-mail included information about the research, pseudonymization of data, and information about whom to contact for questions about the study. One reminder was sent to them. Finally, 13 GPs participated in this study: 3 general practitioners in training, 5 alumni general practitioners who finished their general practice after 2014, and 5 more advanced general practitioners were interviewed. Professionals were informed again before the start of the interview about the general nature of the study and gave verbal consent. For characteristics of the participants, see **Table 1**.

In-depth semi-structured interviews were conducted with GPs (in training) of the Northern Region of the Netherlands between March and July 2017. Interviews were held in the participant's workplace or home. Interviews lasted approximately 45 min.

A vignette was used at the start of the interview to obtain information from the participants about knowledge, attitudes, and perceptions regarding the research topic. Subsequently, the societal, personal, and professional factors and patient characteristics were questioned, being the basis for the topics of the interview schedule. The vignette was developed by the researchers using their experiences and knowledge of psychiatry, general practice, and sociology. With utilization of the research tool of vignettes, information can be gathered on difficult or sensitive topics (Hughes and Huby, 2002). In this research, it represented a young adult with complaints of sadness (**Figure 1**). It is a fictitious scenario and is purely hypothetical. After the vignette was developed, several GPs revised the vignette to check the credibility.

All interviews were audio-taped and transcribed. For ethical reasons, pseudonyms were used in transcription to protect the identities of the interviewees quoted in this article. We stored the data securely so only the research team could gain access to it. A thematic analytical approach was applied, with the principles of grounded theory in mind (Strauss and Corbin, 1990) and with both inductive and deductive coding using Atlas.ti 8.4.3 by the first author. Analysis commenced with an "open" reading of the data to code the text. Axial coding through an iterative process was then conducted in accordance with the four constituent elements: societal, personal, and professional factors and patient characteristics. To enhance the validity of the analysis, a second author, AD, also coded the transcripts. The researchers compared their coding and discussed the differences until they reached consensus. The remaining interviews were coded according to the revised code list. Saturation was achieved after coding six interviews, since no new codes emerged. Furthermore, thick descriptions were made from the data by reading the data and delving deeper into each issue by exploring its context, its meaning, and the nuances that surround it. During the process, there were critical discussions in the research team to enhance the consistency and validity of the data.

FINDINGS

In what follows, we present our findings in three sections. First, we show the GPs' responses on the presented vignette. Second, we demonstrate how their attitude towards complaints of sadness among young adults is influenced by societal, personal, and professional factors and patient characteristics. Third and summarizing, based on the findings, we show a drafted typology of GPs. We refer to the interviewed GPs using their group abbreviation and number.

TABLE 2 | GPs assessment and intervention.

	GP1	GP2	GP3	GP4	GP5
First response	Not pathological. A moment later: depressive symptoms. It does not "feel" like a depression	Does not want to label. Determines a few minutes later a "possible depression"	If the complaints exceed 2 weeks, she meets the diagnosis of depression according to the DSM	Thinks a depression is unlikely	Mood disorder
Diagnose	Using NHG standards. Not sure if symptoms meet the criteria "Maybe"	When the symptoms meet the NHG standards	A depression. Clearly, according to the DSM.	Does not use the NHG standards and DSM. No diagnosis by the GP.	Not yet.
Action	At first, normalizing. Follow up contact or consult at PN-MH.	First exclude physical causes. Consult PN-MH when symptoms meet NHG standards	Depending on the complaints PN-MH, a psychologist, or psychiatrist. Possibly start with antidepressants	Exclude physical causes. Further action depends on questionnaire completed by the patient	Follow up contact or consult at PN-MH for knowing the degree of severity
Other	Prescribes less antidepressants than 10 years ago. GP has also a societal function	Argues to take life phase problem out of the medical domain	Important to use DSM criteria for the common understanding; otherwise, there will be confusion	Sees GP more as a guide. Diagnose and prescribing antidepressants belongs to the task of a psychiatrist	Thinks there needs to happen more on societal level regarding the subject

TABLE 3 | Alumni's assessment and intervention.

	A1	A2	A3	A4	A5
First response	Being "stuck" because of more societal factors. Insomnia, eating problems, inactivity	Life phase problems. Logical questions on this age. Little later: depressive complaints	Complaints could fit a depression but they do not necessarily have to. Assessment is based on presentation, complaints and impression	Depression. When nothing happens, she will be in crisis in no time	"Quite" depressed not a "starting" depression
Diagnose	Depressive complaints. Could be or could become a depression. Uses NHG standards as a tool, not to diagnose	Suspicion of depressive complaints. Does not diagnose it herself. Instead, the PN-MH or the psychologist diagnose. Thinks the GP is only for an estimation	Needs to know more to diagnose	Depression according to the NHG standards and DSM. Already or very soon when nothing happens	Using the NHG standards for depression globally, only clearly for prescribing antidepressants
Action	Consult with PN-MH, job coach, social worker, or a psychologist when she wants	A questionnaire for the degree of severity of the complaints. Normalizing. Starting consultation at the PN-MH.	Assess the degree of severity him/herself or by the PN-MH. Psychologist is also an option	Start antidepressants. Refer to psychiatry, until that time consultation with the PN-MH to bridge the gap	Possibly an indication for the psychiatry
Other	Thinks that on a societal level there needs to be more attention for life phase problems	When it meets the DSM criteria for depression it is a depression. Also when there is a huge impact on life on the short term. Reluctant with antidepressants. Argues for more alternatives of the medical domain	Does not use the NHG standards to diagnose. Only sometimes to start with antidepressants	"Better to overstate than to understate." This participant experienced a patient who committed suicide after she already referred this patient to psychiatry	Psychiatry is a sluggish system. More preferable is a consultation with the PN-MH or the psychologist. Prefers therapy over prescribing antidepressants

TABLE 4 | GPs in training assessment and intervention.

	GP-T1	GP-T2	GP-T3
First response	Characteristics of depressive complaints, much less a depression, depending on the time and duration of it. "This demands action"	Meets the criteria of depression with underlying secureness. Could also possibly be a personality disorder	Life phase problems. Does not think the problem starts with a depression
Diagnose	Diagnose according to the NHG standards	Diagnose according to the NHG standards. Meets the suspicion of a DSM disorder	Assesses according to the DSM. Does not know if it means a depression according to the DSM, "could be"
Action	Consultation with the PN-MH or refer to a psychologist	Refer to a psychologist, in the meantime follow up at GP or PN-MH.	Coach or counsellor. Thinks this is a better way to deal with the problem
Other	Participant GP-T1 does not yet feel competent to deal with it him/herself. Reluctant with antidepressants	Reluctant with antidepressants	Ambivalent towards use of the DSM. At first, the participant concretely mentioned to use it; a moment later, this was contradicted

GPs Response on the Vignette

GPs' Reaction

Tables 2–4 describe how the three groups of GPs (GP, A, and GP-T) respectively responded to the presented case in the vignette "Maryse" (**Figure 1**) and the corresponding questions: "what's your first response," "what's your diagnosis," "what kind of action would you undertake," and other important notabilities. The participants responded very differently to the vignette. Some participants tended to diagnose the sadness complaints as depression, some were doubting but were almost sure of a depression, and others tended more to consider the complaints as life-phase problems. Remarkably, the participants' first response to the vignette was milder. As the interviewed GPs read the vignette for the second time or when they paid more attention on how they would diagnose the complaints, their assessment became more serious. They tended to diagnose more depressive complaints or a depression:

> "Yes, this is, this is a lady with feelings of insufficiencies, I think she's not depressed. Maybe relatively sad. She thinks she has a depression…yes, ok… She is not sleeping well, it's hard for her to get up in the morning. Ok. I think she is in it, ok. She feels empty. Yes there are symptoms of depression." (GP4).

At first, eight participants—three more advanced GPs, three alumni, and two GPs in training—thought of related life phase problems or light depressed complaints when it comes to the presented case in the vignette. When the interviewer later asked them how they would diagnose the complaints of the patient in the case in the vignette, two alumni clearly answered that there are depressive complaints or a depression. One more advanced GP, one alumnus, and one GP in training answered that they did not know yet. Two more advanced GPs did not diagnose the case in the vignette. One of them also said that a GP is also not the right person to diagnose a depression.

Furthermore, seven participants—two more advanced GPs, three alumni, and two GPs in training—had the opinion that the girl in the vignette had a depression. When the interviewer asked when they diagnose someone with a depression, the participants answered that they rely on the criteria of the Dutch NHG standards[1] or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Of the 13 participants, 11 mentioned the use of the DSM or the derived NHG standards to diagnose someone with a depression or to start antidepressants. The other two participants, two more advanced GPs, did not use the NHG but they did know the standard.

GPs' Action

All participants said that they would undertake some form of action in response to the case in the vignette (**Tables 2–4**). None of the participants would send the patient from the vignette home empty handed. They all wanted to do at least something for the patient. As mentioned in the previous paragraph, six participants thought the patient from the case had a depression. One of them would immediately refer her to a psychiatrist. Another participant mentioned that it could be an indication for psychiatry. Four of the six participants who diagnosed the patient's complaints as normal "life related" problems made a follow-up appointment or referred to their "physician assistant specialized in mental health." Two participants suggested an approach outside of the medical perspective, for example, a coach or a counsellor. When it comes to prescribing antidepressants, it was remarkable that all the GPs in training and a few alumni were skeptical. They preferred a nonmedicinal therapy for sadness complaints among young adults.

Factors Influencing GPs' Attitude

Below, we will describe how GPs are influenced by societal, personal, and professional factors and patient characteristics in the way they are dealing with complaints of sadness among young adults.

Societal Factors

Most of the interviewed participants explained the increase of sadness complaints among young adults by pointing at societal factors. Societal "pressure" was mentioned frequently during the interviews. According to the interviewed GPs, societal pressure may lead to perceived high expectations among young adults, which expresses itself in a high pressure to perform. The high pressure to perform was also mentioned to be caused by government policies and the general multitude of choices nowadays.

> "And also the binding recommendation on continuation of studies eh … and all those things. So they have to achieve a lot. And also … they have to look good, be slim, smart. So yeah well … A lot is asked of them, indirectly. So that has a little … well. If that doesn't work out, you can feel like you have failed." (GP3)

Also, technology and social media were mentioned 18 times by nine interviewed participants as a societal factor that may contribute to an increase of sadness complaints among young adults. According to the GPs, social media may lead to a disturbed perception of reality.

> "And of course, well, it is because … Maybe social media plays a role in it too. Everybody has to share happy pictures. To prove that everything is fine with you. That completely drives you crazy, doesn't it?" (GP4).

Furthermore, hedonistic characteristics and the way they were raised by their parents were mentioned as contributing factors to complaints of sadness among young adults.

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[1] The NHG clinical practice standards are most important in Dutch general practice. The NHG standard for depression is derived by the diagnostic criteria for depression in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV).

Influence of Societal Factors on the Practice of the GP

A few of the interviewed participants spontaneously started to talk about medicalization. They talked about medicalization in a negative way and as something that needs to be prevented when it comes to sadness complaints among young adults.

> "Yes, I think it's very important to respond to phase of life issues and to de-medicalize it and . . . to try and keep the label of a depression diagnosis off. Because this label . . . will be remembered and will be taken along." (A2)

The participants did not consider psychological treatment as a form of medicalization. They mentioned that a psychologist can help to deal with emotions, for example, through cognitive behavior therapy. Some interviewed participants mentioned that the medical domain is entered when visiting the GP, which can contribute to (over) medicalization. They argue that in order to avoid entering the medical domain with mild complaints of sadness, it is important to offer alternatives like community centers and schools. Other participants took opposite positions. When asked how they would de-medicalize, they seemed to struggle answering this question:

> I: How do you try not to medicalize?
>
> P: Ehm. . .. Yes, actually by naming it. By saying that I think that. . .. that the problem isn't a disease or something like that. But more about how someone is dealing with, or isn't capable to deal with more societal issues so to speak. But that's difficult, because yes, not being able to deal with certain things (?) can also be. . . a problem you know. So yes, it's complex, everything, has an impact on something else. You have to be aware of that in the sense that you look at the individual but you also take the background into account. And I think as a GP you need to do that, because you are the one who knows something about the background and you can ask things more easily." (A3)

Reflecting on the identified struggle of GPs to deal with medicalization and to adopt a more de-medicalized attitude towards complaints of sadness among young adults, the GPs also mentioned the use of a nurse practitioner. Furthermore, they emphasized to focus on the patient's own responsibility and to encourage patients to discuss problems with their family and friends.

When the interviewer introduced the statement of The Dutch Council for Health and Society (2017) on reducing the medical professional access in order to diminish medicalization and to encourage alternative professional perspectives, all participants agreed to this.

> "In fact it would be a good thing when schools and universities would pay more attention to the subject. Ehmm . . . for example small scale education with coaching . . . more attention should be paid to this during studies in schools." (A2)

During the interviews, all GPs reflected on their professional responsibility concerning sadness complaints. All GPs agreed that their responsibilities may transcend pure "medical" problems such as fractures or infections and explained that GPs are often consulted by patients for non-medical issues such as financial or relational problems or problems at work. Therefore, some of the interviewed GPs also see an important role for themselves on a more societal level. A few participants called it the "societal function" of the GP: "someone with whom you can discuss life questions and existential difficulties."

> "I am not only there for the medical function in a strictly medical domain. It's more like . . . as you can see there are unfortunately less and less pastors, priests and that sort of people. We, the practitioners, adopted that function more or less naturally. People used to go to the pastor, the priest, depending on the religion one had; the imam . . . And with . . . with the secularisation of the world, the GP became one of the people who took that role." (GP1)

Professional Factors

The interviewed participants frequently mentioned standards and guidelines when they explain how they are dealing with complaints of sadness among young adults. Of those, the NHG clinical practice standards[2] are the most important in Dutch general practice. The NHG standard for depression is derived by the diagnostic criteria for depression in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). The NHG standards guide the GP in diagnosing and treating depression. The way the interviewed GPs used the NHG standards strongly differed. Most participants suggested that NHG standards are more or less "in their head," meaning that they globally know the content of the NHG standards. They said not to use and follow the NHG standard exactly.

> "Those are more books of reference. It's not that we . . . it's not a questionnaire. Well, of course in psychology and psychiatry there are questionnaires which are used to determine if someone has a depression or not and the seriousness of it . . . that is something we do not do in general practice." (A3)

One participant did not use the NHG standards at all. Four other participants explained that they explicitly consult the NHG standards when prescribing medication. When asked about the difference between sadness complaints and a depression, four participants referred to the criteria for depression as stated in the DSM IV.

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[2] The Dutch College of General Practitioners (Nederlands Huisartsen Genootschap, NHG) provides maximum scientific support for general practice, thus facilitating the work of the individual GP. One way in which the NHG provides support to GPs is through the development of medical and pharmacotherapeutical guidelines. The guidelines cannot be enforced legally, but are held in high regard by Dutch GPs. These guidelines contain recommendations about anamnesis, examination, treatment, prescription and referring (Schäfer et al., 2010).

A second professional factor influencing the way the interviewed GPs deal with sadness complaints is experience. Three GPs stated that the more experience they had, the more they developed a more normalizing and de-medicalizing attitude towards complaints of sadness. Because of their experience, GPs feel capable to tell clients that their feelings are not weird or crazy and sometimes just part of life. Experience, usually connected with age, is a professional factor that results in a more normalizing attitude as well to a more moderate attitude towards medicalization:

> P: Yes . . . I do think you de-medicalise more when you become older.
>
> I: How come? Is it because you get older yourself or because you have become more experienced?
>
> P: I think you recognise the relativity of the medical circuit, among other things. (GP1)

The more experienced participants called their own "gut feeling" important when they deal with complaints of sadness among young adults. Three GPs and one alumni talked among other things about an "intuitive" feeling. One GP, for example, remarked the following about the patient in the vignette:

Knowledge about complaints of sadness, which was closely connected to experience, also influenced the participants. In particular, the younger and more inexperienced participants (one alumnus and two GP residents) argued that they were not educated enough about complaints of sadness or light mental problems during their GP specialization/medical studies. This is why they did not feel fully competent to deal with this kind of problem.

Finally, from the interviews, it was also evident that there is a great "willingness to act" among the participants when it comes to the subject. Two participants explicitly argued that they would tell the patient in the vignette case that he or she wants to do "something," to help and will do so. This also reflects the "struggle" the interviewed participants seem to have when it comes to complaints of sadness. Because of their "willingness to act" they tend to act proactively instead of adopting a more "wait and see" attitude.

> "It's obvious that we can do something, but first I would . . . euh, I would take stock of what the complaints are and euh(. . .) So . . . but I would certainly confirm I can do something. But in the first contact, that's what I would do." (A3)

Personal Factors

The personal curiosity and preference of the interviewed participants influenced the way they deal with young adults with complaints of sadness. Participants who had a lot of affinity with complaints of sadness showed a more active role than the participants who did not have much interest in the subject. Affinity could also impact the way one acts towards complaints of sadness:

> "If I have known the patients for a long time, or if I've got a special interest in problem I tend to 'keep them' (i.e., patient to be treated by the GP). That's better because they have also known me longer, then it's easier for them. So yeah, then it's a matter of how much affinity you have with the patient or with the problem. As a GP you always have to consider what you can do yourself or when to send to a specialist. If you had an endless amount of time you could do a lot more yourself. But you have to make choices. When you have affinity with them, you keep them with you longer. Yes, and of course the seriousness of the problem." (GP1)

Affinity with the subject could cause a less fast referral to other disciplines, which is evident from the following quote:

> "No . . . and I'm sure there are colleagues who quickly classify and then refer. But I just think it's . . . euh . . . extremely interesting." (GP5)

From the interviews, it turned out that participants used personal experiences to empathize with the patient, which could lead to a more empathic attitude. Normalizing complaints of sadness was also linked to one's own life experiences. Some GPs explained that they were inclined to a "normalizing attitude" towards sadness complaints, when they recognized a patient's problems from their own personal life. Younger participants, for example, recognized the issues young adults are dealing with from their own experiences as a student.

An interviewed GP, full of emotions, told that after she referred a young girl with complaints of sadness, the young girl committed suicide. This incident had a huge impact on the GP. Since that time, she referred almost every young adult with complaints of sadness to psychiatry or equivalents. The participant said:

> "Yes maybe we refer more often and more fast. And . . . Uhh yes. Maybe I overestimate sometimes. But anyway, yes" (A4).

Patient characteristics

During the interviews, participants sometimes expressed particular ideas about young adults in general that seem to influence the way they deal with individual (young adult) patients. One participant, for example, said that it is popular among young adults to be sad and to "have" a psychologist. This led to a more skeptical attitude towards the problem.

"For I really have the idea that the youth (. . .), that they more often have complaints of sadness. In some subgroups it's 'hot' to have a psychologist, in others it's the exact opposite. Some people come and say: "Everyone in my class has a psychologist and I haven't. There must be something wrong with me. I need a psychiatrist too". Then I start to wonder. Do young people really need to have complaints of sadness in order to fit in their group, to belong." (A1)

Two other participants expressed a more opposite idea, and thought that young adults feel ashamed to be open about their complaints of sadness to family or friends and therefore consult a

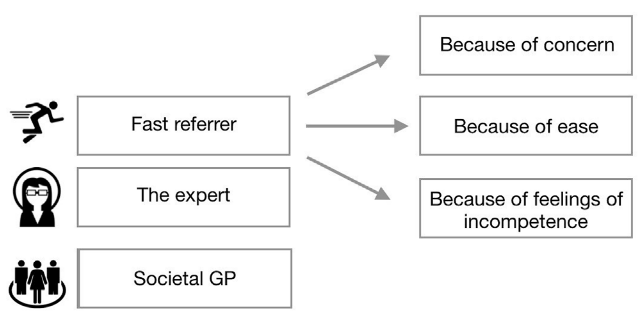

FIGURE 2 | Typology of GPs.

general practitioner. Instead of a skeptical attitude, the GPs are inclined to be extra watchful towards young adults.

> "It happens to everybody once in a while, but if you fly off the handle at such a young age . . . Do you know what I think? Some people consult their GP for every single fart that's bothering them. But many people don't and that certainly includes most young people. They are reluctant to be open about it. Because it's 'not cool' of course." (A5)

Other characteristics of young adults the participants mentioned were flexibility and vulnerability. This can be negative because not much is needed to bring them in a negative mood, as well as positive because some small advice can already be helpful. Another participant said that young people have the best chance for recovery because they are still able to adjust their life and because they are suitable for therapy.

Two experienced GPs argued that young adults are a vulnerable group because they are entering a new life phase in which they have to be more independent. They assume this can be troubling because young people nowadays are raised in a more protective manner. They are not used to deal with setbacks.

> "So yes, what strikes me is that a lot of young people have lived with their parents for a very long time and see their parents as some sort of friend, not as a parent anymore. Yes, maybe I am treading on thin ice right now . . .. But they have always been pampered. The only thing they've ever heard is appraisal: you're great; well done; you're so good; you're the best. But . . . no one is perfect. It's a good thing to fall flat on your face, to fail once in a while. Let me put it this way; it strikes me that many people, young people in particular, cannot cope well with setbacks and disappointments." (GP4)

Suicidal thoughts, earlier treatment in psychiatry, and family members with depression made the participants more alert. This can lead a GP to a quick referral to psychiatry, giving the diagnosis of depression and starting with antidepressants sooner. Six participants, three alumni and three more experienced GPs, mentioned this. Familiarity and awareness of family members with depression only occurred in the GPs who had their own practice.

Finally, from the interviews, it appeared that the participants were also influenced when patients came up with their own diagnoses. One participant mentioned that especially students in social studies tend to diagnose themselves. The risk of this "self-diagnosing" is that GPs become biased, they said, especially with subjective complaints like complaints of sadness.

The Drafted Typology

Based on the results of this research—how the participants dealt with the subject—we created a typology of GPs (**Figure 2**). In this

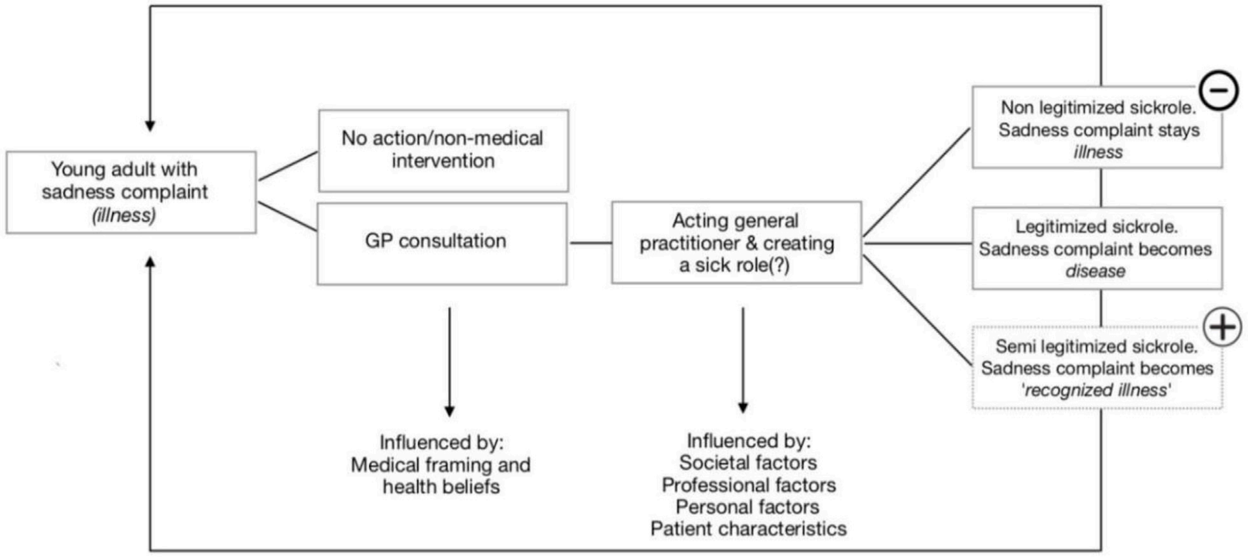

FIGURE 3 | Conceptual model with the introduced semi-legitimized sick role.

typology, we distinguish how the interviewed GPs were influenced by social factors, personal factors, professional factors, and patient characteristics. The first type is the fast referrer. It can be divided again into three subtypes regarding the reasons the GP has for referring the patient. The first one is *the referrer because of concern*. For example, there was a participant who experienced a suicide of someone she just referred to psychiatry some time before. For her, this experience is a reason to refer almost everybody with complaints of sadness to psychiatry. "Better overestimating than under estimating", this GP argued. The second one is *the fast referrer because of ease*. A GP of this type, for example, was convinced that it is not the GP's task to deal with complaints of sadness. GPs of this type were not very keen on the subject either. The third one is *the fast referrer because of feelings of incompetence*. These were mostly young doctors who said they lacked knowledge and training in how to deal with complaints of sadness. Therefore, it felt better for them to refer to another discipline.

The second type is *the expert*. This was the GP type that was interested in and felt competent with mental problems and therefore also tended to treat this kind of patient themselves. They used the DSM for this kind of problems and, if necessary, started antidepressants and sometimes even therapy by themselves.

The third type is *the societal GP*. This GP type considered that their responsibility may transcend pure "medical" problems and also see an important role for themselves on a more societal level: as someone with whom you can discuss life questions and existential difficulties. According to this type, in our secularized society, a GP also has the role of a "pastor" with whom people can discuss their problems. A GP of the "societal" type also argued that it is very important to abstain from sticking labels on people, especially on young adults.

DISCUSSION

Macro Versus Micro Level

The results show that participating GPs strongly differ in the way they deal with complaints of sadness among young adults although they are all inclined to act proactively. An important finding was the diagnostic struggle the participants showed. There seems to be a paradox in the way GPs think about de-medicalization on a macro level and the way they are proactively acting on a micro level. On a macro level, the interviewed participants all recognized the social factors that may lead to an increase in complaints of sadness among young adults. They mentioned the importance of refraining to stick medical labels on patients too easily and the importance of alternative perspectives instead of just the medical perspective. On a micro level, however, with a patient actually sitting in front of them, all GPs want to do something, although all the participants acted differently and they clearly "struggled" with it. Standards such as the DSM and the derived NHG standard for depression seem to contribute to this. Dutch GPs are more or less bound to the DSM and the derived NHG standards, which include medical and pharmacotherapeutic guidelines. The guidelines are held in high regard by Dutch GPs (Schäfer et al., 2010). The criteria of the DSM (and the derived NHG standards) only involve the individual (complaints). They are not being placed in a broader psycho-social context. This is part of the medical paradigm that, according to psychologist Verhaeghe et al. (2013), makes it hard to have a more societal view on the difficulties people are experiencing. The medical paradigm with corresponding language (disorders) and the subsequent goal of "treatment" (discipline) lead to a redefining and expansion of what we see as "sick" (Devisch, 2013).

Twaddle and Parsons

For a better understanding of the difference between a complaint of sadness and a recognized depression, a clear definition of the concepts disease, illness, and sickness can be useful. This full trial was firstly applied by Twaddle (1968). The distinction between disease, illness, and sickness has become commonplace in medical sociology, medical anthropology, and philosophy of medicine (Hofmann and Hofmann, 2002). According to Twaddle, disease is defined as a "health problem that consists of a physiological malfunction that results in an actual or potential reduction in physical capacities and/or a reduced life expectancy" (Twaddle, 1968, p. 8). Illness, on the other hand, is defined as "a subjectively interpreted undesirable state of health. It consists of subjective feeling states, perceptions of the adequacy of the bodily functioning, and/or feelings of competence" (Twaddle, 1968, p. 10). Sickness is defined as "a social identity". It is the poor health or the health problem(s) of an individual defined by others with reference to the social activity of that individual" (Twaddle, 1968, p. 11). Receiving a diagnosis from a physician can legitimize the complaints. Something that was labeled as a complaint (illness) before is from then on a disease (Jutel, 2009). This has also been emphasized by Parsons (1951), who coined the classic concept of the "sick role" to define illness from a sociological perspective. He argued that being ill was not only a biological condition, but also a social role with a set of norms and values assigned to it. According to Parsons (1951), seeking for medical care is part of the sick role. A physician has the exclusive right to legitimize a sick role: an illness ("a subjectively interpreted undesirable state of health") becomes transformed into a disease when this is considered applicable. Doctors can in this way be seen as "moral entrepreneurs" (Becker, 1963).

The Semi-Legitimized Sick Role

Because the participants in the present study always undertook some kind of action based on the complaint of sadness, we introduce the terms "semi-legitimized sick role" and the "recognized illness." The developed conceptual model in this research (**Figure 3**) displays this using the plus sign. This option applies for cases in which the GPs do act proactively and recognize the sadness complaints, but do not call it a depression yet. When they do label it as depression, a shift occurs between "illness" and "disease", and the sick role (Parsons, 1951) is completely legitimized. The non-legitimized sick role where a complaint of sadness remains an illness after consulting the GPs is no longer relevant because the participants always acted in some way. This option (an illness that stays an illness) is therefore erased from the conceptual model, which is depicted in **Figure 3** by the minus sign.

The results in this study are in line with the research of Mik-Meyer and Obling, 2012 who found that for a legitimate sick role, a traditional objective pathology in the body is not necessarily needed and subjective complaints (illness) may be enough for a GP to construct and legitimize the sick role. This happens by constructing and negotiating a sick role even when there is a lack of a clear-cut medical diagnosis and it is difficult to label a particular illness. This study also shows that "psychiatrization" is not an "exclusive problem" of only psychiatry and psychiatrists, but something that is also driven by non-psychiatric professionals, like GPs.

CONCLUSION

Findings

Based on our interviews with 13 GPs on how they handle complaints of sadness of youth, three typologies were identified: the fast referrer, the expert, and the societal GP. All participants endorsed de-medicalization on a macro level, but many had difficulties to put this into practice on a micro level.

According to the typology of GPs (**Figure 2**), the first subtype is *the fast referrer*: *the referrer because of concern*. This concern, coming from personal factors, could lead to refer most (young) people with complaints of sadness to psychiatry. This type therefore tends to legitimize the sick role relatively fast, with "illness" becoming "disease." For the other two subtypes, the fast referrer because of ease and the fast referrer because of feelings of incompetence, it is not yet clear whether the sick role is going to be fully legitimized or semi-legitimized; this depends on the type and content of the follow-up contact.

In the second type, *the expert* tends to follow the more traditional script, working strictly according to the DSM and prescribing antidepressants themselves. This is why the sick role is legitimized relatively fast and easy whereby "illness" becomes "disease."

The third type, *the societal* GP, prefers working without strictly adhering to the DSM and other standards. In this type, GPs seem to be most able to take off their medical glasses and show a more multifactorial view on complaints of sadness. Therefore, this type connects most to a course of de-medicalization that the Dutch Council for Health and Society (RvS, 2017) is pleading for. Also, this type does not tend to traditionally legitimize the sick role. Still, we did not want to do anything, that is why, in this study, we call this a semi-legitimized sick role where "illness" becomes "recognized illness."

Limitations

This research has an important restriction: the size of the included groups of GPs was too small to be able to say something about the influence of the change of the Dutch healthcare system in 2015.

Practical Implications

Our research is useful in constructing how the sick role is (semi) legitimized for young adults with complaints of sadness by GPs and how GPs are influenced by different factors by using the typology of GPs (**Figure 2**). This also leads towards a better understanding in how GPs could be able and feel competent to take off their medical glasses and show a more multifactorial view on complaints of sadness. The obtained insights and knowledge from this study are a useful contribution to critical medical sociology but could also be used for (a more reflexive) practice in education and training of (future) GPs. For example, considering the finding that all GPs in our study are inclined to act and do something for youths presenting themselves with sadness complaints, future GPs could be reminded of the noble "art of doing nothing." The principle of the (semi)legitimized sick role and the consequences of it may be helpful in learning to use time as both a diagnostic and a therapeutic tool (Heath, 2012).

Future Research

Recommendations for further research would be to gain more information about the definition and prevalence of the different GP types. Another recommendation is to gain more information on the "recognized illness" with a semi-legitimized sick role that is introduced in this study, for example, by applying the constructs on recent research showing that adolescents who had received a mental health disorder diagnosis were often excluded from the labor market and education as young adults (Ringbom et al., 2021). By using the semi-legitimized sick role, contributions can be made to better understand how individuals are affected by diagnoses through the legitimizing of the sick role and how subsequently society is.

DATA AVAILABILITY STATEMENT

The data supporting the conclusion of this article will be available on request to the corresponding author.

ETHICS STATEMENT

At the time of data collection (March-July 2017), oral informed consent for participation was required and received for this study and ethical review and approval were not required. In accordance with the present national legislation and institutional requirements to get ethical approval to use this research for the PhD of ED we are currently in a process of obtaining written consent from all the participants.

AUTHOR CONTRIBUTIONS

ED, DT, and AD contributed to conception and design of the study. ED collected the data. ED and AD performed the data analysis. ED wrote the manuscript. All authors contributed to manuscript revision, read, and approved the submitted version.

REFERENCES

Abidi, L., Oenema, A., Verhaak, P., Tan, F. E. S., and Van de Mheen, D. (2019). The Introduction of the Practice Nurse Mental Health in General Practices in the Netherlands: Effects on Number of Diagnoses of Chronic and Acute Alcohol Abuse. *BMC Fam. Pract.* 20 (1), 48–49. doi:10.1186/s12875-019-0938-3

Becker, H. S. (1963). *Outsiders; Studies in the Sociology of Deviance*. London: Free Press of Glencoe.

Beeker, T., Bhugra, D., Te Meerman, S., Thoma, S., Heinze, M., and Von Peter, S. (2021). Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research. *Front. Psychiatry* 12. doi:10.3389/fpsyt.2021.645556

Cbs Statline (2017) Gezondheid en zorggebruik; persoonskenmerken; kerncijfers. Available at: https://opendata.cbs.nl/#/CBS/nl/dataset/81628NED/table?ts=1534161606613. (Accessed 18 december 2020).

Chambers, T., and Elliott, C. (Editors) (2004). *Prozac as a Way of Life*. University of North Carolina Press.

Conrad, P. (2005). The Shifting Engines of Medicalization. *J. Health Soc. Behav.* 46 (1), 3–14. doi:10.1177/002214650504600102

Conrad, P. (1992). Medicalization and Social Control. *Annu. Rev. Sociol.* 18 (1), 209–232. doi:10.1146/annurev.so.18.080192.001233

Devisch, I. (2013). *Ziek Van Gezondheid: Voor elk Probleem Een Pil*. Antwerpen.

Heath, I. (2012). The Art of Doing Nothing. *Huisarts en Wetenschap* 55 (12), 580–583.

Hofmann, B., and Hofmann, B. (2002). On the Triad Disease, Illness and Sickness. *J. Med. Philos.* 27 (6), 651–673. doi:10.1076/jmep.27.6.651.13793

Horwitz, A. V., and Wakefield, J. C. (2007). *The Loss of Sadness: How Psychiatry Transformed normal Sorrow into Depressive Disorder*. Oxford University Press.

Hughes, R., and Huby, M. (2002). The Application of Vignettes in Social and Nursing Research. *J. Adv. Nurs.* 37 (4), 382–386. doi:10.1046/j.1365-2648.2002.02100.x

Illich, I. (1975). *Medical Nemesis*. The University of California.

Jutel, A. (2009). Sociology of Diagnosis: A Preliminary Review. *Sociol. Health Illn* 31 (2), 278–299. doi:10.1111/j.1467-9566.2008.01152.x

Kaczmarek, E. (2019). How to Distinguish Medicalization from Over-medicalization. *Med. Health Care Philos.* 22 (1), 119–128. doi:10.1007/s11019-018-9850-1

Kitanaka, J. (2011). *Depression in Japan: Psychiatric Cures for a Society in Distress*. Princeton University Press.

Lépine, J. P., and Briley, M. (2011). The Increasing burden of Depression. *Neuropsychiatr. Dis. Treat.* 7 (1), 3–7. doi:10.2147/NDT.S19617

Magnée, T., de Beurs, D. P., Boxem, R., de Bakker, D. H., and Verhaak, P. F. (2017). Potential for Substitution of Mental Health Care towards Family Practices: an Observational Study. *BMC Fam. Pract.* 18 (1), 10. doi:10.1186/s12875-017-0586-4

Mik-Meyer, N., and Obling, A. R. (2012). The Negotiation of the Sick Role: General Practitioners' Classification of Patients with Medically Unexplained Symptoms. *Sociol. Health Illn* 34 (7), 1025–1038. doi:10.1111/j.1467-9566.2011.01448.x

Parens, E. (2013). On Good and Bad Forms of Medicalization. *Bioethics* 27, 28–35. doi:10.1111/j.1467-8519.2011.01885.x

Parsons, T. (1951). *The Social System*. Glencoe: Free Press.

Ringbom, I., Suvisaari, J., Kääriälä, A., Sourander, A., Gissler, M., Ristikari, T., et al. (2021). Psychiatric Disorders Diagnosed in Adolescence and Subsequent Long-Term Exclusion from Education, Employment or Training: Longitudinal National Birth Cohort Study. *Br. J. Psychiatry*, 1–6. doi:10.1192/bjp.2021.146

RIVM (2018). *Themaverkenning 1: Zorgvraag van de toekomst. De mentale druk op jongeren lijkt toe te nemen*. Volksgezondheid Toekomst Verkenning.

RvS (2017). *Recept Voor Maatschappelijk Probleem*. Den Haag: medicalisering van levensfasen.

Schäfer, W., Kroneman, M., Boerma, W., van den Berg, M., Westert, G., Devillé, W., et al. (20102010). The Netherlands: Health System Review. *Health Syst. Transit.* 12 (1), v–228.

Strauss, A., and Corbin, J. (1990). *Basics of Qualitative Research*. Thousand Oaks, CA: Sage publications.

Trimbos-institute (2014). *Trendrapportage GGZ, themarapport. Versterking van de GGZ in de huisartsenpraktijk*. Utrecht: Mental Health Report. Strengthening of Mental Health in General Practice.

Twaddle, A. (1968). *Influence and Illness: Definitions and Definers of Illness Behavior Among Older Males in Providence*. Rhode Island: Brown University.

Verhaak, P. F., Kamsma, H., and van der Niet, A. (2013). Mental Health Treatment provided by Primary Care Psychologists in the Netherlands. *Psychiatr. Serv.* 64 (1), 94–97. doi:10.1176/appi.ps.201100541

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Psychiatrization in mental health care: The emergency department

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Background: In the light of high incidences of diagnosed mental disorders and the growing utilization of mental healthcare services, a progressing psychiatrization of society has been hypothesized as the underlying dynamic of these developments. Mental healthcare institutions, such as psychiatric hospitals, may play a decisive role in this. However, there is a scarcity of research into how psychiatrization emerges in hospital settings. This paper explores whether the emergency department (ED) can be considered as a site where psychiatrization happens, becomes observable, and which factors in the context of the ED may be its potential drivers.

Methods: Two cases as encountered in an interdisciplinary ED will be presented in the following in an anonymized way. Although the cases originate from individual consultations, they can be considered as prototypical. The cases were collected and discussed using the method of interactive interviewing. The results will be analyzed against the backdrop of current theoretic concepts of psychiatrization.

Findings: The ED can be seen as an important area of contact between society and psychiatry. Decisions whether to label a certain condition as a "mental disorder" and to therefore initiate psychiatric treatment, or not, can be highly difficult, especially in cases where the (health) concerns are rather moderate, and clearly associated with common life problems. Psychiatrists' decisions may be largely influenced in favor of psychiatrization by a wide array of disciplinary, institutional, interpersonal, personal, cultural, and social factors.

Conclusions: The ED appears to be a promising field for research into the mechanisms and motives through which psychiatrization may emerge in mental healthcare settings. Psychiatrists in the ED work within a complex sphere of top-down and bottom-up drivers of psychiatrization. Encounters in the ED can be an important step toward adequate support for many individuals, but they also risk becoming the starting point of psychiatrization by interpreting certain problems through the psychiatric gaze, which may induce diagnoses of questionable validity and treatment of little use.

KEYWORDS

psychiatrization, emergency care, case study, transdisciplinary research, psychiatric epidemiology, medicalization, overdiagnosis, health system research

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Introduction and state of research

Psychiatrization

On a global scale, there have been claims of consistently high or even rising incidences of mental disorders over the last decades (World Health Organization, 2019), resulting in an increasing financial burden on the global economy (Chisholm et al., 2016; World Health Organization, 2016). Survey-based epidemiological studies suggest a lifetime-prevalence of nearly 50% for a mental disorder among the US-population (Kessler et al., 2005; NIMH, 2019), while a meta-analysis across 63 countries identified an average 12-month prevalence of 17.6% for common mental disorders (Steel et al., 2014). These findings resonate well with similar or even higher numbers that are popularized by various mental health advocacy groups and awareness campaigns (MIND, 2021; NAMI, 2021). Currently, there is also widespread concern that the incidences of mental disorders may rise even further due to the COVID-19 pandemic (Hossain et al., 2020; Nearchou et al., 2020; Torales et al., 2020; Kola et al., 2021).

These high incidences are paralleled by a steadily growing utilization of in- and out-patient mental health services, which regularly entail the prescription of psychotropic medication (Lipson et al., 2019; Olfson et al., 2019). While prescription-rates for antidepressants more than doubled in many OECD countries from 2000 to 2015 (OECD, 2020), one in six US-adults is estimated to be on psychotropic medication over the course of a year (Moore and Mattison, 2017). Explanations for these developments are diverse. On the one hand, improvements in recognition and destigmatization of mental disorders are speculated to be causal (Mojtabai, 2010; Richter and Berger, 2013; Mars et al., 2017) as well as deteriorating working and living conditions (Ehrenberg, 1998; Eckersley, 2005; Dittmar et al., 2014; Rosa, 2015). On the other hand, overdiagnosis (Moynihan et al., 2012; Frances, 2013) and flaws in epidemiologic methodology (Horwitz and Wakefield, 2006; Jorm, 2006; Brhlikova et al., 2011) may also contribute to what appears to be a global mental health crisis.

In Beeker et al. (2021a), it has been suggested to understand the high, or rising incidences and the growing utilization of mental health services as different parts of a higher-order sociocultural process, which could be described as a *psychiatrization of society*. Psychiatrization is defined there as "a *complex process of interaction between individuals, society and psychiatry* through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole" (p. 3). Psychiatrization, thus, is conceived of as dynamic, heterogeneous, and as consisting of various sub-processes. The latter may comprise material as well as ideological aspects (see Figure 1).

The effects of psychiatrization are deeply ambivalent. On the one hand, some individuals or groups might benefit from lower-threshold access to an expanding mental healthcare system. Especially in underserved areas, the installation or the strengthening of facilities providing mental healthcare may first address existing unmet need and help close what has been referred to as "treatment gap" (Lancet Global Mental Health Group et al., 2007; Thornicroft et al., 2017). The more widespread provision of care and easier access to it may also be important steps toward a normalization of seeking professional help for what is widely perceived as mental disorders. That could contribute to lowering the remaining high pressures through stigma on people suffering from different kinds of mental distress (Thornicroft et al., 2009; Henderson et al., 2014). On the other hand, there is growing concern about the potential harms of psychiatrization. To individuals, psychiatrization may be detrimental through overtreatment and overdiagnosis (Kirsch et al., 2008; Turner et al., 2008; Whitaker, 2010; Read et al., 2014), or the psychological burden of being labeled (Livingston and Boyd, 2010; Chang and Bassman, 2019). From a public health perspective, psychiatrization risks exploding healthcare costs and widespread inverse care (Hart, 1971; Miller et al., 1988; Wang et al., 2007). In society as a whole, psychiatrization may further narrow down the scope of what is perceived as "normal" and encourage medical solutions for social and political problems (Behrouzan, 2016; Brinkmann, 2016; Davies, 2017; Klein and Mills, 2017).

One core feature of psychiatrization is its strong drive towards expansion. On a structural level, this may happen through the steady growth of psychiatric infrastructures or by changes in diagnostic practices (Rose, 2006; Batstra and Frances, 2012a; Cosgrove and Whitaker, 2015; Paris, 2015). These changes may be accompanied by more subtle transformations in discourse and public opinion, e.g., when psychiatric concepts become widely popularized and negative experiences are increasingly perceived through the psychiatric lens (Furedi, 2004; Brinkmann, 2016; Haslam, 2016). On the individual level, psychiatry may expand when people seeking help for common life issues, or mere individual variation are turned into psychiatric patients by being diagnosed and treated as mentally ill. This kind of low-threshold psychiatrization risks initiating avoidable patient careers by obscuring individual or life problems with psychiatric concepts. This may encourage individual identification with psychiatric labels, a weakening of self-efficacy, and, thus, ultimately create dependency on the mental health services (Rose, 2003; Martin, 2007; von Peter, 2013; Haslam and Kvaale, 2015).

In the medical field, research from different disciplines has shed light on various developments that bear relevance as the origins, mechanisms, or effects of psychiatrization, among them overtreatment, overdiagnosis, inflated epidemiological data,

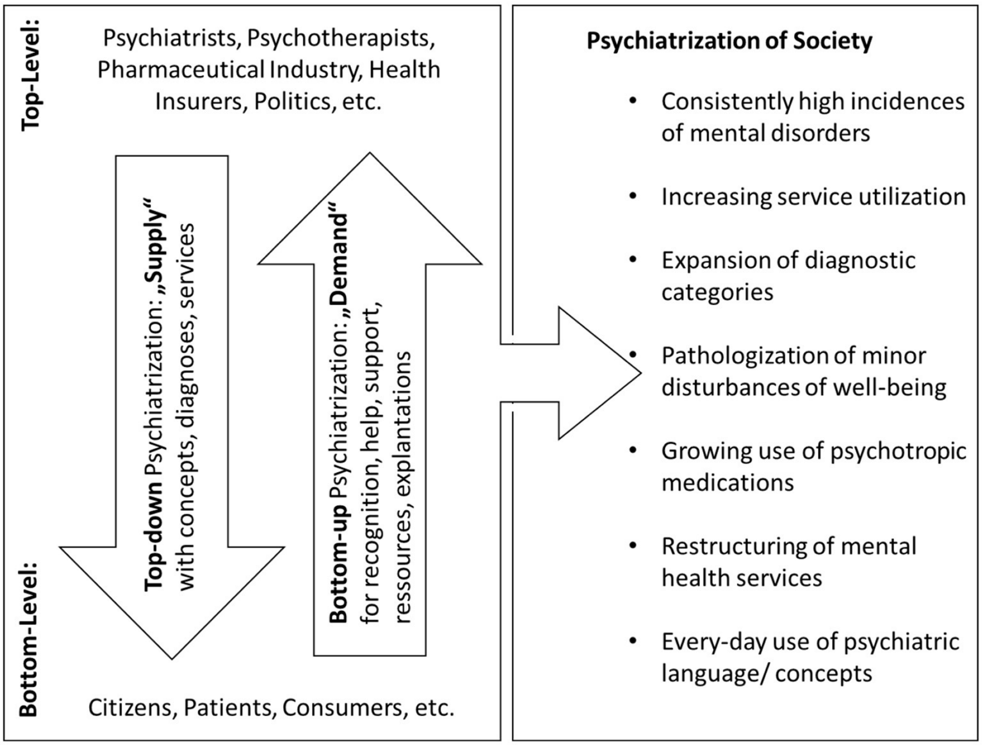

FIGURE 1
Top-down and bottom-up psychiatrization. Main protagonists and vectors of psychiatrization consisting of heterogeneous sub-processes, of which the most important are listed on the right side of the figure. First published in Beeker et al. (2021a).

drug-safety, and the rising prescription rates of psychotropic medication (Castner et al., 2000; Horwitz and Wakefield, 2006; Faber et al., 2012; Moynihan et al., 2012; Read et al., 2014). In this context, several measures which aim at countering some of the negative effects of psychiatrization have been suggested or applied on a relatively small scale, such as introducing stepped diagnosis (Batstra and Frances, 2012c), implementing open dialogue as a less psychiatrizing means of psychosocial support (von Peter et al., 2021), advocating alternative frameworks to psychiatric diagnosis (Baumgardt and Weinmann, 2022), limiting the influence of psychiatric corporate interest and pharmaceutical companies (Frances, 2013; Cosgrove and Whitaker, 2015) or, with a growing importance, fostering user-involvement in research and care (Gillard et al., 2010; Wright and Kongats, 2018; Beeker et al., 2021b). Nevertheless, a far wider array of aspects of psychiatrization has been described in non-medical disciplines, such as anthropology, critical psychology, sociology or Mad Studies, using different theoretical frameworks, methodologies, and terminologies (LeFrançois et al., 2013; Behrouzan, 2016; Jain and Orr, 2016; Russo and Sweeney, 2017). Research on psychiatrization heavily draws on the existing body of scientific research on medicalization (Zola, 1972; Illich, 1974; Conrad, 1992, 2005, 2007), biomedicalization (Clarke et al., 2003), pharmaceuticalization (Fox and Ward, 2008; Abraham, 2010; Jenkins, 2011), therapeutization (Furedi, 2004; Sommers and Satel, 2005), and psychologization (De Vos, 2010; Gordo Lopez and De Vos, 2010; Haslam, 2016). Seminal works in this broader context are, among others, those of the philosopher of science Ian Hacking on how psychiatric classifications evolve while circulating in “feedback-loops” between psychiatry and society and their power of “bringing into being” different kinds of people (Hacking, 1985, 1995a,b, 1998, 1999). Many arguments of those different strains of thought are still fueled by the radical skepticism toward psychiatry expressed in the classic anti-psychiatric literature of the 1960s and 70s (Goffman, 1961; Foucault, 1965; Laing, 1965; Cooper, 1967). Authors like Thomas Szasz famously challenged the idea that the behaviors or the emotions of human beings, however aberrant or unusual they may be, can be meaningfully construed as “mental illness” in the same sense as a somatic disease can be conceptualized (Szasz, 1974). Instead, the seemingly scientific disease categories of psychiatry would rather rely on moral judgment and social convention than on any kind of physiological basis. By casting fundamental doubts on the medical nature of psychiatric conditions, anti-psychiatric authors also raised the question if psychiatry can rightfully claim to be a medical specialty at all.

As a potential starting point for transdisciplinary inquiry into psychiatrization, a comprehensive model (see Figure 1) has been suggested in Beeker et al. (2021a). The relevant protagonists of psychiatrization have been classified into agents on the top- and the bottom-level, the latter consisting of "laypeople" without professional ties to the mental healthcare system. Within this model, drivers of psychiatrization can be imagined as vectors running either from top to down or vice versa, which can also involve the looping effects theorized by Hacking (1985, 1995b). On a large scale, top-down psychiatrization may be driven by diverse factors such as political decisions, interests of psychiatric professionals' organizations, scientists promoting their area of expertise, or financial incentives (Scott, 2006; Conrad, 2013; Cosgrove and Whitaker, 2015; Horwitz, 2015). Motives for bottom-up psychiatrization may be the "needs and desires of patients, proto-patients and consumers" (Beeker et al., 2021a, p. 5).

The emergency department as research field

There is a need for research on where exactly, how, and for which reasons psychiatrization emerges from mental health care. Against this background, the interactions between psychiatrists and people in need of help, which are taking place within the institutions of clinical psychiatry, are of particular interest. In many countries, psychiatric hospitals or general hospitals with psychiatric divisions are a central pillar of the mental healthcare system. In Germany, more than half of the practicing psychiatric specialists work in hospitals (DGPPN, 2021), making them an important locus for the research on psychiatrization. Within psychiatric hospitals, many *first contacts* between psychiatry as an institution and people in mental distress take place in the emergency department (ED), where clinical psychiatrists encounter people who may often be in the middle of an acute situation of crisis, which requires an interpretation that may entail psychiatric diagnosis and treatment as well—or not. From a sociological point of view, the decision whether a medical diagnosis is conferred may have important implications, as it determines if an individual obtains the entitlements and obligations associated with what Talcott Parsons coined as the "sick role" (Parsons, 1951). The ED might, thus, be a particularly interesting site for the inquiry into the origins, motives, mechanisms, and effects of psychiatrization, and into how these become tangible in the everyday work of clinical psychiatrists.

In multidisciplinary EDs, different medical specialties provide treatment to a broad spectrum of illnesses and injuries. They are the common entry point for patients in need of immediate care at hospitals in Germany and many other countries (Roppolo, 2007; Wyatt et al., 2012). Patients usually come to the ED without an appointment. They are either brought in by ambulance or arrive by their own means. Typically, the identification of the primary concern, a first assessment of the severity of the case, and the assignment to the medical specialty in charge ("triage") is performed by nursing professionals (Wyatt et al., 2012, p. 7). If hospitals dispose of a psychiatric department, the triage will also preselect patients for referral to the psychiatrist on duty. Broadly speaking, the main task of the psychiatric specialist is to recognize and specify mental disorders in accordance with the standards of psychiatric classification, and, if appropriate, to initiate treatment.

There is a variety of research from the social sciences on several aspects of the ED as "a complex space that can be interpreted on individual, societal and systemic levels" (Grace, 2020, p. 875). Scholars generally acknowledge the centrality of the ED in the organization of hospitals (Vosk and Milofsky, 2002c; Hillman, 2016; Grace, 2020). In this context, the ED serves as "gateway to higher levels of medical care" (Grace, 2020, p. 876). Organizational sociological perspectives often stress the fact that medical care in the ED is delivered rather by multidisciplinary teams than by individual specialists, making the ED a promising ground for the inquiry into interprofessional interactions and social hierarchies (Vosk and Milofsky, 2002a,b; Grace, 2020). Another branch of research focuses on gatekeeping-processes, which have a long tradition of being perceived as value-laden or economically driven exclusionary practices which can serve as barriers denying access to medical care to vulnerable groups (Jeffery, 1979; Dingwall and Murray, 1983; Hughes, 1989; Vassy, 2001; Hillman, 2014). The ED may, thus, contribute to and perpetuate basic health inequalities. However, there are also more ambivalent findings in this regard. Dodier and Camus (1998) characterize the ED's functioning as situated within a tension between the two poles of "openness" to spontaneous and heterogenous demands for medical care and "specialization". This points to the ED's task of selecting patients, who are eligible for immediate care, and of referring them to the responsible medical specialty. In a similar vein, Hillman's (2016) ethnographic study of an NHS hospital reveals how staff at the ED copes with the increasing tensions between their own moral commitment to good care and institutional concerns about resource rationalization and accountability. In a similar vein, Buchbinder (2017) challenges the traditionally negative connotations of gatekeeping and advocates a more balanced view, which does not narrow down its functioning to restrictive, exclusionary practices. More importantly, gatekeeping in the ED may rather facilitate the provision of appropriate medical care by diverting patients to alternative, better fitting sites of treatment or non-medical support, which often aligns well with' the genuine interests of the patients (Buchbinder, 2017).

In the following passages, two cases of psychiatric consultations in the ED of a general hospital will be presented. They will serve as material for exploring how psychiatrization may occur in psychiatric hospital settings as a first step toward the realization of broader empirical studies with larger samples and a wider array of methods. The exploration and analysis will be guided by following preliminary research questions: Is the ED, as an area of contact between psychiatry and society, a place where psychiatrization may emerge in an observable way? If so, which aspects of psychiatrization can be found there? Which top-down and bottom-up drivers of psychiatrization may become tangible in the ED? What can we learn about psychiatrization by analyzing the interactions between ordinary psychiatrists and patients in this specific setting? And, ultimately, how do these findings relate to previous conceptualizations of psychiatrization?

Methods and material

Approach and position of the author

Since psychiatrization itself is an interdisciplinary research object in between medicine and the social sciences, this case study posits itself in the tradition of two different methodological approaches with regard to the selection and analysis of individual cases. In the medical tradition, case studies or case reports usually present particular cases in which medical professionals had to deal with extraordinary challenges concerning diagnosis and treatment of a patient (Carleton and Webb, 2012). As such, case studies do not aim at generating statistically significant outcomes, but at an in-depth understanding of a special phenomenon or situation. Detailing clinical considerations and decisions, a case study is understood to have a double function: It serves as educational material for practitioners as well as a prospective first step toward the design of specific clinical studies with the aim of further investigating the phenomenon described (Nissen and Wynn, 2014). Case studies are typically written by the medical experts who themselves were responsible for the management of the particular case. The author's double role as the practitioner who handled the case and thereby actively contributed to the production of the material that she later describes and analyzes as researcher is usually not problematized. Rather, such case studies are valued for this kind of ex-post self-reflectivity, which may help to improve the provision of care in similar cases in the future (Solomon, 2006; Budgell, 2008; Carleton and Webb, 2012).

In the social sciences, case studies on medical topics are usually far more complex, refer to larger sets of data, not just to individual patients, and make use of a more sophisticated methodology. The researchers involved are typically not identical with the medical practitioners, whose actions contributed to produce the analyzed material. The potential bias inherent to individual perspectives is often sought to be counterbalanced *via* different kinds of triangulation (Keen and Packwood, 1995; Yin, 2009). Crowe et al. (2011) define the purpose of case study approaches as "to obtain an in-depth appreciation of an issue, event, or phenomenon of interest in its natural real-life context" (p. 1). Such case studies may thereby "provide insights into aspects of the clinical case and, in doing so, illustrate broader lessons that may be learnt" (p. 1). Crowe et al. (2011) further distinguish between three different types of epistemological approaches that may underlie case study research: The *critical approach* resembles the case studies in the medical tradition and has as its aim that the researchers involved openly question their own assumptions in the light of political and social factors such as power relations. *Interpretative approaches* aim at theory building and aspire to view the phenomenon in question from different perspectives in order to "understand individual and shared social meanings" (p. 4). The *positivist approach* usually focuses on "testing and refining" (p. 4) a pre-existing theory by studying variables established in advance and by contrasting them with the findings.

The approach taken in this article can be understood as standing at an intermediary position in between the above traditions. The same is true for the role of the author, who actively contributed to the collection and selection of the material, by which act he resembles the researcher in the medical tradition of case studies. In doing so, the author's position may be best described with Pols's concept of the "involved insider", who engages in the practice of "contextual reflexivity" (Pols, 2006). However, there are also some features in which the study presented here overlaps with the social sciences' tradition of case studies: Accordingly, self-reflection on the part of the practitioners is a desideratum of what Crowe et al. (2011) categorize as "critical approaches" to case studies as well. Furthermore, the selection and discussion of the cases is not exclusively performed by the author himself here but supported by the constant change of perspective through the process of interactive interviewing. In addition, the selection of the cases and of an ED as the research site are based on theory, the findings are interpreted in the light of theory and are supposed to help its further development. This, in sum, constitutes a significant overlap with the positivist approach to case studies in Crowe et al.'s taxonomy.

Case selection and analytical methods

For the case selection, the author, who is a psychiatric resident with 6 years working experience, engaged in "interactive interviewing" with three fellow residents from the same hospital (Tillmann-Healy and Kiesinger, 2001; Tillmann-Healy, 2003; Ellis, 2004; Adams, 2008). In interactive interviewing, participants mutually interview each other about their personal experiences with specific topics. The researchers, who engage in the process of interviewing, therefore, act as research participants themselves. The narratives which are thus produced are re-discussed and systematically reflected upon in the group. The aim of interactive interviewing is an in-depth understanding of another person's experience of complex and sometimes very personal matters. This can serve as a launching pad for a reflection which proceeds to more abstract concepts and starts the process of theory building or helps refining an existing one.

After a short introduction by the author into the concept of psychiatrization, all participants were instructed to think of “gray area-cases” they had personally encountered during shifts at the ED. In this respect, they were encouraged to focus on cases in which (a) fundamental questions arose about whether a displayed phenomenon truly fell within psychiatric expertise and/or whether (b) clinical decisions to handle a case in a medical way (e.g., by providing diagnosis and treatment) or not were outstandingly difficult and could have easily been decided the other way with equal plausibility.

From the collection of cases made in the interviewing process, two cases were selected. All participants agreed that they represented prototypical constellations for contacts in the ED in which practitioners experience fundamental doubts. These doubts were characterized as being much more about the question *if a psychiatric diagnosis was applicable at all* than about which diagnosis would fit best. In both cases, the practitioners’ doubts arose mainly from a central question. In short, case (1) is an example of a patient who displayed some sort of psychopathology, but his symptoms seemed completely understandable and proportional when judged in the context of his biography and an ongoing marital crisis. Case (2) presented a situation which was highly dramatic at first sight and in which different understandings of suicidality and sadness were at stake.

Interpretation and analysis of the cases were performed in two steps. The aspects displayed immediately after the individual cases were mainly derived from the process of interactive interviewing. However, they have then been subjected to a more profound consideration by the author. The second step of interpretation consists of the analysis in the discussion part, which was exclusively performed by the author himself. It aims at summarizing generalizable features of the cases and connecting them to broader developments relevant to psychiatrization. Interpretation and analysis of the cases are, thus, both enabled by a theoretical framework and by the experience of the author as an involved insider, reflecting again the hybrid nature of this case study between the traditions of medical and social sciences.

Cases

Within this section, two cases of psychiatric consultations in the ED of a medium-sized hospital with a psychiatric unit will be presented. All personal information about the help-seeking persons and their relatives has been anonymized. Details about specific persons or events were altered in a way that identification by third parties is impossible. Both cases originate from the hospital where the author and all participants of the interactive interviewing are currently or were working as psychiatric residents.

The hospital is located in the rural surroundings of Berlin/GER. The department of psychiatry comprises 94 beds for in-patients, among which 21 beds belong to the sub-specialty of psychosomatics. It includes three psychiatric day hospitals, three out-patient departments, and a home treatment-team and is part of the Brandenburg Medical School, a decentralized medical university established in 2014. The psychiatric unit is in charge of approximately 200.000 inhabitants of two counties, which belong to the federal state of Brandenburg. The ED is organized by nursing professionals and led by the specialty of internal medicine. Seven different specialties, including psychiatry, are involved in the acute treatment of a wide range of illnesses and injuries. Night- and weekend-shifts are typically covered by resident physicians, who are backed up by supervising senior physicians available on call.

The described hospital can be assumed to be neither especially prone to nor exceptionally resistant against psychiatrization and, thus, should most likely represent a (not yet quantifiable) average. For example, it is neither an ideological stronghold of biological psychiatry nor a place where standard psychiatric procedures are routinely undermined. Moreover, the selection of this hospital as the research site of this study enabled the participation of the author as an involved insider. From an ethical point of view, this also aligns with his conviction that research on psychiatrization from within psychiatry should include a high degree of self-critical thinking on the part of the practitioners.

Case 1: Depression or just a marital crisis?

> Mr. A., a 51-year-old elementary school teacher, came to the ED with his wife, wishing to talk to a psychiatrist. He gave a very worried and somewhat burdened impression. In private conversation, he revealed that he sought help, because he was convinced to be suffering from a severe depressive episode. He stated that a self-test on the internet, belonging to an app for the online treatment of depression, told him so just that day. When asked about his complaints, Mr. A. described a depressive mood, a lack of energy, and a decrease in activity accompanied by loss of appetite, agitation, and sleeping problems. Mr. A. reported his complaints in accurate medical language, hinting at prior treatment experience and extensive engagement with the concept of depression. When asked about this, Mr. A. confirmed that his wife had received psychiatric treatment for depression some years ago. She also was the driving force prompting him to do a self-test for depression and behind his coming to the ED in the first place. He himself had no prior contact with psychiatrists or psychotherapists, except

> for the probatory use of an app and extensive search of information on the internet.
>
> A more detailed examination of his complaints revealed that he had been suffering from an unstable mood over the last weeks, which did not appear to be consistently depressive. His primary concern was rather an inner restlessness, originating from intense worries about his future, which also impacted the quality of his sleep. His lack of appetite was only moderate, there was no sign of weight loss. Mr. A.'s level of energy was sufficient to keep doing his ordinary work and to take care of his 8-year-old daughter. He did not give the impression of being emotionally numb or unresponsive during the conversation and also confirmed that he had experienced some good moments during pleasurable activities with his daughter over the course of the last weeks.
>
> All in all, standard psychopathological examination showed no signs of severe depression. Mr. A., relieved by this information, elaborated on his situation: 3 weeks ago, he had found out that one of his friends had been making advances on his wife. After some casual flirting *via* WhatsApp, said friend openly confessed his love to Mrs. A. The latter was perplexed by this and showed the messages to her husband. She immediately replied to this declaration of love that she had no such feelings and requested the friend to stop contacting her. Nevertheless, Mr. A. remained deeply worried about this situation, because his last long-term relationship came to an end in a very similar way more than 10 years ago. In addition, his wife was 12 years younger than him. He had thus lived for years with the fear of losing her to a younger, more vital, and more exciting man. When asked about this, he admitted that he and his wife had encountered some conflicts before, because he tended to be suspicious and jealous when his wife met male friends or took part in leisure activities on her own.

While standard examination of psychopathology discouraged Mr. A.'s self-diagnosis, there were sufficient symptoms to justify the diagnosis of a mild to moderate depressive episode. However, the exploration of the context of Mr. A.'s complaints raised some doubts: From a strictly psychopathological point of view, the psychiatrist in charge remained unsure whether his symptoms, such as the described depressive mood or decrease in energy, appeared consistently or only sporadically, which would discourage a diagnosis of depression. In addition, she reported to have had a strong intuition that Mr. A.'s symptoms occurred as a very understandable, if not "normal" response to what had happened, and to how it had reopened emotional wounds. In the end, the psychiatrist who managed the case decided to diagnose a moderate depressive disorder according to ICD-10 (F32.1). Given that there was no sign of imminent danger and Mr. A. still seemed to handle many parts of his life quite well, she referred him to an out-patient service. Mr. A. also indicated that he would appreciate some pharmacological help for his restlessness and insomnia. The psychiatrist eventually handed out a small amount of Mirtazapine, an antidepressant with slight sedation as a welcome side-effect. She prescribed him a starter dose and suggested that his GP could augment it in 2–4 weeks. Although not being a formal standard, this proceeding corresponds to the clinical routines practiced by many residents, which are usually backed by their supervisors as medically rational.

Retrospectively, the psychiatrist in charge reported that Mr. A.'s case occurred to her as a typical gray area-case in which she could have refrained from psychiatric diagnosis and treatment with plausible reasons as well. She also stated that, thinking about it now, she would have preferred to take a second look at Mr. A.'s problematic 1 or 2 weeks later, before deciding about treatment and diagnosis. She did not consider this to be an option at the time, because she knew that keeping direct contact with the patient for watchful waiting would be impossible within the organizational structures of the ED and the hospital, where residents work in shifts and planned individual appointments are neither feasible nor reimbursable. In the following process of interactive interviewing, several other factors increasing the likelihood of a decision in favor of a psychiatric management of this case became visible: Mr. A. had a very clear notion of the nature of his complaints. He reported them in psychiatric vernacular and cited a self-test as proof of credibility. Furthermore, his wife had reassured him that he might be in a similar condition she used to be in when she was labeled depressive. All these factors, on the one hand, not only pre-formed Mr. A.'s own assumptions about his condition, but also shaped how he experienced and displayed his concerns as symptoms of depression. On the other hand, his expression and articulation of his complaints were very likely to influence the perception of the psychiatrist in charge, as clinicians may be susceptible to buzzwords and are trained to be on the watch for signs of hidden depression against the background of its widely postulated under-recognition and the dangers lying therein (e.g., Demyttenaere et al., 2004; Kohn et al., 2004; Merikangas et al., 2011; Werlen et al., 2020).

In sum, Mr. A. and his wife presented with the more or less explicit wish for a medical diagnosis of Mr. A.'s condition followed by medical treatment. Their expectations and desires were thus expressed in a way, that was inviting for psychiatrization. By coming to the ED, the couple also underlined that they were looking for *immediate* help and judged their problem to be urgent, at least too urgent to risk the typically long waiting times for an appointment with an out-patient psychiatrist or psychotherapist instead. Although the psychiatrist in charge reported that she did not feel directly pressured, she confirmed that she sensed that not giving in to her patient's expectation, refusing or postponing pharmacological treatment, would have entailed a time-consuming discussion and probably even generated an open conflict. In the end, clinical diagnosis and the start of treatment largely confirmed Mr. A.'s preexisting assumptions and may very likely have cemented his perception that his complaints originated from or were part of a mental disorder.

During the process of interactive interviewing, the participants tried to figure out what a less psychiatrizing intervention could have been like: One option for the psychiatrist in charge might have been to communicate to Mr. A. that she found his current health concerns and worries adequate, especially in the light of his prior experience with existential crisis in a similar situation. She could also have emphasized the harmlessness and presumably transient character of this episode of crisis. Furthermore, she could have offered a non-pathological explanation by suggesting to understand the problematic primarily as a marital crisis. This would have entailed a shift of perspective to the couple, instead of singling out Mr. A. as the "ill individual". Against the backdrop of a systemic instead of an individualistic concept, the psychiatrist on duty could have also encouraged Mr. A. to make his feelings and fears transparent to his wife (Fryszer and Schwing, 2014). If enough time had been available, she even could have started this process by inviting Mrs. A. to a short conversation while still in the ED. Thus, she could have emphasized the importance of open communication and of spending time with each other to the couple's relationship.

Other questions that surfaced during interactive interviewing were in which respect the intervention of the psychiatrist on duty was helpful and what other course of action could have been beneficial to Mr. A.'s situation. As there was no follow-up of his case, these questions remained purely hypothetical. Of course, the antidepressant may have had an immediate soothing effect and later-on possibly lifted Mr. A.'s mood. But opposed to the psychiatrization, to which Mr. A. has been submitted by means of the diagnosis and the subsequent treatment, enabling open communication about the hidden, maybe unconscious motives behind the couple's desires for psychiatric help could have been beneficial to both of them—especially in the long run. Moreover, from Mr. A.'s point of view, the diagnosis of a severe mental disorder could have been understood as symbolizing the severity of his suffering and, as such, served as proof of affection for his wife. Mrs. A., by contrast, by urging him to seek psychiatric help, signaled to her husband that she cared for him and that she took his suffering seriously. Seeking to make these complex dimensions of the situation visible to the couple might have been more helpful than diagnosis and pharmacological treatment. The interview group agreed that shifting the focus of attention to pharmacological treatment (e.g., by inducing intensive thinking about effects, side-effects, dosage, ability to drive, becoming addicted, etc.) could even have been counterproductive by distracting from what really was at stake. The processes of understanding and reconciliation which seemed to be central to Mr. and Mrs. A's crisis could thus have been hampered.

Case 2: Suicidal or just sad?

> On a Sunday afternoon, Ms. B., a barely 19-year-old apprentice in web design, was brought by ambulance to the ED from nearby Berlin. The paramedics announced her to be suicidal but cooperative. The ambulance was accompanied by the police, who had forced their entry into Ms. B.'s apartment, after having been warned that she might be in the immediate danger of suicide.
>
> Ms. B. agreed to talk with the psychiatrist on duty. She was genuinely polite and gave a sad and somehow intimidated impression. In private conversation, she explained that everything went terribly wrong that day, actually not only that day but over the course of a longer period of time prior to her admission. According to her, it had all started with the sudden death of her father 4 months before. Her father had been suffering for several years from a carcinoma with a relatively good prognosis. It used to be under control, but, all of a sudden, severe complications occurred, and he died within a few days. At about the same time, Ms. B. moved from the suburbs to more central Berlin. This change of residence was planned in advance due to her apprenticeship in Berlin. This move initially appeared to help her to cope with her father's death by providing her some inner distance and symbolizing a new, positive step in her life. Furthermore, her relationship with her boyfriend used to help her through this difficult time. They had had a long-distance relationship, but had managed to see each other every other weekend for more than a year.
>
> Ten days before her admission, her boyfriend told her that he had fallen in love with her best friend and therefore wanted to end their relationship. For Ms. B., this came totally unexpected and also struck her as quite absurd, because she knew that the friend in question was not very fond of her boyfriend. Thus, Ms. B. felt heart-broken, alone, and terribly sad. Because her boyfriend lived in a distant city, she could not even talk to him in person. She sent him messages and sometimes called him for a couple of minutes in a desperate attempt to understand what had gone wrong and how she could fix it. For the 4 days prior to her admission, she had shut down all contact with her ex, because she felt that it was dragging her down. She had realized that she was unable to change his decision. However, earlier that day he had called her to ask if she was alright. Ms. B. was emotionally overwhelmed by this and told him that she was feeling terrible, and that she did not know how to go on with her life. She then hung up, shut down her phone, laid down on her bed, and turned on loud music on her headphones. One

> hour later, the police came crashing through her door. It turned out that, when her ex had realized that he was unable to reach her on her mobile phone, he had called her mother, who decided to alert the police out of deep worry for the life of her daughter.
>
> In close examination, Ms. B. confirmed intense feelings of sadness. She did not sleep well, had troubles concentrating, had little appetite, and was not enjoying her hobbies very much over the course of the last 10 days. However, she reported that she had managed to keep doing all the tasks related to her apprenticeship. Moreover, spending time with friends had done her good. Sometimes, there were even moments when she started to sense that she would eventually overcome her broken heart and soon be fine again. She admitted that she had been thinking a lot about suicide over the last days. Such thoughts were entirely new to her. She experienced them as both frightening and somehow soothing to her inner pain. Nevertheless, she argued quite convincingly that it was very unlikely that she would actually commit suicide: She had never engaged in precise planning or preparation, she was rather the type for overthinking than for impulsive action and she could never do such harm to her mother and her younger brother, who had just suffered the tragic loss of her father.
>
> The psychiatrist on duty asked Ms. B. how she would like to proceed. Ms. B. told him that she just wanted to go home after this nightmarish trip to the hospital and maybe do some sports or read a book. The psychiatrist suggested that her mother could pick her up, but she asked for not involving her mother any further. They agreed that there was no need for medication at the moment and that Ms. B. should consider getting some support through a psychotherapy at some point, should she feel unable to cope alone with her situation in the future. The psychiatrist in charge showed her how to look for therapists on the internet. After short communication with the supervising senior doctor, he released Ms. B. from the ED under the condition of a telephone call the next day to confirm that she would be alright.

The psychiatrist on duty reported that he had very ambivalent feelings about the case of Ms. B. and about how to manage it. On the one hand, when strictly following the ICD-10 manual, neither the time criteria nor the symptom criteria for a depressive episode were fully satisfied (World Health Organization, 1993). In addition, there was no sign of any other preexisting mental disorder. On the other hand, it was obvious that Ms. B. was not well for very good reasons. Giving her no diagnosis at all would have felt to him like failing to acknowledge this fact. Eventually, the psychiatrist in charge decided to label her problematic as an adjustment disorder (F43.2), which is one of the very few diagnoses in the ICD characterized by being self-limited, directly caused by stressful life events, and free from strong neurobiological assumptions (Bachem and Casey, 2018; O'Donnell et al., 2019; Strain, 2019). Furthermore, it was clear that a diagnosis was required for the financial compensation of the hospital's services.

The interview group agreed that the case of Ms. B. was a gray area-case in which many colleagues, and the participants themselves as well, could have decided quite differently with very convincing arguments. The most difficult decision in this case was identified as being not which diagnosis would be accurate, but whether to admit Ms. B. to the psychiatric ward, or to discharge her from the ED. In this specific case, the psychiatrist on duty consulted his supervisor, because he was aware that discharging a patient who had been announced as suicidal and brought in by the police was rather unusual compared to the clinical routines. Finally, they worked out together that an immediate discharge was clinically justified and that, in the absence of legal criteria for an involuntary admission, the wish of the patient had to be paramount.

Several reasons why professionals could be inclined to favor the hospitalization of Ms. B. surfaced in the group discussion, among which risk reduction was the most salient: Although it may have been small, the risk that Ms. B. would eventually commit suicide—maybe in an impulsive act after another destabilizing call by her ex—could not be ruled out entirely. Inpatient treatment might have diminished this risk for Ms. B. as well as the legal risks for the psychiatrist on duty. In this specific case, he and his supervisor consciously accepted to take a (legal) risk by letting Ms. B. leave the hospital.

The interview group agreed that they themselves often felt a strong intuition that a person suffering to the point that she experiences suicidal thoughts *must have some kind of depression* regardless of the diagnostic criteria. This intuition may be rooted in psychiatric commonplace knowledge, e.g., that the majority of suicides is related to mental disorders and that depression, especially, constitutes a risk factor (Bertolote et al., 2004; Ferrari et al., 2014; Bachmann, 2018). But this intuition also seems to correlate with a widespread cultural assumption that echoes still existing taboos about suicide or, to be more abstract, about death and mortality in modern westernized societies in general (Becker, 1973; Ariès, 1974; Améry, 1976; Elias, 1985; Jacobsen, 2016). Against the backdrop of psychiatrization, the assumption that suicidal thoughts imply mental disorders could be problematic, as it seems to suggest the categorical exclusion of suicidality from the realm of what is "normal". Instead, suicidality is thus conferred to the realm of health problems and relegated to psychiatry as the medical discipline in charge of handling it. However, the taboo on suicidality could also be understood as a hint at a high, but hidden prevalence of suicidal thoughts and behaviors, possibly being more "normal" features of human life than society and institutional psychiatry believe or wish them to be.

From a broader perspective, the case of Ms. B. may point to even more cultural issues. As Horwitz and Wakefield (2007) claim in their seminal work "The Loss of Sadness", there is a deep running cultural deficit to perceive sadness through a non-medicalized gaze. This deficit originates from a cultural vacuum of concepts which would allow to perceive intense sadness, grief, and human suffering as something different than a mental disorder and also becomes palpable in Ms. B.'s case. Following Horwitz and Wakefield, it has become nearly unthinkable that suffering from a sadness deep enough to consider suicide could be anything other than the manifestation of a depression. Thus, soft factors, such as the cultural repository of concepts of sadness, might pave the way for diagnosis and treatment, even in cases where the diagnostic criteria of depression are not entirely satisfied.

To conclude the discussion, the interview group deliberated on the hypothetical question whether admitting Ms. B. to the psychiatric ward would have been an act of psychiatrization or not. The participants referred to their experience that hospitalization usually goes along with giving patients a rather severe diagnosis (such as depression compared to adjustment disorder). In addition, inpatient treatment is very prone to include medication. Both of these aspects could have a strong psychiatrizing effect. They could constitute the starting point of a prolonged and recurrent use of hospitals and other psychiatric services. This could have entailed a gradual redefinition of Ms. B.'s concept of herself and her problems in psychiatric terms. In the case of Ms. B., prolonged hospital stays were perceived as a realistic risk, since she was in an intrinsically difficult period of her life with challenges such as her move out from home and the start of a new professional career. Moreover, she had to cope with the premature death of a parent and the emotional turbulence of lost first love. In her case, the interview group agreed that in-patient-treatment could have had the effect of rather distracting her from tackling these challenges. By contrast, discharging Ms. B. from the ED with a vague recommendation of seeing a psychotherapist was perceived as a rather supportive move which could potentially help her to process her grief and to re-calibrate her life. Furthermore, the relatively pale and obscure diagnosis of adjustment disorder was judged to be less of an entry point for a psychiatric re-shaping of Ms. B.'s identity than a depressive episode, which was seen as inviting much more for identification and becoming a lived reality.

Discussion

Studies with a double focus on the ED and on psychiatry as an institution are rare. Literature from the psychiatric discipline is mostly concerned with the practical management of cases perceived as psychiatric emergencies (e.g., Chanmugam et al., 2013; Nicholls, 2015; Riba et al., 2016). In addition, there is a rich literature dedicated to the broader topics of violence reduction in psychiatric settings (e.g., Gerdtz et al., 2020; Biondi et al., 2021) or on involuntary hospitalizations (Weich et al., 2017; Sheridan Rains et al., 2019; Walker et al., 2019), which only touches upon the ED in some respect. In the social sciences, there is a long tradition of inquiry into cases of involuntary commitment to psychiatry and their underlying social determinants. For instance, being black, male, or arriving with the police has been found to increase the risk of involuntary hospitalization (Jeffery, 1979; Horwitz, 1982; Rosenfield, 1982, 1984; Lindsey and Paul, 1989; Way et al., 1993). However, more recent studies, such as Lincoln (2006), indicate the need for a paradigm shift: Conflicts in and around the ED may be increasingly about patients' interests in getting access to psychiatric care and the professional denial thereof. In times of growing economic constraints on hospitals, people from vulnerable groups might, thus, be much more likely to be exposed to the risk of being excluded from adequate care than of being socially controlled by involuntary hospitalization. In a similar vein, Lane (2020) points out how psychiatric diagnosis, as the key to medical care, has become an increasingly contested terrain with intense negotiations taking place between professionals and help-seekers in all settings which involve psychiatric assessment. Although psychiatric diagnosis is traditionally thought of as "stigma-laden" (Thornicroft et al., 2009; Henderson et al., 2014) and thus seems intrinsically highly undesirable, these negotiations point to the fact that it may also be appealing for people to receive a psychiatric diagnosis under some circumstances. Motives for the desire for a psychiatric diagnosis may be diverse but could partly be illuminated with Parson's classic concept of the sick role, that shifts the main responsibility to solve the then medically framed problems to the healthcare system and deflects moral judgment and guilt from the individual (Parsons, 1951). This may be especially attractive in cases such as those of Mr. A., when socially unwanted behavior would otherwise be explained as personal weakness or flaws in character (Moncrieff, 2020).

Psychiatrization in the ED

Two individual cases from the ED of a middle-sized hospital with a psychiatric unit have been presented and interpreted above. These cases have in common that it was deeply uncertain to which degree the presented phenomena fell within psychiatric expertise or not. Although gray area cases of this type may be frequent, many clinical psychiatrists would most certainly insist that the vast majority of patients presenting in the ED are either unambiguously "non-psychiatric cases", for example when an underlying somatic pathology can be identified or when symptoms clearly do not reach the threshold for diagnosis, or "psychiatric cases" in the sense that diagnostic criteria for a mental disorder are obviously fulfilled. Also, many people coming to the ED have long histories of psychiatric treatment under a certain diagnosis, during which their problematic has been assessed and reviewed by several experts. In these cases, the medical act of conferring the right diagnosis might be of minor, rather abstract importance in the ED from the practitioner's point of view, compared to much more concrete matters such as finding the right setting for acute treatment or improving insufficient individual medication. The gray area cases analyzed within this article thus only represent a certain part of the every-day work of psychiatrists in the ED, but, as will be demonstrated, a part that bears special relevance for advancing the understanding of psychiatrization in mental health care.

The overall results of this case study corroborate the recent paradigm shift in research toward emphasizing the agency of help-seekers and their relatives in the ED. They align well with Lincoln's (2006) and Lane's (2020) observation that psychiatric diagnosis and treatment in the ED may often be the result of complex negotiations, but also add to their findings by providing detailed insights into the negotiation process and the situational and ex-post reflections of psychiatric professionals. However, the central research question of whether the ED as an area of contact between psychiatry and society could be a place where psychiatrization may emerge in an observable way remains difficult to answer.

In the case of Mr. A., it can be argued that psychiatrization appeared in the specific sense that a certain problem, whose nature was fundamentally unclear, was claimed to fall within psychiatric expertise by its interpretation, diagnosis, and treatment as depression. In other words, through diagnosis and treatment Mr. A.'s depression *came into being* in an (at least) three-fold sense: (a) as a subjective conviction, which may gradually become a lived reality, (b) as an intersubjectively shared social reality (e.g., when relatives or professionals refer to the diagnosis and perceive a person through a certain diagnostic category), and (c) as a legal entity, which entitles to health care or other means of support. This constellation is comparable to the case of Ms. B., although she did not receive specific treatment and it is unclear whether the unspecific and rather pale diagnosis of an adjustment disorder really has the potential to become a subjective conviction that could evolve into a lived reality. Nonetheless, the doubts about the re-shaping of personal identities through psychiatric diagnosis and treatment in her case point to an important aspect: When it comes to individual cases, psychiatrization and its effects may be much better observable in a longitudinal perspective than by research designs which only cover a very limited timeframe. Without a follow-up on the cases, there is no way to know if Mr. A. ended up rejecting his medication and diagnostic label, or if Ms. B. went to an out-patient-psychiatrist and requested and received antidepressants. However, the above cases, as well as case study approaches to psychiatrization in general, may be useful to show situations which are crucial to individuals, since they constitute their first point of contact with the mental healthcare system in a situation of crisis. In this context, the explanations offered by practitioners and their decisions may significantly increase or decrease the chances of inducing profound changes within the identities of help-seekers and kick-start psychiatric patient-careers by means of—but not limited to—diagnosis, service-use, and medication.

Drivers of psychiatrization

Despite lacking a long-term perspective, the above cases contribute to deepening the understanding of psychiatrization by giving insights into the considerations of psychiatric practitioners, by outlining their range of action and revealing some of the factors that influence their decisions. Several factors that arguably increase the likelihood of psychiatrization in bottom-up or top-down ways became visible, of which not all have directly impacted the two above cases. However, these factors were part of the practitioners' considerations either in the original situation or in retrospective. Many of them might be generalizable in the sense that they may favor decisions with a higher risk of psychiatrization compared to a less psychiatrization-prone approach also in other cases and in different settings. In the terminology of the comprehensive model (see Figure 1) they, thus, can be classified as *drivers of psychiatrization* that either predominately run top-down or vice versa (see Figure 2).

In addition to the drivers listed above, several soft factors, which shape the context for both top-level and bottom-level agents, surfaced in the cases. These contextual factors are difficult to categorize. They may encompass general notions of normalcy that circulate in society as well as concepts which are culturally available to explain, understand, and give meaning to human suffering. Furthermore, there are many smaller or larger narratives which provide interpretations to crisis-like situations and may also determine what seems the right thing to do to when in such a situation. It is possible that these notions, concepts, and narratives are heavily influenced by psychiatric expertise, e.g., when crystallized into the form of a classificatory system. However, it seems convincing to assume with Hacking that there are strong reciprocal connections between society and psychiatric knowledge (Hacking, 1985, 1995b). Following this train of thought, even the act of creating a psychiatric classificatory system would be strongly impacted by assumptions about human suffering and about what is to be considered "normal" or "pathological" that were already present in society and nurtured by many other sources apart from psychiatry such as religion, spirituality, art, and the media.

In addition, a few other drivers appeared for which it seems unclear whether they primarily work in a bottom-up or a top-down way. For example, it is difficult to categorize the role of paramedics, who have a general medical training but are not specialized in matters of mental health. They, thus, do

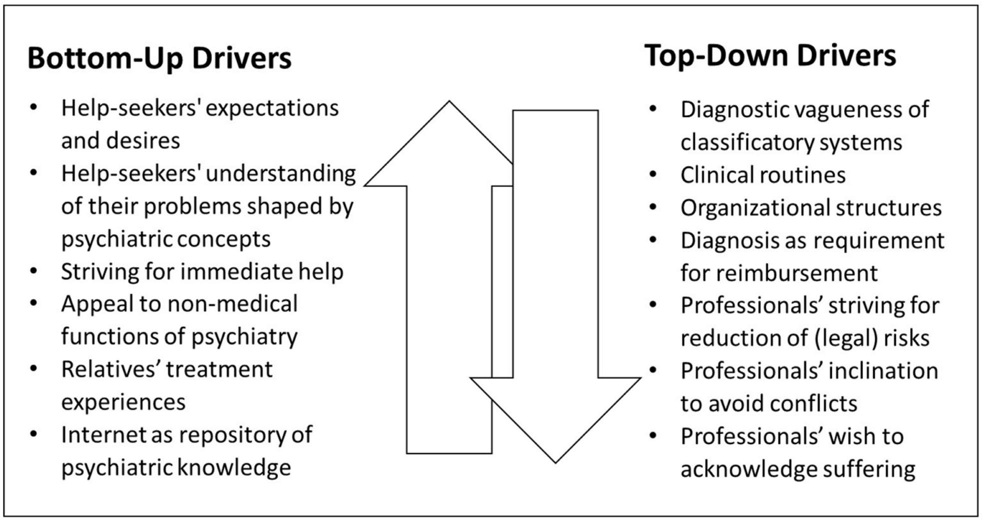

FIGURE 2
Drivers of bottom-up and top-down psychiatrization in the ED. **Bottom-up drivers**: (a) Help-seekers' expectations, encompassing their own diagnostic assumptions, and more or less specific desires for psychiatric diagnosis and treatment. (b) Help-seekers' understanding of their own problems that may have been shaped by psychiatric concepts and delineated by means of psychiatric vernacular. (c) Help-seekers' striving for immediate help, that may create an atmosphere of urgency even when watchful waiting would be suitable. (d) Help-seekers' appeal to psychiatry for non-medical functions, which may be related to its implicit (pedagogical, symbolic, ritualistic, mediating, etc.) dimensions. (e) Treatment experiences of help-seekers' relatives who may act as multiplicators of psychiatric expertise by providing psychiatric interpretations and giving recommendations based on how they were previously treated and what they were told by psychiatric professionals. (f) The internet as a repository of psychiatric knowledge, which is easily accessible and often consists of strongly simplified, popularized versions of expert-knowledge. **Top-down drivers**: (a) The diagnostic vagueness of psychiatric classificatory systems, that encourages ascribing diagnoses when operating in the gray area and opens up a space for negotiation between professionals and help-seekers. (b) Clinical routines that favor medication or hospitalization, e.g., when alternatives are not available in the ED-setting and finding individual pathways for psycho-social help is more time-consuming than following standardized medical procedures. (c) Organizational structures that impede watchful waiting and, thus, encourage diagnosis and the immediate initiation of (pharmacological) treatment, e.g., when psychiatrists working in the ED have no means to make follow-up appointments or cannot be sure if help-seekers will be able to see an out-patient psychiatrist soon. (d) Diagnosis as requirement for the reimbursement of services, putting economic pressures on hospitals and EDs, which increases the likelihood that people seeking help in situations of distress will receive a psychiatric diagnosis. (e) Professionals striving for risk reduction, including (their own) legal risks when underestimating or missing potential dangers, which may considerably lower the threshold for hospitalizations, diagnosis and treatment. (f) Professionals' inclination to avoid conflicts, which are likely to arise when help-seekers' (or their relatives') expectations and desires for a certain diagnosis or treatment are not met. (g) Professionals' wish to acknowledge and dignify human suffering through diagnosis and treatment, e.g., when watchful waiting would cause disappointment and feel like disregarding the problem causal for coming to the ED.

not clearly belong to the group of experts on the top-level. However, when called to an emergency, they might happen to be the first professionals who offer an interpretation of a situation or (health) problematic. This preliminary label may influence how a case is perceived and managed, e.g., whether patients are intentionally brought to a psychiatric unit, whether their chief complaint is announced as being psychiatric to the triage nurses, or whether help-seekers are directly handed over to psychiatrists. In a similar vein, many patients are brought to the ED by the police without the involvement of any medical professionals. Although police officers have no special medical training, which would support categorizing them as laypeople, they represent the state's authority and have the power to instigate an involuntary commitment to psychiatry, which would justify classifying them as agents of top-level-psychiatrization.

Many of the various drivers of psychiatrization which surfaced in the above cases would deserve a more detailed reflection. Given the scope of this paper, only four of them were selected for further considerations. This selection comprises (a) classificatory systems and diagnostic vagueness, (b) multiplicators of psychiatric knowledge, (c) non-medical functions of psychiatry, and (d) the power of narratives. While (a) mainly represents a top-down driver of psychiatrization and (d) is rather a contextual factor, (b) and (c) were selected to underline the significance of bottom-up psychiatrization. All four drivers are important in the context to the ED but may also be generalizable in the sense that they are likely to play an important role in many more cases than the above and in different settings. Thus, they could broaden the understanding of how and why psychiatrization may take place wherever mental health professionals need to determine whether the persons seeking help should receive a psychiatric diagnosis and treatment or not.

a) Classificatory systems and diagnostic vagueness

As has been exemplified above, diagnosis seems crucial to either inducing a psychiatric interpretation, management, and treatment of a specific problem, or not. In spite of this paramount importance of diagnosis as a kind of watershed moment, the available diagnostic manuals (ICD and DSM) have, since their introduction, been ongoingly challenged for their poor reliability and questionable validity (Frances, 2013; Regier et al., 2013; Lilienfeld, 2014; Wakefield, 2015; Fried, 2017; Fried et al., 2020).[1] This weak spot may be especially problematic when it comes to the increasing number of patients utilizing mental health services for what professionals perceive as mild or moderate disturbances (Hart, 1971; Wang et al., 2007; Olfson et al., 2019). With the mere presence of clusters of symptoms as defining criteria for diagnoses, and with little regard given to symptom severity (notwithstanding poor means to objectify severity), classificatory problems when using ICD or DSM may emerge, in particular, if some symptoms are to be found but they do not seem severe.

For instance, the diagnosis of a depressive disorder was plausibly applied to case 1 and could have been plausibly applied to case 2 as well. The definition of a depressive episode includes a broad spectrum of relatively unspecific symptoms of mental distress. Against this background, it appears only logical that anyone facing a larger life problem or any kind of personal loss will display at least some of these symptoms to a certain extent (Horwitz and Wakefield, 2006; Horwitz, 2015; Wakefield, 2015). Since this certain extent is not quantified in DSM or ICD, psychiatrists may tend to rely on vague overall impressions in order to fathom whether a certain psychological reaction is proportional or whether it is to be considered as excessive. However, when operating in such a space of diagnostic vagueness psychiatrists' decisions may very likely be influenced by factors that promote psychiatrization such as the above listed drivers. Of those, the role of the economic necessities of hospitals should not be underestimated. Since mental health services in many countries depend on psychiatric diagnosis for their reimbursement, this constitutes a strong systemic incentive to apply psychiatric labels to people seeking help in the ED as well (Batstra and Frances, 2012b,c). In many cases, this labeling may only be possible, when classificatory systems comprise unspecific diagnostic codes and criteria for diagnosis that can be handled quite loosely. The funding of clinical psychiatric settings may, thus, rely to a certain extent on the vagueness of classificatory systems.

The diagnostic vagueness of the existing classificatory systems, which may become most salient at their margins, might, thus, be fundamental to the psychiatrization of persons in distress in the ED and in other settings. Consequently, the creation of diagnostic manuals that generate diagnostic vagueness and encourage psychiatric diagnosis, when operating in a gray area, may constitute a powerful driver of top-down psychiatrization.[2] However, and somewhat paradoxically, the vagueness of the classificatory systems may also enable bottom-up psychiatrization, since it opens up a space to negotiations between professionals and help-seekers. Nonetheless, the manual's construction, interpretation, and application ultimately lie in the hands of psychiatrists. Therefore, it seems legitimate to classify diagnostic vagueness mainly as a top-down-driver of psychiatrization.

Nevertheless, this criticism risks being misleading. The fact that a person's symptoms fit into the frame of a certain diagnostic category does by no means prove that an individual is "mentally ill" in the sense that there is a distinct disease entity from which the individual is suffering. The ontological foundations of psychiatry are far from being unequivocal. In other words: The formally correct application of a diagnostic category on an individual case does neither prove that the applied specific category is valid nor that the overall assumption that mental disorders exist and can be classified is true. However, the complex scientific and philosophical debate about the existence, or reality of mental disorders, which has accompanied modern psychiatry from its beginnings (e.g., Szasz, 1974; Bolton, 2008; Hyman, 2010; Graham, 2013; Kendler, 2016) cannot be settled satisfactorily within the confines of this article. For the purpose of this analysis, it seems sufficient to acknowledge that, once a psychiatric diagnosis is ascribed to an individual, a mental disorder becomes real in the aforementioned three-fold sense of a subjective, lived reality, an intersubjectively shared social reality, and a legal entity.

Following this line of argument, the main criticism to be leveled against classificatory systems is not that they are weak tools to tell the people who "really" are mentally ill in an ontological sense from the people who are not.[3] Once a diagnosis is made, a person who does not actively refuse it *is really mentally*

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[1] As a matter of fact and somewhat ironically, the creation of DSM III was intended as an attempt to once and for all overcome the lack of reliability that characterized the psychoanalytically infused former two editions of the DSM by introducing an atheoretical, less etiological and more descriptive approach to psychiatric diagnosis (Horwitz, 2021). The historical background for this attempt was, among other factors, the harsh criticism of psychiatry originating from the social sciences and the anti-psychiatric movement and the loss of credibility of psychiatry as a scientifically based medical specialty, propelled by its inability to tell the mentally 'sane' from the 'insane' as famously unveiled by the Rosenhan experiment (Rosenhan, 1973).

[2] The power of classificatory systems may also be underlined by the very rare examples of de-psychiatrization through eliminating certain categories, as happened to homosexuality (Drescher, 2015) and seems to be currently happening with the transformation of *gender identity disorder* from ICD-10 into *gender incongruence* in ICD-11 (Reed et al., 2016).

ill in the above three-fold sense. Moreover, the point is that classificatory systems put up very low barriers to bring many people with mild, unclear, and unusual (health) complaints into being as mentally ill subjects. However, from a clinician's perspective, this criticism may contain some ambivalence: As also the most severe and disabling conditions might begin with mild or unclear symptoms, early detection of those with a high risk of developing severe and enduring mental disorders can potentially also be an opportunity to intervene before mental distress erupts into a full-blown crisis or becomes chronic (Trivedi et al., 2014; Arango et al., 2018). A more rigorous, less vague classificatory system with higher thresholds for diagnosis thus could also mean to curtail the chances for early intervention or even prevention of severe mental distress.

b) Multiplicators of psychiatric knowledge

As psychiatrization implies the increasing influence of psychiatric concepts in society, it may be worth asking what the above cases contribute toward an understanding of how psychiatric knowledge circulates between professionals and laypeople. The case of Mr. A. hints at two different ways how psychiatric knowledge may become a determining factor of how people cope with a crisis-like situation even without consulting a psychiatrist.

First, it is noteworthy that the admission of Mr. A. to the ED was prompted by his own internet research, through which he came across an online intervention for depression. As in many other aspects of life, the internet has become an important repository of easily accessible knowledge. This also holds true, when it comes to the matter of mental health (Christensen and Griffiths, 2000; Baker et al., 2003; Hesse et al., 2005; Loos, 2013). However, unless such research is very specific, the information suggested, when one types in general terms like "depression" and "treatment", are very likely to represent the hegemonic biomedical positions, as the algorithms of search engines obey to the laws of the attention economy (van Dijck, 2010; Morozov, 2012; Bozdag and van den Hoven, 2015). These may include exaggerated guesses about the prevalence of mental disorders as well as an increasing number of online interventions that encourage self-diagnosis and are aggressively marketed by private companies (Beeker and Thoma, 2019; Cosgrove et al., 2020).

It is easy to imagine that stumbling upon such information or "help" in a very early state of making sense of one's own "not feeling well" can impact subjective interpretations and expectations. What is striking about Mr. A. is that he described his condition in accurate psychopathological terminology and that he arrived at the ED with the clear expectation that his self-diagnosis would be confirmed. Prior to any contact with a psychiatrist, he already started to categorize, perceive, and experience his ailments as a matter of mental health or, more specifically, as symptoms of depression. Although it remained empirically unclear how much his internet research contributed to this psychiatric re-shaping of his identity, as compared to other influences, his case gives a rough impression of how the internet could be an important multiplicator of psychiatrization by popularizing psychiatric concepts, encouraging identification with them, preforming expectations about diagnosis and treatment, and disseminating the vernacular of psychiatry in society.

Second, it is also remarkable that Mr. A.'s notion of being mentally ill was firmly supported by his wife. She had prior treatment experience and was fairly convinced that her husband was in need of psychiatric treatment as well. The role of Mrs. A. points to an important aspect as to how psychiatric knowledge circulates in society. Laypeople who have experienced psychiatric treatment themselves and who have, as opposed to psychiatric "survivors" (LeFrançois et al., 2013), accepted their psychiatric labels, might act as *spreaders of psychiatric concepts*. They may impact their relatives, friends, colleagues, etc. by providing psychiatric interpretations to problems or health concerns and by promulgating recommendations based on their own experiences as well as on what they were told by professionals. They, thus, may contribute to disseminate psychiatric knowledge (or: a personalized, possibly simplified version of psychiatric expert knowledge) and ideas of how to help someone in mental distress. In doing so, ways of how to react to individuals' crises may be inscribed into the body of common-sense knowledge of a society. Laypeople with treatment-experience, thus, may act as multiplicators and reinforcers of bottom-up psychiatrization by iterating and spreading top-down expert knowledge (Beeker et al., 2020). They thereby participate, presumably for benevolent reasons, in ingraining patterns of perception, interpretation, and action, which are essentially shaped by psychiatry, into their social networks and society as a whole.

c) Non-medical functions of psychiatry

Many admissions to psychiatry may be prompted by relatives of the individuals in distress. Their motives for this can be diverse: As in both above cases, the primary reason is frequently the honest belief in the necessity of psychiatric treatment and the assumption that it would be helpful. But relatives may also wish to share responsibility with professionals, as in case 1, or even to shift the main responsibility to institutional psychiatry.

Apart from this, an admission to psychiatry may sometimes also be resorted to for *pedagogical* reasons. In case 1, bringing Mr. A. to the ED also signifies that his level of worrying exceeded what Mrs. A. perceived as tolerable. The case of Ms. B. provides

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[3] It is worth noting that following the most radical critics of psychiatry, this distinction would be entirely meaningless, as there just are no people being rightly classified as mentally ill, when the idea of the existence of mental disorders as a whole is refused.

a much stronger example. Her encounter with psychiatry was initiated by her mother and her ex-boyfriend as a reaction to her implicit threatening with suicide. Her admission to psychiatry, including the dramatic act of the police forcing their entry through her door, can, thus, also be understood as a very powerful statement that it means crossing a red line to utter suicidal thoughts and then shut off one's phone. Beside more benevolent motives, psychiatry was used here to teach Ms. B. a pedagogical lesson, namely that she went too far in a way considered not "normal" and intolerable.

In contrast to this pedagogical function, seeking help from a psychiatrist can also have a more positive *symbolic* or *ritualistic* dimension. When Mr. and Mrs. A. decided to come to the ED, their decision was based on the mutual acknowledgment of a need for change. For them, seeking professional help was not only intended as a first practical step, *it was* an act of reconciliation in itself. In this context, psychiatry is appealed to as an abstract authority which bears witness to the agreement that "something has to change" and to acknowledge the sincerity of this desire for change. In some cases, the role of the psychiatrist may, thus, rather resemble the role of a priest, or of a notary, than the role of a physician. Moreover, psychiatrists may often also act as *mediators*, not only witnessing, but actively facilitating the reconciliation of people coming to the ED.

In sum, psychiatry may be appealed to for non-medical functions as well, e.g., as a pedagogical, ritualistic, or mediating authority. These functions of psychiatry seem to be rather implicit reasons for consultations. When compared to the often much more explicit display of symptoms, it can be difficult for psychiatrists to discover whether or not non-medical motives predominate in a specific case. From a more general perspective, it is debatable whether psychiatry is (or: should be) equipped to handle such needs or if these kinds of needs are misdirected and should be delegated to other (therapeutic) professionals. However, in relation to psychiatrization, desires for genuinely non-medical services may become problematic, at least when they are answered by diagnostic and therapeutic reflexes.[4] Such a reflex response may be considerably facilitated by the above criticized vagueness of the classificatory systems. Laypersons' somewhat misguided desires and psychiatrists' professional tendency to perceive, classify, and handle them in a medical way may, thus, also be contributing to increase the risk for psychiatrization in emergency care settings.

d) The power of narratives

Narratives appear to belong to the "soft" factors which may pave the way for a psychiatric interpretation of distress and crisis. A broad corpus of scholarship from the humanities and social sciences has stressed the importance of narratives as meta-structures through which people make sense of themselves, other people, or different aspects of life (Todorov, 1969; Gubrium and Holstein, 2009; Frank, 2010; Puckett, 2016; De Fina and Georgakopoulou, 2019). In this sense, narratives are a universal feature of our social world and a constitutive part of each individual's identity. Accordingly, it is obvious that storytelling is also omnipresent in psychiatry. This starts with listening to the (life-)stories of patients, which are then condensed and retold, when the cases are presented to colleagues or written down in an anamnesis or epicrisis. When listening to, telling, retelling, and writing down stories, aspects or facts are brought into a comprehensible order, following unconscious, but influential rules of how to construct a narrative. In the end, people tend to produce logical and coherent stories, which are implicitly also tailored to their aesthetic and dramaturgic inclinations. Moreover, such stories tend to have similar climaxes, or punch lines as the dominant narratives circulating in society (Gubrium and Holstein, 2009; Frank, 2010; Puckett, 2016).

From a narrative perspective, both cases have all the ingredients of a very compelling story: Mr. A used to lead a happy life with his beloved wife and his daughter, when he suddenly realized that he was on the verge of losing his wife to a younger man. But he was wrong: With the help of the internet, his caring wife, and a competent psychiatrist he found out that he was just in a state of depression, which was casting a shadow on his mind and soul. In Ms. B's story, the protagonist used to be a thriving young woman who was looking forward to moving to the big city and standing on her own feet, when she tragically lost two of the most important figures in her life, one after the other. In reaction, a deep depression entered her life and she became suicidal, but overcame this crisis through the help of psychiatry.

In both constellations, depression figures as an easy-to-understand cause for the protagonists' encounter with psychiatry. But it also is the meta-structure that gives meaning to everything before and after their encounter with psychiatry and that makes the overall plot convincing. Moreover, in both cases, "depression" nearly materializes into an independent agent which intrudes into a happy state ("disruption") and has to be expelled before again reaching the former equilibrium, a

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[4] Interestingly, the ICD-10 acknowledges that also non-medical conditions may lead to the use of medical services and provides the so-called "Z-codes" to code for the different reasons for these encounters. Z-codes are intended to mark individual social or economic needs that may not require a specific medical intervention but were causal for the medical consultation anyway and might be relevant as context for future treatments. However, documentation rates for Z-codes are very low, as consultations based only on Z-codes are usually not re-imbursed by health insurances (McCormack and Madlock-Brown, 2021). For the same reason, it is very unlikely that Z-codes have the potential to replace psychiatric diagnosis using F-codes in healthcare settings, although they might often be the more accurate description for the reason for a medical consultation.

structure that vastly resembles Todorov (1969) influential theory of narratives.

What may be most important when analyzing the above cases in the light of narrative theory, is that the strong intuition that Mr. A. and Ms. B. must have some kind of depression may originate less from clinical evidence but rather from the human inclination to tell compelling stories. Such stories connect well with the culturally available narratives which serve as their prototypes. Clinical psychiatrists, thus, may sometimes be at risk of succumbing to the charm of compelling narratives which may only seem to be based in psychiatric nosology because the culturally dominant stories of human suffering include psychiatric concepts and vernacular and a mental disorder may easily take the shape of an independent protagonist. In a similar way, the interpretations and expectations of help-seekers and their relatives may be largely shaped by the culturally dominant narratives. The power of (medicalized) narratives about distress, crisis, and suffering, thus, may be an important driver of psychiatrization, that can have decisive influence on how both top-level and bottom-level agents think, act, and decide.

Concluding remarks

The ED as an area of contact between psychiatry and society appears to be a promising field for research on psychiatrization and on how it emerges from the institutions of mental healthcare. In the above cases and during the process of active interviewing, a wide array of drivers for top-down and bottom-up psychiatrization have surfaced. All these drivers may influence encounters in the ED in favor of psychiatric diagnosis and treatment, especially in cases where diagnosis is negotiable, because its clinical appropriateness is highly unclear. Besides, some soft and rather contextual factors that might promote psychiatrization in a more general way were identified, among which notions of normalcy or narratives about suffering circulating in society. From a broader perspective, the described cases and their analysis illustrate some fundamental difficulties that arise when certain human problems are understood, labeled, and treated as medical conditions. Even if the concept of psychiatrization were left aside, the case study may thus contribute to larger debates on the nature of mental illness, the use of offering explicitly *medical* interventions for those who experience mental distress for diverse reasons, and the appropriateness of diagnosis to capture the very meaning of these experiences.

In an attempt to summarize, some central findings of this case study about the ED as a place where psychiatrization potentially happens could be outlined as follows:

1. From a structural point of view, the ED can be characterized as a place where psychiatrists as top-level-agents directly interact with help-seekers as agents from the bottom-level. In more abstract terms, the ED, thus, constitutes an area of contact between individuals and the mental healthcare system or *between society and psychiatry*. Remaining in a spatial imagery, the ED may also be considered as a place from which psychiatric knowledge encroaches upon the social sphere.
2. Psychiatrization is about turning a phenomenon not (yet) psychiatric into something psychiatric. When a person in need encounters a psychiatrist for the very first time, the specific problems, or the conditions causal to coming to the ED, are not yet classified or interpreted. Therefore, some kind of gatekeeping is required here (Buchbinder, 2017). The ED is, thus, one of the special places where different kinds of personal issues or life problems, distress, or health conditions may be categorized as falling within psychiatric expertise—or not. It is precisely this fundamental openness of the situation in the ED which attracts scientific inquiry into the various reasons beyond clinical considerations why exactly certain cases are judged to be psychiatric and others are not (Dodier and Camus, 1998).
3. The ED is a typical place where psychiatric diagnoses are ascribed to individuals *for the very first time*. For research on psychiatrization, such places are of particular interest, since psychiatric diagnoses can be seen as the converging point of several sub-processes of psychiatrization (see Figure 1): They may be the entry point for service utilization, entail the prescription of psychotropics, be a result of the expansion of diagnostic categories, an act of pathologization of minor disturbances and a contribution to the high incidences of mental disorders.
4. With the ED being a "gateway to higher levels of medical care" (Grace, 2020, p. 876), the encounter in the ED is likely to be the starting point for some kind of treatment regime, ranging from direct admission to the psychiatric ward to the referral to out-patient services. Whichever psychiatric diagnosis is given, or whichever treatment is initiated, it may prompt gradual transformations in an individual's identity, over the course of which a person's narrative and sense of self may fundamentally change through the integration of psychiatric concepts (Rose, 2003; Martin, 2007; von Peter, 2013; Haslam and Kvaale, 2015). The ED may, thus, be the place where the psychiatric reshaping of identity as a central effect of psychiatrization *begins*.
5. From a social constructivist perspective and in the terms of Hacking, mental disorders *come into being* at the very moment, when a problem is interpreted through the psychiatric gaze and classified as belonging to a distinct diagnostic category (Hacking, 1985). In this regard, although the problems causal for a patient to come to the ED may have existed before, the ED may be one of the peculiar places where a mental disorder becomes real through diagnosis in an (at least) three-fold sense: (a) as a subjective conviction, which may gradually become a lived reality, (b) as an intersubjectively shared social reality, and (c) as a legal entity.

Further research could try to expand the inquiry into several directions. Some next steps to empirically establish psychiatrization in the ED and comparable settings could consist of (a) quantitatively expanding the scope of investigation through the inclusion of more cases from different hospitals, (b) shifting the focus of investigation by contrasting cases from the ED with cases from other settings where first contacts between psychiatry and society take place (e.g., the offices of general practitioners, crisis intervention teams, or community mental health services), (c) adding different perspectives on data collection and interpretation, e.g., by involving service-users or other professions than psychiatrists, (d) triangulating by the use of different methods (e.g., focus groups, expert interviews, participatory observation) and different types of evidence (e.g., patient records, discharge letters), and (e) gathering longitudinal data by following up the individual cases.

In particular, longitudinal data could generate new insights, especially when combined with a research design which features a control group (e.g., discharge with vs. discharge without psychiatric diagnosis). In this scenario, prospective research questions could be how the health status of individuals evolved after their ED contact, if and how individual problems or crises were settled, if other institutions of healthcare were consulted, and which other medical or non-medical actors stepped in when a person's indisposition was defined as being not primarily "psychiatric". A longitudinal design would also allow inquiry into how the ED contact changed the identity and agency of the help-seekers or how the provided (psychiatric) explanations and concepts were incorporated or resisted in relationships, families, and other networks. Research of this kind could possibly also establish which specific interventions would be helpful to limit some of the negative aspects of psychiatrization, be it on the conceptual level through the promotion of alternative frameworks to understand mental distress or on the structural level through enabling professional counseling also in hospitals that has not been based on a psychiatric diagnosis for its reimbursement. Although hypothetical, conferring a psychiatric diagnosis might have been avoided in both described cases if there had been a chance for the psychiatrists in charge to practice such a simple measure as "watchful waiting" by scheduling a second appointment a few days later with Mr. A. and Ms. B (Iglesias-González et al., 2017). The cases thus may be hints that relatively obvious organizational constraints of healthcare institutions could be main targets for practical interventions to reduce the risk of psychiatrization in comparable gray area situations.

In addition, the above analysis indicates the need to continue theory development. The cases suggest that further theory building should attempt to clarify integral parts of the terminology with regard to the comprehensive model that served as starting point for this study. For instance, the diagnostic vagueness created by the classificatory systems was considered to be a *driver* of psychiatrization, while help-seekers' appeals to psychiatry for its non-medical functions were equally qualified as a driver. However, consulting psychiatry primarily for non-medical reasons may not be likely to result in psychiatrization, unless psychiatric diagnosis is applied in a space of vagueness. The vagueness of classificatory systems, thus, seems to function as an *enabler* of or *precondition* to other drivers of psychiatrization. This raises the question whether the concept of "drivers" is too broad and needs to be differentiated into separate categories.

Moreover, the classification of clinical psychiatrists as typical "top-level-agents" of psychiatrization may demand some modifications. Their actions may be shaped by top-level drivers, and their decisions may be guided by top-level knowledge, but the above material clearly shows that bottom-up drivers seem to exert a significant influence on how practitioners handle individual cases. Clinical psychiatrists working in the ED and comparable settings may, thus, quite often be in a mediating position between top- and bottom-level, a result, which also resonates recent studies on psychiatric emergency care (Lincoln, 2006; Buchbinder, 2017; Lane, 2020). Accordingly, a revised conceptualization of psychiatrization could possibly benefit from the introduction of an *intermediate category of agents*, which would serve to complexify the dichotomy between top-level and bottom-level agents.

Data availability statement

The original contributions presented in the study are included in the article, further inquiries can be directed to the corresponding author.

Author contributions

TB was responsible for devising the article, writing the manuscript, and drafting the final version.

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Conflict of interest

The author declares that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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References

Abraham, J. (2010). Pharmaceuticalization of society in context: theoretical, empirical and health dimensions. *Sociology* 44, 603–622. doi: 10.1177/0038038510369368

Adams, T. E. (2008). A review of narrative ethics. *Qual. Inq.* 14, 175–194. doi: 10.1177/107780040730 4417

Améry, J. (1976). *On Suicide: A Discourse on Voluntary Death*. Bloomington: Indiana University Press.

Arango, C., Díaz-Caneja, C. M., McGorry, P. D., Rapoport, J., Sommer, I. E., Vorstman, J. A., et al. (2018). Preventive strategies for mental health. *Lancet Psychiatry* 5, 591–604. doi: 10.1016/S2215-0366(18)30057-9

Ariès, P. (1974). *Western Attitudes Toward Death From the Middle Ages to the Present*. Baltimore: Johns Hopkins University Press.

Bachem, R., and Casey, P. (2018). Adjustment disorder: a diagnosis whose time has come. *J. Affect. Disord.* 227, 243–253. doi: 10.1016/j.jad.2017.10.034

Bachmann, S. (2018). Epidemiology of suicide and the psychiatric perspective. *Int. J. Environ. Res. Public Health* 15, 1425. doi: 10.3390/ijerph15071425

Baker, L., Wagner, T. H., Singer, S., and Bundorf, M. K. (2003). Use of the Internet and e-mail for health care information: results from a national survey. *JAMA* 289, 2400–2406. doi: 10.1001/jama.289.18.2400

Batstra, L., and Frances, A. (2012a). Diagnostic inflation: causes and a suggested cure. *J. Nerv. Ment. Dis.* 200, 474–479. doi: 10.1097/NMD.0b013e318257c4a2

Batstra, L., and Frances, A. (2012b). DSM-V further inflates attention deficit hyperactivity disorder. *J. Nerv. Ment. Dis.* 200, 486–488. doi: 10.1097/NMD.0b013e318257c4b6

Batstra, L., and Frances, A. (2012c). Holding the line against diagnostic inflation in psychiatry. *Psychother. Psychosom.* 81, 5–10. doi: 10.1159/000331565

Baumgardt, J., and Weinmann, S. (2022). Using crisis theory in dealing with severe mental illness–a step toward normalization? *Front. Sociol.* 7:805604. doi: 10.3389/fsoc.2022.805604

Becker, E. (1973). *The Denial of Death*. New York: Simon & Schuster.

Beeker, T., Glück, R. K., Ziegenhagen, J., Göppert, L., Jänchen, P., Krispin, H., et al. (2021b). Designed to clash? Reflecting on the practical, personal, and structural challenges of collaborative research in psychiatry. *Front. Psychiatry* 12, 701312. doi: 10.3389/fpsyt.2021.701312

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021a). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12, 645556. doi: 10.3389/fpsyt.2021.645556

Beeker, T., and Thoma, S. (2019). Die digitale Psychiatrie zwischen User-Empowerment und Psychiatrisierung. *Suizidprophylaxe*. 46, 82–98.

Beeker, T., Witeska-Młynarczyk, A., te Meerman, S., and Mills, C. (2020). Psychiatrization of, with and by children: drawing a complex picture. *Global Stud Childhood* 10, 12–25. doi: 10.1177/2043610619890074

Behrouzan, O. (2016). *Prozak Diaries: Psychiatry and generational memory in Iran*. Bloomington: Stanford University Press.

Bertolote, J. M., Fleischmann, A., De Leo, D., and Wasserman, D. (2004). Psychiatric diagnoses and suicide: revisiting the evidence. *Crisis* 25, 147–155. doi: 10.1027/0227-5910.25.4.147

Biondi, M., Pasquini, M., and Tarsitani, L. (2021). *Empathy, Normalization and De-escalation Management of the Agitated Patient in Emergency and Critical Situations*. Berlin: Springer.

Bolton, D. (2008). *What Is Mental Disorder? An Essay in Philosophy, Science, and Values*. Oxford, New York: Oxford University Press.

Bozdag, E., and van den Hoven, J. (2015). Breaking the filter bubble: democracy and design. *Ethics Inf. Technol.* 17, 249–265. doi: 10.1007/s10676-015-9380-y

Brhlikova, P., Pollock, A. M., and Manners, R. (2011). Global Burden of Disease estimates of depression-how reliable is the epidemiological evidence? *J. R. Soc. Med.* 104, 25–34. doi: 10.1258/jrsm.2010.100080

Brinkmann, S. (2016). *Diagnostic Cultures: A Cultural Approach to Pathologization of Modern Life*. New York: Routledge.

Buchbinder, M. (2017). Keeping out and getting in: reframing emergency department gatekeeping as structural competence. *Sociol. Health Illn.* 39, 1166–1179. doi: 10.1111/1467-9566.12566

Budgell, B. (2008). Guidelines to the writing of case studies. *J. Can. Chiropr. Assoc.* 52, 199–204.

Carleton, H. A., and Webb, M. L. (2012). The case report in context. *Yale J. Biol. Med.* 85, 93–96.

Castner, S. A., Williams, G. V., and Goldman Rakic, P. S. (2000). Reversal of antipsychotic-induced working memory deficits by short-term dopamineD1 receptor stimulation. *Science* 287, 2020–2022. doi: 10.1126/science.287.5460.2020

Chang, C. R., and Bassman, R. (2019). Psychiatric diagnosis and the power of names. *J. Humanist. Psychol.* 59, 1–23. doi: 10.1177/0022167819852786

Chanmugam, A., Triplett, P., and Kelen, G. (2013). *Emergency Psychiatry*. Cambridge: Cambridge University Press.

Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., et al. (2016). Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry* 3, 415–424. doi: 10.1016/S2215-0366(16)30024-4

Christensen, H., and Griffiths, K. (2000). The internet and mental health literacy. *Aust. New Zeal. J. Psychiatry* 34, 975–979. doi: 10.1080/000486700272

Clarke, A., Shim, J., Mamo, L., Fosket, J., and Fishman, J. (2003). Biomedicalization: technoscientific transformations of health, illness, and U.S. biomedicine. *Am. Soc. Rev.* 68, 161–194. doi: 10.2307/1519765

Conrad, P. (1992). Medicalization and social control. *Annu. Rev. Sociol.* 18, 209–232. doi: 10.1146/annurev.so.18.080192.001233

Conrad, P. (2005). The shifting engines of medicalization. *J. Health Soc. Behav.* 46, 3–14. doi: 10.1177/002214650504600102

Conrad, P. (2007). *The Medicalization of Society. On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: John Hopkins University Press.

Conrad, P. (2013). "The medicalization of mental disorder," in *Handbook of the Sociology of Mental Health*, ed. C. S. Aneshensel, J. C. Phelan, and A. Biermann (Dordrecht: Springer), 61–73.

Cooper, D. (1967). *Psychiatry and Anti-Psychiatry*. London: Tavistock/Paladin.

Cosgrove, L., Karter, J. M., Morrill, Z., and McGinley, M. (2020). Psychology and surveillance capitalism: the risk of pushing mental health apps during the COVID-19 pandemic. *J. Hum. Psychol.* 60, 611–625. doi: 10.1177/00221678209 37498

Cosgrove, L., and Whitaker, R. (2015). *Psychiatry Under the Influence. Institutional Corruption, Social Injury, and Prescriptions for Reform*. New York: Palgrave Macmillan.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., and Sheikh, A. (2011). The case study approach. *BMC Med. Res. Methodol.* 11, 100. doi: 10.1186/1471-2288-11-100

Davies, J. (2017). "Political pills: psychopharmaceuticals and neoliberalism as mutually supporting," in *The Sedated Society*, ed J. Davies (Cham: Palgrave Macmillan), 189–225.

De Fina, A., and Georgakopoulou, A. (2019). *The Handbook of Narrative Analysis*. Hoboken, NJ, and Oxford: Wiley Blackwell.

De Vos, J. (2010). From Milgram to Zimbardo: the double birth of postwar psychology/psychologization. *Hist. Hum. Sci.* 23, 156–175. doi: 10.1177/0952695110384774

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., et al. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA* 291, 2581–2590. doi: 10.1001/jama.291.21.2581

DGPPN (2021). *Basisdaten psychische Erkrankungen*. Deutsche Gesellschaft für Psychiatrie, Psychotherapie, Psychosomatik und Nervenheilkunde. Available online at: https://www.dgppn.de/_Resources/Persistent/17452fbcf559a53a36e71334cde8d18e8d6793fa/20210727_Factsheet_Kennzahlen.pdf (accessed September 17, 2021).

Dingwall, R., and Murray, T. (1983). Categorisation in accident departments: 'good' patients, 'bad' patients and children. *Sociol. Health Illn.* 5, 127–148. doi: 10.1111/1467-9566.ep10491496

Dittmar, H., Bond, R., Hurst, M., and Kasser, T. (2014). The relationship between materialism and personal well-being: a meta-analysis. *J. Pers. Soc. Psychol.* 107, 879–924. doi: 10.1037/a0037409

Dodier, N., and Camus, A. (1998). Openness and specialisation: dealing with patients in a hospital emergency service. *Sociol. Health Illn.* 20, 413–444. doi: 10.1111/1467-9566.00109

Drescher, J. (2015). Out of DSM: depathologizing homosexuality. *Behav. Sci.* 5, 565–575. doi: 10.3390/bs5040565

Eckersley, R. (2005). Is modern western culture a health hazard? *Int. J. Epidemiol.* 35, 252–258. doi: 10.1093/ije/dyi235

Ehrenberg, A. (1998). *The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age*. Montreal: McGill-Queen's University Press.

Elias, N. (1985). *The Loneliness of the Dying*. London: Continuum.

Ellis, C. (2004). *The Ethnographic I: A Methodological Novel About Autoethnography*. Walnut Creek: Altamira Press.

Faber, G., Smid, H. G. O. M., van Gool, A. R., Wiersma, D., and Van Den Bosch, R. J. (2012). The effects of guided discontinuation of antipsychotics on neurocognition in first onset psychosis. *Eur. Psychiatry* 27, 275–280. doi: 10.1016/j.eurpsy.2011.02.003

Ferrari, A. J., Norman, R. E., Freedman, G., Pirkis, J. E., Harris, M. G., Page, A., et al. (2014). The burden attributable to mental and substance use disorders as risk factors for suicide: findings from the Global Burden of Disease Study 2010. *PLoS ONE* 9, e91936. doi: 10.1371/journal.pone.0091936

Foucault, M. (1965). *Madness and Civilization. A History of Insanity in the Age of Reason.* New York, NY: Random House.

Fox, N. J., and Ward, K. J. (2008). Pharma in the bedroom…and the kitchen….The pharmaceuticalisation of daily life. *Sociol. Health Illn*. 30, 856–868. doi: 10.1111/j.1467-9566.2008.01114.x

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*. New York: William Morrow.

Frank, A. W. (2010). *Letting Stories Breathe: A Socio-Narratology*. Chicago and London: University of Chicago Press.

Fried, E. I. (2017). The 52 symptoms of major depression: lack of content overlap among seven common depression scales. *J. Affect. Disord.* 208, 191–197. doi: 10.1016/j.jad.2016.10.019

Fried, E. I., Coomans, F., and Lorenzo-Luaces, L. (2020). The 341 737 ways of qualifying for the melancholic specifier. *Lancet Psychiatry* 7, 479–480. doi: 10.1016/S2215-0366(20)30169-3

Fryszer, A., and Schwing, R. (2014). *Handbook of Systemic Psychotherapy*. Göttingen: Vandenhoeck & Ruprecht.

Furedi, F. (2004). *Therapy Culture: Cultivating Vulnerability in an Uncertain Age*. London: Routledge.

Gerdtz, M., Daniel, C., Jarden, R., and Kapp, S. (2020). Use of the safewards model in healthcare services: a mixed-method scoping review protocol. *BMJ Open* 10, e039109. doi: 10.1136/bmjopen-2020-039109

Gillard, S., Borschmann, R., Turner, K., Goodrich-Purnell, N., Lovell, K., and Chambers, M. (2010). 'What difference does it make?' Finding evidence of the impact of mental health service user researchers on research into the experiences of detained psychiatric patients. *Health Expect.* 13, 185–194. doi: 10.1111/j.1369-7625.2010.00596.x

Goffman, E. (1961). *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York, NY: Anchor Books.

Gordo Lopez, A., and De Vos, J. (2010). Psychologism, psychologising and de-psychologisation. *Ann. Rev. Crit. Psychol.* 8, 3–7.

Grace, S. G. (2020). Emergency department: a sociological perspective. *Emerg. Med. Aust.* 32, 875–876. doi: 10.1111/1742-6723.13553

Graham, G. (2013). *The Disordered Mind: An Introduction to Philosophy of Mind and Mental Illness*. London, New York: Routledge.

Gubrium, J. F., and Holstein, J. A. (2009). *Analyzing Narrative Reality*. Thousand Oaks, CA: SAGE Publications.

Hacking, I. (1985). "Making up people," in *Reconstructing Individualism*, edd T. L. Heller, M. Sosna, and D. E. Wellbery (Stanford, CA: Stanford University Press), 222–36.

Hacking, I. (1995a). *Rewriting the Soul: Multiple Personality and the Sciences of Memory*. New Jersey: Princeton University Press.

Hacking, I. (1995b). "The looping effects of human kinds," in *Symposia of the Fyssen Foundation. Causal Cognition: A Multidisciplinary Debate*, eds D. Sperber, D. Premack, and A. J. Premack (New York: Clarendon Press), 351–394.

Hacking, I. (1998). *Mad Travelers: Reflections on the Reality of Transient Mental Illnesses*. Charlottesville: University of Virginia Press.

Hacking, I. (1999). *The Social Construction of What?* Cambridge: Harvard University Press.

Hart, J. T. (1971). The inverse care law. *Lancet* 297:405–412. doi: 10.1016/S0140-6736(71)92410-X

Haslam, N. (2016). Concept creep: psychology's expanding concepts of harm and pathology. *Psychol. Inq.* 27, 1–17. doi: 10.1080/1047840X.2016.1082418

Haslam, N., and Kvaale, E. P. (2015). Biogenetic explanations of mental disorder: the mixed-blessings model. *Curr. Dir. Psychol. Sci.* 24, 399–404. doi: 10.1177/0963721415588082

Henderson, C., Noblett, J., Parke, H., Clement, S., Caffrey, A., Gale-Grant, O., et al. (2014). Mental health-related stigma in health care and mental health-care settings. *Lancet Psychiatry* 1, 467–482. doi: 10.1016/S2215-0366(14)00023-6

Hesse, B. W., Nelson, D. E., Kreps, G. L., Croyle, R. T., Arora, N. K., and Rimer, B. K. (2005). Trust and sources of health information: the impact of the Internet and its implications for health care providers: findings from the first Health Information National Trends Survey. *Arch. Intern. Med.* 165, 2618–2624. doi: 10.1001/archinte.165.22.2618

Hillman, A. (2014). 'Why must I wait?' The performance of legitimacy in a hospital emergency department. *Sociol. Health Illn.* 36, 485–499. doi: 10.1111/1467-9566.12072

Hillman, A. (2016). Institutions of care, moral proximity and demoralisation: the case of the emergency department. *Soc. Theory Health* 14, 66–87. doi: 10.1057/sth.2015.10

Horwitz, A. C., and Wakefield, J. C. (2006). The epidemic in mental illness: clinical fact or survey artefact. *Contexts* 5, 19–23. doi: 10.1525/ctx.2006.5.1.19

Horwitz, A. V. (1982). *The Social Control of Mental Illness.* New York: Academic Press.

Horwitz, A. V. (2015). The DSM-5 and the continuing transformation of normal sadness into depressive disorder. *Emot. Rev.* 7, 209–215. doi: 10.1177/1754073915575401

Horwitz, A. V. (2021). *DSM: A History of Psychiatry's Bible*. Amsterdam: Amsterdam University Press.

Horwitz, A. V., and Wakefield, J. C. (2007). *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder.* New York: Oxford University Press.

Hossain, M. M., Tasnim, S., Sultana, A., Faizah, F., and Mazumder, H., Zou, L., et al. (2020). Epidemiology of mental health problems in COVID-19: a review. *F1000Res* 9, 636. doi: 10.12688/f1000research.24457.1

Hughes, D. (1989). Paper and people: the work of the casualty reception clerk. *Sociol. Health Illn.* 11, 382–408. doi: 10.1111/1467-9566.ep11373441

Hyman, S. E. (2010). The diagnosis of mental disorders: the problem of reification. *Annu. Rev. Clin. Psychol.* 6, 155–179. doi: 10.1146/annurev.clinpsy.3.022806.091532

Iglesias-González, M., Aznar-Lou, I., Gil-Girbau, M., Moreno-Peral, P., Peñarrubia-María, M. T., Rubio-Valera, M., et al. (2017). Comparing watchful waiting with antidepressants for the management of subclinical depression symptoms to mild–moderate depression in primary care: a systematic review. *Fam. Pract.* 34, 639–648. doi: 10.1093/fampra/cmx054

Illich, I. (1974). *Medical Nemesis*. London: Calder & Boyars. doi: 10.1016/S0140-6736(74)90361-4

Jacobsen, M. H. (2016). 'Spectacular death'—proposing a new fifth phase to philippe ariès's admirable history of death. *Humanities* 5, 19. doi: 10.3390/h5020019

Jain, S., and Orr, D. M. (2016). Ethnographic perspectives on global mental health. *Transcult. Psychiatr*. 53, 685–695. doi: 10.1177/1363461516679322

Jeffery, R. (1979). Normal rubbish: deviant patients in casualty departments. *Sociol. Health Illn.* 1, 90–107. doi: 10.1111/1467-9566.ep11006793

Jenkins, J. H. (2011). *Pharmaceutical Self: The Global Shaping of Experience in an Age of Psychopharmacology*. Santa Fe: SAR Press.

Jorm, A. F. (2006). National surveys of mental disorders: are they researching scientific facts or constructing useful myths? *Aust. N. Z. J. Psychiatry* 40, 830–834. doi: 10.1080/j.1440-1614.2006.01901.x

Keen, J., and Packwood, T. (1995). Qualitative research; case study evaluation. *BMJ* 311, 444–446. doi: 10.1136/bmj.311.7002.444

Kendler, K. (2016). The nature of psychiatric disorders. *World Psychiatry* 15, 5–12. doi: 10.1002/wps.20292

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., and Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey replication. *Arch. Gen. Psychiatry* 62, 593–603. doi: 10.1001/archpsyc.62.6.593

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., and Johnson, B. T. (2008). Initial severity and antidepressant benefits: a meta-analysis of data submitted to the Food and Drug Administration. *PLoS Med.* 5, e45. doi: 10.1371/journal.pmed.0050045

Klein, E., and Mills, C. (2017). Psy-expertise, therapeutic culture and the politics of the personal in development. *Third World Quart.* 38, 1990–2008. doi: 10.1080/01436597.2017.1319277

Kohn, R., Saxena, S., Levav, I., and Saraceno, B. (2004). The treatment gap in mental health care. *Bull. World Health Organ.* 82, 858–866.

Kola, L., Kohrt, B. A., Hanlon, C., Naslund, J. A., Sikander, S., Balaji, M., et al. (2021). COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. *Lancet Psychiatry* 8, 535–550. doi: 10.1016/S2215-0366(21)00025-0

Laing, R. D. (1965). *The Divided Self*. Harmondsworth: Penguin.

Lancet Global Mental Health Group, Chisholm, D., Flisher, A. J., Lund, C., Patel, V., Saxena, S., Thornicroft, G., et al. (2007). Scale up services for mental disorders: a call for action. *Lancet* 370, 1241–1252. doi: 10.1016/S0140-6736(07)61242-2

Lane, R. (2020). Expanding boundaries in psychiatry: uncertainty in the context of diagnosis-seeking and negotiation. *Sociol. Health Illn.* 42, 69–83. doi: 10.1111/1467-9566.13044

LeFrançois, B. A., Menzies, R., and Reaume, G. (2013). *Mad Matters: A Critical Reader in Canadian Mad Studies*. Toronto, ON: Canadian Scholars Press Inc.

Lilienfeld, S. O. (2014). DSM-5: centripetal scientific and centrifugal antiscientific forces. *Clin. Psychol. Sci. Pract.* 21, 269–279. doi: 10.1111/cpsp.12075

Lincoln, A. (2006). Psychiatric emergency room decision-making, social control and the 'undeserving sick'. *Sociol. Health Illn.* 28, 54–75. doi: 10.1111/j.1467-9566.2006.00482.x

Lindsey, K., and Paul, G. (1989). Involuntary commitments to public mental institutions: issues involving the overrepresentation of blacks and assessment of relevant functioning. *Psychol. Bull.* 106, 171–183. doi: 10.1037/0033-2909.106.2.171

Lipson, S. K., Lattie, E. G., and Eisenberg, D. (2019). Increased rates of mental health service utilization by U.S. college students: 10-year population-level trends (2007-2017). *Psychiatr. Serv.* 70, 60–63. doi: 10.1176/appi.ps.201800332

Livingston, J. D., and Boyd, J. E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: a systematic review and meta-analysis. *Soc. Sci. Med.* 71, 2150–2161. doi: 10.1016/j.socscimed.2010.09.030

Loos, A. (2013). Cyberchondria: too much information for the health anxious patient? *J. Consum. Health Internet* 17, 439–445. doi: 10.1080/15398285.2013.833452

Mars, B., Heron, J., Kessler, D., Davies, N. M., Martin, R. M., Thomas, K. H., et al. (2017). Influences on antidepressant prescribing trends in the UK: 1995–2011. *Soc. Psychiatry Psychiatr. Epidemiol.* 52, 193–200. doi: 10.1007/s00127-016-1306-4

Martin, E. (2007). *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton: Princeton University Press.

McCormack, L. A., and Madlock-Brown, C. (2021). "Social determinant of health documentation trends and their association with emergency department admissions," in *AMIA Annual Symposium Proceedings 2020*, 823–832.

Merikangas, K. R., He, J. P., Burstein, M., Avenevoli, S., Case, B., Georgiades, K., et al. (2011). Service utilization for lifetime mental disorders in U.S. adolescents: results of the National Comorbidity Survey-Adolescent Supplement (NCS-A). *J. Am. Acad. Child Adolesc. Psychiatry* 50, 32–45. doi: 10.1016/j.jaac.2010.10.006

Miller, D., Acton, T. M., and Hedge, B. (1988). The worried well: their identification and management. *J. R. Coll. Physicians Lond.* 22, 158–165.

MIND (2021). *Mental Health Facts and Statistics*. Available online at: https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#HowCommonAreMentalHealthProblems (accessed October 8, 2021).

Mojtabai, R. (2010). Mental illness stigma and willingness to seek mental health care in the European Union. *Soc. Psychiatry Psychiatr. Epidemiol.* 44, 705–712. doi: 10.1007/s00127-009-0109-2

Moncrieff, J. (2020). "It was the brain tumor that done it!": Szasz and Wittgenstein on the importance of distinguishing disease from behavior and implications for the nature of mental disorder. *Philos. Psychiatry Psychol.* 27, 169–181. doi: 10.1353/ppp.2020.0017

Moore, T. J., and Mattison, D. R. (2017). Adult utilization of psychiatric drugs and difference by sex, age and race. *JAMA Intern. Med.* 177, 274–275. doi: 10.1001/jamainternmed.2016.7507

Morozov, E. (2012). *The Net Delusion: How Not to Liberate the World*. Penguin: London.

Moynihan, R., Doust, J., and Henry, D. (2012). Preventing overdiagnosis: how to stop harming the healthy. *BMJ* 344, e3502. doi: 10.1136/bmj.e3502

NAMI (2021). *Mental Health Conditions*. National Alliance on Mental Illness. Available online at: https://www.nami.org/About-Mental-Illness/Mental-Health-Conditions (accessed October 8, 2021).

Nearchou, F., Flinn, C., Niland, R., Subramaniam, S. S., and Hennessy, E. (2020). Exploring the impact of COVID-19 on mental health outcomes in children and adolescents: a systematic review. *Int. J. Environ. Res. Public Health* 17, 8479. doi: 10.3390/ijerph17228479

Nicholls, K. (2015). *Emergency Psychiatry*. Cambridge: Royal College of Psychiatrists.

NIMH (2019). *Statistics Mental Illness*. National Institute of Mental Health. Available online at: https://www.nimh.nih.gov/health/statistics/mental-illness.shtml (accessed October 8, 2021).

Nissen, T., and Wynn, R. (2014). The clinical case report: a review of its merits and limitations. *BMC Res. Notes* 7, 264. doi: 10.1186/1756-0500-7-264

O'Donnell, M. L., Agathos, J. A., Metcalf, O., Gibson, K., and Lau, W. (2019). Adjustment disorder: current developments and future directions. *Int. J. Environ. Res. Public Health* 16, 2537. doi: 10.3390/ijerph16142537

OECD (2020). *Statistics Health Status*. Organization for Economic Co-Operation and Development. Available online at: https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT# (accessed October 8, 2021).

Olfson, M., Wang, S., Wall, M., Marcus, S. C., and Blanco, C. (2019). Trends in serious psychological distress and outpatient mental health care of US adults. *JAMA Psychiatry* 76, 152–161. doi: 10.1001/jamapsychiatry.2018.3550

Paris, J. (2015). *Overdiagnosis in Psychiatry. How Modern Psychiatry Lost Its Way While Creating a Diagnosis for Almost All of Life's Misfortunes*. New York: Oxford University Press.

Parsons, T. (1951). *The Social System*. Glencoe, IL: The Free Press.

Pols, J. (2006). Accounting and washing: good care in long-term psychiatry. *Sci. Technol. Human Values* 31, 409–430. doi: 10.1177/0162243906287544

Puckett, K. (2016). *Narrative Theory: A Critical Introduction*. Cambridge: Cambridge University Press.

Read, J., Cartwright, C., and Gibson, K. (2014). Adverse emotional and interpersonal effects reported by 1829 New Zealanders while taking antidepressants. *Psychiatry Res.* 216, 67–73. doi: 10.1016/j.psychres.2014.01.042

Reed, G. M., Drescher, J., Krueger, R. B., Atalla, E., Cochran, S. D., First, et al. (2016). Disorders related to sexuality and gender identity in the ICD-11: revising the ICD-10 classification based on current scientific evidence, best clinical practices, and human rights considerations. *World Psychiatry* 15, 205–221. doi: 10.1002/wps.20354

Regier, D. A., Narrow, W. E., Clarke, D. E., Kraemer, H. C., Kuramoto, S. J., Kuhl, E. A., et al. (2013). DSM-5 field trials in the united states and Canada, part II: test-retest reliability of selected categorical diagnoses. *AJP* 170, 59–70. doi: 10.1176/appi.ajp.2012.12070999

Riba, M., Ravindranath, D., Winder, G., and American Psychiatric Association (2016). *Clinical Manual of Emergency Psychiatry*. Arlington, Virginia: APA Publishing.

Richter, D., and Berger, K. (2013). Are mental disorders increasing? Update of a systematic review on repeated cross-sectional studies. *Psychiat. Prax* 40, 176–182. doi: 10.1055/s-0032-1333060

Roppolo, L. P. (2007). *Emergency Medicine Handbook: Critical Concepts for Clinical Practice*. Philadelphia, PA: Mosby.

Rosa, H. (2015). *Social Acceleration. A New Theory of Modernity*. New York: Columbia University Press.

Rose, N. (2003). Neurochemical selves. *Society* 6, 46–59. doi: 10.1007/BF02688204

Rose, N. (2006). Disorders without borders? The expanding scope of psychiatric practice. *BioSocieties* 1, 465–484. doi: 10.1017/S1745855206004078

Rosenfield, S. (1982). Sex roles and societal reactions to mental illness: the labeling of 'deviant' deviance. *J. Health Soc. Behav.* 23, 18–24. doi: 10.2307/2136386

Rosenfield, S. (1984). Race differences in involuntary hospitalization: psychiatric v. labeling perspectives. *J. Health Soc. Behav.* 25, 14–23. doi: 10.2307/2136701

Rosenhan, D. L. (1973). On being sane in insane places. *Science* 179, 250–258. doi: 10.1126/science.179.4070.250

Russo, J., and Sweeney, A. (2017). *Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies*. Monmouth: PCCS Books.

Scott, S. (2006). The medicalisation of shyness: from social misfits to social fitness. *Sociol. Health Illn.* 28, 133–153. doi: 10.1111/j.1467-9566.2006.00485.x

Sheridan Rains, L., Zenina, T., Dias, M. C., Jones, R., Jeffreys, S., Branthonne-Foster, S., et al. (2019). Variations in patterns of involuntary hospitalisation and in legal frameworks: an international comparative study. *Lancet Psychiatry* 6, 403–417. doi: 10.1016/S2215-0366(19)30090-2

Solomon, J. (2006). Case studies: why are they important? *Nat. Rev. Cardiol.* 3, 579. doi: 10.1038/ncpcardio0704

Sommers, C. H., and Satel, S. (2005). *One Nation Under Therapy: How the Helping Culture is Eroding Self-Reliance*. New York, NY: St Martin's Press.

Steel, Z., Marnane, C., Iranpour, C., Chey, T., Jackson, J. W., Patel, V., et al. (2014). The global prevalence of common mental disorders: a systematic review and meta-analysis 1980-2013. *Int. J. Epidemiol.* 43, 476-493. doi: 10.1093/ije/dyu038

Strain, J. J. (2019). The adjustment disorder diagnosis, its importance to liaison psychiatry, and its psychobiology. *Int. J. Environ. Res. Public Health.* 16, 4645. doi: 10.3390/ijerph16234645

Szasz, T. S. (1974). *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct*. New York, NY: Harper & Row.

Thornicroft, G., Brohan, E., Rose, D., Sartorius, N., and Leese, M. (2009). Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. *Lancet* 373, 408–415 doi: 10.1016/S0140-6736(08)61817-6

Thornicroft, G., Chatterji, S., Evans-Lacko, S., Gruber, M., Sampson, N., Aguilar-Gaxiola, S., et al. (2017). Undertreatment of people with major depressive disorder in 21 countries. *Br. J. Psychiatry* 210, 119–124. doi: 10.1192/bjp.bp.116.188078

Tillmann-Healy, L. M. (2003). Friendship as method. *Qual. Inq.* 9, 729–749. doi: 10.1177/1077800403254894

Tillmann-Healy, L. M., and Kiesinger, C. (2001). "Mirrors: seeing each other and ourselves through fieldwork," in *The Emotional Nature of Qualitative Research*, ed K. Gilbert (Boca Raton, FL: CRC Press), 81–108.

Todorov, T. (1969). Structural analysis of narrative. *Novel Forum Fiction* 3, 70–76. doi: 10.2307/1345003

Torales, J., O'Higgins, M., Castaldelli-Maia, J. M., and Ventriglio, A. (2020). The outbreak of COVID-19 coronavirus and its impact on global mental health. *Int. J. Soc. Psychiatry*. 66, 317–320. doi: 10.1177/0020764020915212

Trivedi, J. K., Tripathi, A., Dhanasekaran, S., and Moussaoui, D. (2014). Preventive psychiatry: concept appraisal and future directions. *Int. J. Soc. Psychiatry* 60, 321–329. doi: 10.1177/0020764013488570

Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., and Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *N. Engl. J. Med.* 358, 252–260. doi: 10.1056/NEJMsa065779

van Dijck, J. (2010). Search engines and the production of academic knowledge. *Int. J. Cult. Stud.* 13, 574–592. doi: 10.1177/1367877910376582

Vassy, C. (2001). Categorisation and micro-rationing: access to care in a French emergency department. *Sociol. Health Illn.* 23, 615–632. doi: 10.1111/1467-9566.00268

von Peter, S. (2013). 'Chronic' identities in mental illness. *Anthropol. Med.* 20, 48–58. doi: 10.1080/13648470.2013.772493

von Peter, S., Bergstrøm, T., Nenoff-Herchenbach, I., Hopfenbeck, M. S., Pocobello, R., Aderhold, V., et al. (2021). Dialogue as a response to the psychiatrization of society? Potentials of the open dialogue approach. *Front. Sociol.* 6, 806437. doi: 10.3389/fsoc.2021.806437

Vosk, A., and Milofsky, C. (2002a). The sociology of emergency medicine. *Emerg. Med. News*. 24, 3–5. doi: 10.1097/00132981-200202000-00003

Vosk, A., and Milofsky, C. (2002b). The sociology of emergency medicine: gatekeeping, protocols, and consultants. *Emerg. Med. News* 24, 42–44. doi: 10.1097/00132981-200203000-00005

Vosk, A., and Milofsky, C. (2002c). The sociology of emergency medicine: power, authority, and control. *Emerg. Med. News* 24, 39–42. doi: 10.1097/01.EEM.0000334170.72468.05

Wakefield, J. C. (2015). DSM-5, psychiatric epidemiology and the false positives problem. *Epidemiol. Psychiatr. Sci.* 24, 188–196. doi: 10.1017/S2045796015000116

Walker, S., Mackay, E., Barnett, P., Sheridan Rains, L., Leverton, M., Dalton-Locke, C., et al. (2019). Clinical and social factors associated with increased risk for involuntary psychiatric hospitalisation: a systematic review, meta-analysis, and narrative synthesis. *Lancet Psychiatry* 6, 1039–1053. doi: 10.1016/S2215-0366(19)30406-7

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., et al. (2007). Worldwide use of mental health services for anxiety, mood and substance disorders: results from 17 countries in the WHO World Mental Health (WMH) Surveys. *Lancet* 370, 841–850. doi: 10.1016/S0140-6736(07)61414-7

Way, B., Evans, M., and Banks, S. (1993). Factors predicting referral to inpatient or outpatient treatment from psychiatric emergency services. *Hosp. Community Psychiatry* 43, 703–708. doi: 10.1176/ps.43.7.703

Weich, S., McBride, O., Twigg, L., Duncan, C., Keown, P., Crepaz-Keay, D., et al. (2017). Variation in compulsory psychiatric inpatient admission in England: a cross-classified, multilevel analysis. *Lancet Psychiatry* 4, 619–626. doi: 10.1016/S2215-0366(17)30207-9

Werlen, L., Puhan, M. A., Landolt, M. A., and Mohler-Kuo, M. (2020). Mind the treatment gap: the prevalence of common mental disorder symptoms, risky substance use and service utilization among young Swiss adults. *BMC Public Health* 20, 1470. doi: 10.1186/s12889-020-09577-6

Whitaker, R. (2010). *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*. New York: Broadway Books.

World Health Organization (1993). *The ICD-10 Classification of Mental and Behavioural Disorders*. Genève, Switzerland: World Health Organization.

World Health Organization (2019). *Fact Sheet Mental Disorders*. Available online at: http://www.who.int/mediacentre/factsheets/fs396/en/ (accessed October 8, 2021).

World Health Organization (2016). *Out of the Shadow: Making Mental Health a Global Priority*. Available online at: https://www.who.int/news/item/13-04-2016-investing-in-treatment-for-depression-and-anxiety-leads-to-fourfold-return (accessed October 8, 2021).

Wright, M. T., and Kongats, K. (2018). *Participatory Health Research: Voices from Around the World*. Berlin: Springer.

Wyatt, J. P., Clancy, M., and Robertson, C. (2012). *Oxford Handbook of Emergency Medicine*. Oxford, New York: Oxford University Press.

Yin, R. K. (2009). *Case Study Research, Design and Method*. London: Sage Publications.

Zola, I. K. (1972). Medicine as an institution of social control. *Soc Rev.* 4, 487–504. doi: 10.1111/j.1467-954X.1972.tb00220.x

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CONCEPTUAL ANALYSIS
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Using Crisis Theory in Dealing With Severe Mental Illness–A Step Toward Normalization?

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The perception of mental distress varies with time and culture, e.g., concerning its origin as either social or medical. This may be one reason for the moderate reliability of descriptive psychiatric diagnoses. Additionally, the mechanisms of action of most psychiatric treatments and psychotherapeutic interventions are generally unknown. Thus, these treatments have to be labeled as mostly unspecific even if they help in coping with mental distress. The psychiatric concept of mental disorders therefore has inherent limitations of precision and comprises rather fuzzy boundaries. Against this background, many people question the current process of diagnosing and categorizing mental illnesses. However, many scholars reject new approaches discussed in this context. They rather hold on to traditional diagnostic categories which therefore still play a central role in mental health practice and research and. In order to better understand the adherence to traditional psychiatric concepts, we take a closer look at one of the most widely adopted traditional concepts – the *Stress-Vulnerability Model*. This model has originally been introduced to tackle some problems of biological psychiatry. However, it has been misapplied with the result of drawing attention preferentially to *biological* vulnerability instead of a wider array of vulnerability factors including social adversity. Thus, in its current use, the *Stress-Vulnerability Model* provides only a vague theory for understanding mental phenomena. Therefore, we discuss the advantages and allegedly limited applicability of *Crisis Theory* as an alternative heuristic model for understanding the nature and development of mental distress. We outline the problems of this theory especially in applying it to severe mental disorders. We finally argue that an understanding of *Crisis Theory* supported by a systemic approach can be applied to most types of severe psychological disturbances implying that such an understanding may prevent or manage some negative aspects of the psychiatrization of psychosocial problems.

Keywords: psychiatrization, psychiatric diagnoses, *Recovery Model*, *Crisis Theory*, *Stress-Vulnerability Model*

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INTRODUCTION

Psychiatric terminology has become increasingly influential in the everyday lives of many people in the Western world; a growing body of evidence even suggests that we are witnessing a psychiatrization of society (Beeker et al., 2021). More and more, we view psychosocial phenomena in psychiatric terms and qualify them as objects for treatment (Frances, 2010). At the same time, there is no compelling evidence that the actual burden of suffering from psychological problems has increased substantially (Richter et al., 2019). Currently, in order to quantify psychiatric burden in population-based studies, one counts "treated morbidity" as well as problems that are not yet treated but being classified as psychiatric and therefore receive a commonly accepted psychiatric diagnosis (Cova Solar et al., 2020). This is a problematic approach since the definition of what counts as a mental health problem varies by time and culture, e.g., concerning the perception of psychological problems as either social or medical. Existing attributions range from mental crisis seen as a reaction to life events up to the occurrence of an – assumed – underlying mental health disorder that manifests under certain circumstances (Kleinman et al., 1978; Viswanath and Chaturvedi, 2012). Thus, it can be stated that orthodox psychiatric nosology as well as the process of current diagnostics are increasingly being challenged (Dean, 2012).

Amidst the different conceptualizations of what constitutes a psychiatric disorder and what not, the task of the clinical psychiatrist is to identify the correct – in the sense of best suitable – classification and to start treatment assuming that the applied interventions are disorder-specific. However, the latter assumption is built upon empirical efficacy studies with participants diagnosed according to the prevailing diagnostic guidelines at a particular time and against a certain cultural (Western) background (Fàbrega, 2001). Additionally, it has to be taken into account that the scientific basis for classification is weak. There are no usable biomarkers to detect or confirm psychiatric disorders or give us a hint for selecting or refining treatment interventions (de Leon, 2013; Margraf and Schneider, 2016). Additionally, there is also no tangible evidence of a concrete biological vulnerability factor predisposing to any classical psychiatric disorder. This also holds true for the so-called severe mental disorders such as schizophrenia (Fusar-Poli and Meyer-Lindenberg, 2016). For example, the etiology of schizophrenia was thought to be based on an excess of dopamine. This hypothesis falls short because it does not capture the complex influences and factors contributing to the mental experiences and behaviors associated with schizophrenia. Nevertheless, many scholars assume an underlying condition in the sense of a biological or neurodevelopmental disorder of the brain causing the symptoms. Such symptoms are thought to be based on an imbalance that cannot be cured but only corrected, compensated, or attenuated. Even if a severe psychological crises or severe mental disorder is thought to be triggered by life events (Beards et al., 2013), these events are seldom perceived as causal. Such an understanding of mental disorders not only entails prejudices as well as stigma but can also lead to unnecessary medicalization of psychosocial problems in general (Hyman, 2010; Pierre and Frances, 2016).

Considering the lack of biological tests, fuzzy boundaries, cultural influences on what people perceive as a mental health problem and further shortcomings, current psychiatric diagnoses can be seen as rather heuristic constructs instead of biological entities. This is exactly what the Diagnostic and Statistical Manual of Mental Disorders IV-text revision guidebook (DSM-IV-TR) states by saying that mental disorders defined are best conceived as "*valuable heuristic constructs*" rather than of "*well-defined entities that describe nature exactly as it is*" (Frances et al., 1995, p. 12). Thus, mental disorders can neither be objectified nor counted (Allsopp et al., 2019) – making e.g., epidemiologic numbers quite an imperfect proxy to *real* psychiatric morbidity (Thornicroft, 2007). While alternative models of psychiatric disorders like dimensional concepts or concepts of psychosocial crises of shorter or longer duration could be helpful at this point, many scholars are reluctant to use them. Except for common mental disorders or crises directly related to a specific stressful life event, they mostly reject such theories and their usefulness (Caplan, 1989). Even scholars who tried to adapt psychosocial theories such as the *Crisis Theory* to people with severe mental disorders emphasized the differences to "normal people" and asserted that the theory needs to be considerably modified to be helpful in this target group (Ball et al., 2005).

To better understand the rejection of psychosocial concepts, it appears helpful to take a closer look at the reasons for the strong adherence to traditional models of severe mental disorders. Hereby it is worthwhile to investigate not only psychiatric disorder concepts, but also heuristic models such as the *Stress-Vulnerability Concept* since it seems to bridge the gulf between what we do not know (etiology) and what we see (the so-called signs and symptoms).

CONCEPTUAL PROBLEMS IN PSYCHIATRY: THE STRESS-VULNERABILITY MODEL

A seemingly comprehensive and useful model for explaining why some people become psychiatrically ill and others not, is the *Stress-vulnerability model* of Zubin and Spring (1977). This model has been welcomed widely on an international scale and used for decades. It was originally developed for a deeper understanding of schizophrenia. Over time, it was extended to other psychiatric diagnoses. Despite being criticized for not having included resilience as well as gene-environment interaction (Rutten et al., 2013), the *Stress-vulnerability model* appears to be consistent, acceptable, and adaptable for all professions dealing with people with psychological disorders over the past decades (Monroe and Simons, 1991).

Background and Definition

The *Stress-vulnerability model* proposes that each human being is endowed with a genetic predisposition to stress – his or her individual mental vulnerability (Zubin and Spring, 1977). This vulnerability interacts with psychosocial stressors and results in a disruption to wellbeing and mental health. Vulnerability can be defined as "*the empirical probability that an individual will experience an episode of psychiatric disorder*" (Zubin and Spring, 1977, p. 123). The authors call this an *"enduring trait"* which affects the capacity to cope with external stressors or rather one's *"coping ability"* (Zubin and Spring, 1977, p. 123). Thus, individuals may experience a *"coping breakdown"* in the case of being exposed to substantial or even catastrophic stress. This breakdown does not necessarily lead to an episode of a psychiatric disorder. The originators of the model therefore argue that only individuals with a higher vulnerability experience coping breakdown episodes of time-limited or chronic illness (Zubin and Spring, 1977, p. 109). The diversity of possible variations in vulnerability is explained by the fact that an individual's degree of vulnerability is as well inherited and acquainted over the life span e.g., through trauma, disorders, perinatal complications, family experiences, adolescent peer interactions, and other life events. Consequences of such events are thereby compared to consequences of somatic events and therefore understood as something like a 'neuro-psychiatric injury' (Read et al., 2009).

Original Conceptualization of Vulnerability

Externalizing causes of mental stress or making brain and function responsible for mental disorders was thought to relieve a person from possible feelings of guilt or shame – which in turn was expected to lower stigmatization of mental disorders. The authors of the *Stress-vulnerability model* also hoped that using the word "vulnerability" rather than "disorder" would help to regard individuals as suffering from a (hopefully) temporary episode rather than a chronic disorder (Zubin and Spring, 1977). Besides offering a plausible explanation of psychiatric episodes, the *Stress-vulnerability model* was also developed to guide interventions. Zubin and Spring (1977) offered two avenues for intervention: On one hand, they suggested that vulnerability can be "*reduced or inhibited from full-blown expression through psychopharmacological intervention*" (Zubin and Spring, 1977, p. 122). On the other hand, psychological interventions might be applied to *"restore coping ability or reduce the threatening nature of life events that produce the breakdown."* (Zubin and Spring, 1977, p. 122). These suggestions as well as the later use of the model show that the authors already had the biological level in mind when they spoke of vulnerability. Such an alleged biological vulnerability in turn is comprised of e.g., putative genetic risks and changes in protein expression, structural and functional brain anomalies, neurochemical deficits, anomalies or particularities, impairments, problems of connectivity or neurons among others (Beauchaine et al., 2008; Sullivan et al., 2012).

The Hegemony of Biological Vulnerability and Its Consequences

Combining biological, psychological and social aspects, the *Stress-vulnerability model* became the foundation of the so called 'bio-psycho-social model of psychiatric disorders'. This model was welcomed widely by psychiatry (Engel, 1978; Engert et al., 2020). However, this model was of rather low additional informative value, because it did not move past the biomedical model in any meaningful way (Ghaemi, 2009). Additionally, it was frequently used as a pure slogan rather than actually integrated into a holistic understanding of mental disorders. It is e.g., argued that the 'bio-psycho-social model of psychiatric disorders' is mostly used as just a 'bio-bio-bio' or at least as a 'bio-bio-psychological model of mental disorder' (Read et al., 2009), granting a causal role to social factors but limiting them to being 'causal chain links' leading inexorably to biological processes. Such an understanding shows no significant difference to the biomedical model in any meaningful way and is therefore in line with the almost hegemonic biogenetic conceptual framework in understanding mental disorders (Malla et al., 2015).

Maintaining a biological understanding of psychological problems despite the above described brings about several problematic repercussions:

1. Without biomarkers, valid criteria and boundaries for psychiatric disorders, psychological suffering always bears a risk of being seen as a psychiatric problem. In the absence of objective standards of verification, it is almost impossible to establish what a specific disorder is and who is affected (Gupta, 2014, p. 86). Thus, it allowed psychiatrists e.g., to expand the *Stress-vulnerability model* to minor psychological problems with a certain amount of suffering, such as mild or moderate depression and consequently prescribe psychiatric treatments (Kinser and Lyon, 2014). In our view, this effect is aggravated by the widespread availability of biological treatments, which are not limited to severe disorders but are also prescribed in minor psychological crises. Even though such an approach might alleviate suffering for a certain individual, one has to keep in mind that a biased understanding and use of the *Stress-vulnerability model* together with the application of a biological understanding of psychological problems might contribute unintendedly as a 'top-down factor to psychiatrization' (Beeker et al., 2021). Top-down psychiatrization hereby refers to constructing and restructuring images of mental health by psychiatrists and researchers in order to put the problem into the context of a medical and medically treatable disorder – with a minor role of the social world in which the person affected and the problem are located.
2. Evidence shows that biological narratives are not linked to reduced blame (Loughman and Haslam, 2018). In fact, neurobiological or genetic explanations for psychiatric disorders seem to lead to an even greater desire for social distance, greater perceived dangerousness, and greater prognostic pessimism (Pescosolido et al., 2010). This in turn results in higher stigmatization of people with so-called severe mental illness – which was the exact opposite of what Zubin and Spring (1977) originally intended.
3. A primarily biological understanding of mental crisis ignores existing evidence of the central importance of the social context that might be associated with relational stress and increasing the vulnerability to psychiatric disorders e.g., in the case of psychosis (Longden and Read, 2016; Jongsma et al., 2021).

4. Despite a lack of evidence, the dominant biological narrative increased the use of psychiatric medication since they are claimed – among other effects – to decrease vulnerability. Additionally, there is increasing evidence about short and long-term side effects e.g., even of modern antidepressants and antipsychotics (Moncrieff, 2006; Kendall, 2011; Davies et al., 2019). Particularly antidepressants carry a high level of risk of withdrawal and rebound phenomena (Henssler et al., 2019; Lerner and Klein, 2019), which in turn is not in line with its effectiveness narrative. In addition, there is considerable evidence that antidepressants prescribed over a longer term worsen the outcome of depression (Fava, 2003).
5. A focus on biological vulnerability might unnecessarily lead to neglecting the psychosocial aspect concerning the care of people with severe psychological symptoms, e.g., regarding research and the application of interventions. There is evidence that such a focus e.g., leads to a smaller consideration of biographic and adverse life events in the which in turn is associated with oftentimes unnecessarily and sometimes very aggressive pharmacological interventions for too long and at a too high dosage (Paris, 2017). This might not only increase stigmatizing attitudes in professionals but also undermine self-healing powers in patients and might push them to adopt the biological model to themselves (Lebowitz and Appelbaum, 2019).
6. A biological understanding fails to provide early psychosocial interventions because it suggests a correction of biological vulnerability before psychosocial measures can be applied "in addition." Thus, whenever a situation occurs in which a person's behavior or reported internal world resembles a classification of the DSM or ICD, we assume a biological vulnerability. Consequently, we tend to look for biological remedies to alleviate it. In addition, psychosocial interventions are oftentimes implemented with the aim to strengthen the individual's coping ability, resilience, or acceptance of the assumed "disorder" in order to improve the outcome (Ross, 2014). This simplified understanding of the *Stress-vulnerability model* is the opposite of what its authors aimed at: They proposed the *Stress-vulnerability model* with the aim to substitute a mainly medical understanding of continuing psychiatric disorders such as schizophrenia with a holistic view of temporary episodes in vulnerable individuals whose problem is in the majority of cases self-curing (Zubin and Spring, 1977, p. 121-122).

AN ALTERNATIVE MODEL FOR MENTAL DISTRESS: THE CRISIS THEORY

As outlined above, in its current use, the *Stress-vulnerability model* gives preference to biological narratives and remedies and only provides a vague and rather reductionist theory to understand minor as well as major psychological and social phenomena and disturbances. Other models such as *Crisis Theory* (Caplan, 1964; Hobbs, 1984) may better convey the process and nature of mental crises and offer a more inclusive approach to dealing with them. Furthermore, in our view, *Crisis Theory* represents an important tool in preventive psychiatry since it provides a conceptual framework for an increasing number of community-based multidisciplinary psychiatric services.

Background, Definition and Location in Psychiatry

Arising from non-medical disciplines, *Crisis Theory* was originally proposed by Caplan and Hobbs (Caplan, 1964; Hobbs, 1984). It accounts as an explicitly *descriptive* and coherent explanatory model in which the experience of a crisis as a psychological phenomenon is per definition subjective. Hereby, a psychological crisis is defined as a substantial and critical incident that elicits a response to trauma (Hobbs, 1984). Key features of such a psychological crisis are the following: (a) an individualized life experience based on subjective appraisal; (b) acute distress related to feeling overwhelmed and without or only little control over the situation; (c) changes in the day-to-day social functioning abilities and risk behaviors; (d) the importance of social support as potentially protective as well as helpful to cope with the crisis (Hobbs, 1984; Dulmus and Hiarski, 2003). In contrast to an understanding of a mental disorder as being chronic and driven essentially by biology, crises are seen as temporal and episodic phenomena (particularly outside the psychiatric context). These phenomena are thought to be an opportunity for change or a turning point in the life of an individual (Hobbs, 1984). As such, a crisis can offer room for inner development as well as post-traumatic growth (Slaikeu, 1990). This focus on life events and development in turn offers explanations and entering points for interventions without using psychiatric labels: Changes in appraisal of events such as reappraisal of existing beliefs and values, changes in living circumstances, mobilization of social, psychological or financial resources, transitions etc. Against the outlined understanding of a crisis, such interventions maximize the potential for psychic growth and maturation.

"A Close Relative": The *Recovery Model*

A concept that shares some key features with the *Crisis Theory* and that has gained significantly in importance among both users of psychiatric services and service providers is the *Recovery Model* (Shepherd et al., 2008; Amering and Schmolke, 2009). The *Recovery Model* views mental disorders from a perspective that is radically different from traditional psychiatric approaches even though it does not fully explain why people develop psychological problems. The *Recovery Model* rather emphasizes resilience and control over problems and life in situations where some kind of shared experience with others and autonomy have been lost. To our knowledge, there is as yet no single definition of the concept of recovery for people with mental health issues. It is rather understood as a process, an outlook, a conceptual framework with certain guiding principles (Slade et al., 2014). These guiding principles emphasize hope and a strong belief that it is possible for people with mental health problems to regain a meaningful life despite persistent symptoms (ibid). Thereby the *Recovery Model* argues against just treating or managing symptoms but focusing on building resilience in people with mental health problems and supporting those in emotional distress. Thus, for many people, the concept of recovery is mostly about staying in control of their life rather than the elusive state of return to a premorbid level of functioning or an asymptomatic phase of the person's life (Davidson, 2005; Ramon et al., 2007; Bonney and Stickley, 2008; Jacob, 2015). Consequently, the *Recovery Model* implies an understanding of a psychological crisis as being a temporary phenomenon that does not necessarily become a chronic one and that does not have a life-long reference to a specific deficit called vulnerability. In this light, "vulnerability" can be understood as being mainly influenced by factors not inherent in one s genes, such as life events, loneliness, residual symptoms, social disadvantage, lack of social support, lack of sleep, drug consumption as well as conflicts (Ball et al., 2005).

Crisis Theory and Severe Mental Illness

While many users of mental health services prefer a holistic understanding of mental crises, *Crisis Theory* as well as related concepts like the above mentioned *Recovery Model* are seldom fully explored among caregivers and service providers. Additionally, many psychiatrists seem pessimistic about the potential for recovery in people with psychiatric diagnoses (Jacob et al., 2017). We will therefore outline some problems and misunderstandings raised in this context and try to dissolve them:

1. *Crisis Theory cannot be applied widely in psychiatry because there are two distinct groups of people: the severely mentally ill who are victims of their biology and those suffering 'mere' distress in response to life events.*

Some people assume that individuals with severe and persistent mental illness are prone to crises even in the absence of clear external precipitants. They generally perceive a crisis as not lasting months or years, and they assert that it must be traceable to a specific life event. Against this, they argue that people affected by severe mental illness do often experience psychiatric symptoms not as a response to visible interpersonal crises but as a result of a neurobiological deficit which triggers acute episodes. They argue that *Crisis Theory* does not take adequately into account fluctuations in symptomatology over time. The view is that external stressful life events play a minor role in contributing to the pathogenesis of a psychiatric episode and that relapses and acute episodes are based on neurotransmitter disturbances, substance abuse, or medication non-compliance. In addition, with so-called severe mental illness, crisis concepts are rejected because, contrary to the commonly accepted crisis model it is often others who seek help on behalf of the individual in crisis, which does not fit with the theory's assumptions (Ball et al., 2005). Thus, they claim a limited application of *Crisis Theory* in mental health care (Ball et al., 2005). However, this is not an argument against *Crisis Theory* by itself but can be understood as a challenge to adapt classical *Crisis Theory* or one of its shortcomings. Coping with a crisis, either a classical psychological crisis as well as a severe crisis, always depends on previous environmental conditioning besides genetic imprinting. In addition, if staff as well as people with the experience of symptoms of so-called severe mental illness have been socialized by the medical community to medicalize these crisis experiences (Mak and Cheung, 2010), the connection of a severe crisis with external stress factors gets lost.

2. *Judgements in mental health care rely on a rather individualistic approach to psychological breakdowns without capturing the circumstances.*

In many psychiatric institutions, the focus of problem assessment and the starting point for its treatment is almost exclusively on the person with symptoms. In general, this approach does not capture the interpersonal nature of a crisis (Seikkula and Arnkil, 2016). To solve this shortcoming, some advocates of *Crisis Theory* refer to a systems theory approach. In this context, they suggest that an individual's psychological crisis can represent a crisis in the wider system. The bottom line of this construct is the assumption that an individual crisis does not happen in isolation but rather within a social context. Such a systemic approach suggests that phenomena framed as signs and symptoms, such as emotional expressions, thought disorder, anxiety or deviant behavior, should not only be seen as the visible parts in the pathogenesis of an individual disorder process but rather as responses of an individual embedded in a complex surrounding. Furthermore, a systemic perspective views crises as escalating vicious cycles of attempts to resolve a situation in which a threat is perceived (Fraser, 1998). The consequence of such a conceptualization is that the social context has to be taken into consideration when looking out for explanations of the crisis as well as in the endeavor of organizing support and mobilizing help.

3. *One has to make a distinction between a psychological crisis and a psychiatric emergency as part of a psychiatric acute episode.*

In general, typical acute psychiatric symptoms affecting the individual's basic mental functions and coping capacity may carry a risk of self-harm or harm for others. These symptoms determine and guide an emergency situation as well as its treatment. A psychosocial crisis, in turn, is primarily seen as stress-related. Applying the above outlined systemic perspective on *Crisis Theory*, there is no boundary between a psychiatric emergency and a psychosocial crisis even though the expression of the reaction to the external stressors is different in a severe psychiatric crisis. Cognitive and emotional stress, e.g., might be related to previous external stressors. Negative symptoms in a psychotic crisis, e.g., might be associated with avoidance of traumatic memories related to (previous) psychosis and hospitalization (Harrison and Fowler, 2004). Other psychopathological phenomena such as cognitive disorders might also not be explained by crises alone but might be psychological reactions in people with specific traumatic experiences and psychological patterns which have been developed in childhood (Schäfer and Fisher, 2011).

Benefits of a Systemic Approach to Crisis Theory

As outlined above, a systemic perspective of *Crisis Theory* enables us to detect psychosocial problems behind the symptoms even in people with severe psychiatric crises. With such an understanding, these symptoms are part of a spectrum of "normal" responses within a dimensional and systemic perspective. In our view, a systemic perspective of *Crisis Theory* enables us to better identify precipitants and triggers of severe mental crises in the social context of those affected than, e.g., in a hospital setting, where people oftentimes are de-contextualized. Furthermore, a systemic crisis can be more easily addressed by crisis resolution, assertive outreach and home treatment teams as the psychosocial context is more visible within these approaches (Johnson et al., 2008). Since such an approach stresses the transient nature of crises, crisis intervention could act without having to identify and "treat" interpersonal conflicts immediately. This would on one hand release psychiatric staff from always being responsible to find a quick solution and on the other hand release the respective person whose ability to specify or speak about the precipitating social factors might be limited in an acute crisis.

A further benefit of applying a systemic approach of *Crisis Theory* is the fact that it is less prone to medicalization – which opens the possibility of using different approaches, remedies, interventions, or help from various fields of psychiatry in order to cope with or solve a mental health crisis (von Peter and Schwarz, 2021). Finally, a systemic approach of *Crisis Theory* does not put biological vulnerability and the search for it in the center, but focuses on the resources of the individual and his or her social context. Thus, it is a more inclusive approach of dealing with psychological phenomena (Schwarz et al., 2020).

DISCUSSION AND OUTLOOK

In this article, we argued that current psychiatric nosology lacks reliability as well as validity and is still based on unproven biological theories of mental disorders. Although the *Stress-Vulnerability Concept* has originally been developed to counteract a reductionist medical model of psychiatric disorders, its current use places assumed neuro-psychiatric injuries and resulting impairments due to an assumed psychiatric "disorder" on the same level as somatic disorders. In this sense, it seems to have been misapplied: Vulnerability has primarily been framed as biological. However, a primarily biological disorder model using a simple and one-dimensional *Stress-Vulnerability Concept* may contribute to psychiatrization of people in psychosocial stress situations, e.g., since certain ICD or DSM diagnoses in particular imply pharmacologic interventions. To stop this trend and contribute to a more inclusive, less stigmatizing, holistic way of dealing with mental health challenges, different concepts are needed. We suggest a broader *Crisis Theory* with a systemic perspective in which the individual crisis represents a crisis in the wider system. Applying it consequently could contribute to de-medicalize psychosocial suffering and might lead to a different perception. It could also enhance self-perception of mental health problems since these would rather be seen as challenges within a social system. Focusing on such a view could help to avoid dynamics of self-fulfilling prophecies when we speak of a "psychiatric disorder" and of potential "chronic disorders" – which we would have to avoid by using "adequate" treatment.

To ensure that such a model becomes reality, it not only has to be applied in common mental disorders but also for organizing care and support for people experiencing severe psychiatric episodes. Thus, we should not accept or ally ourselves with the concept of biological "otherness," even when people have experienced relief with the help of medication or coercive measures. Such a narrow medical focus of disorder and treatment may result in alienating people from themselves including reducing their trust in themselves and their self-healing powers. Applying pharmaceutical intervention too fast and in too high dosages e.g., might lower the strength and energy of people affected to overcome their crisis– in a sense that the medication may alleviate their symptoms but leaves them with little creative energy to overcome the episode. Such a focus might also bias people in attributing emotional crises to the "disorder" which then might become a part of their personal identity.

Against the outlined in this article, we argue that *Crisis Theory* with a systemic perspective can be judged as very useful to overcome shortcomings of current psychiatric concepts, to empower people affected especially with regard to stating that you can recover even from so-called severe mental illness, to enhance the understanding that a psychological crisis may change your life without dominating it, to fight pessimism concerning recovery, to reduce stigmatization, and to strengthen the role of psychosocial interventions. Thereby, its application could help to prevent or manage some negative aspects of the psychiatrization of psychosocial problems.

AUTHOR CONTRIBUTIONS

SW drafted the first version of the manuscript. Both authors revised the manuscript several times, read, and approved the final version of the manuscript.

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REFERENCES

Allsopp, K., Read, J., Corcoran, R., and Kinderman, P. (2019). Heterogeneity in psychiatric diagnostic classification. *Psychiatry Res.* 279, 15–22. doi: 10.1016/j.psychres.2019.07.005

Amering, M., and Schmolke, M. (2009). *Recovery in Mental Health: Reshaping Scientific and Clinical Responsibilities*. Oxford: Wiley-Blackwell.

Ball, J. S., Links, P. S., Strike, C., and Boydell, K. M. (2005). "It's overwhelming... Everything seems to be too much:" A theory of crisis for individuals with severe persistent mental illness. *Psychiatr Rehabil J.* 29, 10. doi: 10.2975/29.2005.10.17

Beards, S., Gayer-Anderson, C., Borges, S., Dewey, M. E., Fisher, H. L., and Morgan, C. (2013). Life events and psychosis: a review and meta-analysis. *Schizophr. Bull.* 39, 740–747. doi: 10.1093/schbul/sbt065

Beauchaine, T. P., Neuhaus, E., Brenner, S. L., and Gatzke-Kopp, L. (2008). Ten good reasons to consider biological processes in prevention and intervention research. *Dev. Psychopathol.* 20, 745–774. doi: 10.1017/S0954579408000369

Beeker, T., Bhugra, D., Te Meerman, S., Thoma, S., Heinze, M., and Von Peter, S. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12, 645556. doi: 10.3389/fpsyt.2021.645556

Bonney, S., and Stickley, T. (2008). Recovery and mental health: a review of the British Literature. *J. Psychiatr. Ment. Health Nurs.* 15, 140–153. doi: 10.1111/j.1365-2850.2007.01185.x

Caplan, G. (1964). *Principles of Preventive Psychiatry*. Oxford, England: Basic Books.

Caplan, G. (1989). Recent developments in crisis intervention and the promotion of support service. *J. Prim. Prev.* 10, 3–25. doi: 10.1007/BF01324646

Cova Solar, F., Rovengno, C. I., Saldivia Bórquez, S., Rivera, C. N., and Fernández, P. G. (2020). Psychiatric epidemiology, conceptualisation of mental disorders and psychopathologisation: a critical analysis. *Cogent Psychol.* 7, 1847384. doi: 10.1080/23311908.2020.1847384

Davidson, L. (2005). Recovery, self management and the expert patient – Changing the culture of mental health from a UK perspective. *J Ment Health* 14, 25–35. doi: 10.1080/09638230500047968

Davies, J., Read, J., Hengartner, M.P., Cosci, F., Fava, G., Chouinard, G., et al. (2019). Clinical guidelines on antidepressant withdrawal urgently need updating. *Br. Med. J.* 365, l2238. doi: 10.1136/bmj.l2238

de Leon, J. (2013). Is psychiatry scientific? A letter to a 21st century psychiatry resident. *Psychiatry Investig.* 10, 205–217. doi: 10.4306/pi.2013.10.3.205

Dean, C. E. (2012). The death of specificity in psychiatry: cheers or tears? *Perspect. Biol. Med.* 55, 443–460. doi: 10.1353/pbm.2012.0028

Dulmus, C. N., and Hiarski, C. (2003). When stress constitutes trauma and trauma constitutes crisis: The stress-trauma-crisis continuum. *Brief Treat. Crisis Interv.* 3, 27–36. doi: 10.1093/brief-treatment/mhg008

Engel, G. L. (1978). The biopsychosocial model and the education of health professionals. *Ann. N. Y. Acad. Sci.* 310, 169–187. doi: 10.1111/j.1749-6632.1978.tb22070.x

Engert, V., Grant, J. A., and Strauss, B. (2020). Psychosocial factors in disorder and treatment—a call for the biopsychosocial model. *JAMA Psychiatry* 77, 996–997. doi: 10.1001/jamapsychiatry.2020.0364

Fàbrega, H. Jr. (2001). Culture and history in psychiatric diagnosis and practice. *Psychiatr. Clin. North Am.* 24, 391–405. doi: 10.1016/S0193-953X(05)70236-7

Fava, G. A. (2003). Can long-term treatment with antidepressant drugs worsen the course of depression? *J. Clin. Psychiatry* 64, 123–133. doi: 10.4088/JCP.v64n0204

Frances, A. (2010). DSM in philosophyland: curiouser and curiouser. *Assoc. Adv. Philos. Psychiatry (AAPP) Bull.* 17, 3–7. doi: 10.1093/jmp/19.3.207

Frances, A.J., First, M.B., and Pincus, H.A. (1995). *DSM-IV Guidebook*. Washington, DC: American Psychiatric Press. (1995).

Fraser, J. S. (1998). A process view of crisis and crisis intervention: critique and reformulation. *Crisis Interv. Time Limited Treat.* 4, 125–144.

Fusar-Poli, P., and Meyer-Lindenberg, A. (2016). Forty years of structural imaging in psychosis: promises and truth. *Acta Psychiatr. Scand.* 134, 207–224. doi: 10.1111/acps.12619

Ghaemi, S.N. (2009). The rise and fall of the biopsychosocial model. *Br. J. Psychiatry* 195, 3–4 doi: 10.1192/bjp.bp.109.063859

Gupta, M. (2014). *Is Evidence-based Psychiatry Ethical*? Oxford: Oxford University Press.

Harrison, C. L., and Fowler, D. (2004). Negative Symptoms, Trauma, and Autobiographical Memory: An Investigation of Individuals Recovering From Psychosis. *J. Nerv. Ment. Disord.* 192, 745–753. doi: 10.1097/01.nmd.0000144693.12282.11

Henssler, J., Heinz, A., Brandt, L., and Bschor, T. (2019). Antidepressant withdrawal and rebound phenomena. *Dtsch. Ärztebl. Int.* 116, 355. doi: 10.3238/arztebl.2019.0355

Hobbs, M. (1984). Crisis intervention in theory and practice: a selective review. *Br. J. Med. Psychol.* 57, 23–34. doi: 10.1111/j.2044-8341.1984.tb01577.x

Hyman, S. E. (2010). The diagnosis of mental disorders: the problem of reification. *Ann. Rev. Clin. Psychol.* 6, 155–179. doi: 10.1146/annurev.clinpsy.3.022806.091532

Jacob, K. S. (2015). Recovery model of mental illness: a complementary approach to psychiatric care. *Indian J. Psychol. Med.* 37, 117–119. doi: 10.4103/0253-7176.155605

Jacob, S., Munro, I., Taylor, B. J., and Griffiths, D. (2017). Mental health recovery: a review of the peer-reviewed published literature. *Collegian* 24, 53–61. doi: 10.1016/j.colegn.2015.08.001

Johnson, S., Needle, J., Bindman, J. P., and Thornicroft, G. (2008). *Crisis resolution and home treatment in mental health* (Vol. 13). Cambridge: Cambridge University Press.

Jongsma, H.E., Gayer-Anderson, C., Tarricone, I., Velthorst, E., van der Ven, E., Quattrone, D., et al. (2021). Social disadvantage, linguistic distance, ethnic minority status and first-episode psychosis: results from the EU-GEI case-control study. *Psychol. Med.* 51, 1536–1548. doi: 10.1017/S003329172000029X

Kendall, T. (2011). The rise and fall of atypical antipsychotics. *Br. J. Psychiatry* 199, 266–268. doi: 10.1192/bjp.bp.110.083766

Kinser, P.A., and Lyon, D.E. (2014). A conceptual framework of stress vulnerability, depression, and health outcomes in women: potential uses in research on complementary therapies for depression. *Brain Behav.* 4, 665–674 doi: 10.1002/brb3.249

Kleinman, A., Eisenberg, L., and Good, B. (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann. Intern. Med.* 88, 251–258. doi: 10.7326/0003-4819-88-2-251

Lebowitz, M. S., and Appelbaum, P. S. (2019). Biomedical explanations of psychopathology and their implications for attitudes and beliefs about mental disorders. *Ann. Rev. Clin. Psychol.* 15, 555–577. doi: 10.1146/annurev-clinpsy-050718-095416

Lerner, A., and Klein, M. (2019). Dependence, withdrawal and rebound of CNS drugs: an update and regulatory considerations for new drugs development. *Brain Commun.* 1, fcz025. doi: 10.1093/braincomms/fcz025

Longden, E., and Read, J. (2016): Social adversity in the etiology of psychosis: a review of the evidence. *Am. J. Psychother.* 70, 5–33. doi: 10.1176/appi.psychotherapy.2016.70.1.5

Loughman, A., and Haslam, N. (2018). Neuroscientific explanations and the stigma of mental disorder: a meta-analytic study. *Cogn. Res. Princ. Implic.* 3, 43. doi: 10.1186/s41235-018-0136-1

Mak, W.W., and Cheung, R.Y. (2010). Self-stigma among concealable minorities in Hong Kong: conceptualization and unified measurement. *Am. J. Orthopsychiat.* 80, 267–281. doi: 10.1111/j.1939-0025.2010.01030.x

Malla, A., Joober, R., and Garcia, A. (2015). "Mental illness is like any other medical illness": a critical examination of the statement and its impact on patient care and society. *J. Psychiatry Neurosci.* 40, 147–150. doi: 10.1503/jpn.150099

Margraf, J., and Schneider, S. (2016). From neuroleptics to neuroscience and from Pavlov to psychotherapy: more than just the "emperor's new treatments" for mental illnesses? *EMBO Mol. Med.* 8, 1115–1117. doi: 10.15252/emmm.201606650

Moncrieff, J. (2006). Does antipsychotic withdrawal provoke psychosis? Review of the literature of rapid onset psychosis (supersensitivity psychosis) and withdrawal-related relapse. *Acta Psychiatr. Scand.* 114, 3–12. doi: 10.1111/j.1600-0447.2006.00787.x

Monroe, S. M., and Simons, A. D. (1991). Diathesis-stress theories in the context of life stress research: implications for the depressive disorders. *Psychol. Bull.* 110, 406–425. doi: 10.1037/0033-2909.110.3.406

Paris, J. (2017). *Psychotherapy in an Age of Neuroscience.* New York: Oxford University Press.

Pescosolido, B. A., Martin, J. K., Long, J. S., Medina, T. R., Phelan, J. C., and Link, B. G. (2010). "A disorder like any other"? A decade of change in public reactions to schizophrenia, depression, and alcohol dependence. *Am. J. Psychiatry* 167, 1321–1330. doi: 10.1176/appi.ajp.2010.09121743

Pierre, J. M., and Frances, A. (2016). Language in psychiatry: a bedevilling dictionary. *BJPsych Adv.* 22, 313–315. doi: 10.1192/apt.bp.116.016238

Ramon, S., Healy, B., and Renouf, N. (2007). Recovery from mental illness as an emergent concept and practice in Australia and the UK. *Int. J. Soc. Psychiatry* 53, 108–122. doi: 10.1177/002076400607 5018

Read, J., Bentall, R. P., and Fosse, R. (2009). Time to abandon the bio-bio-bio model of psychosis: Exploring the epigenetic and psychological mechanisms by which adverse life events lead to psychotic symptoms. *Epidemiol. Psychiatr. Sci.* 18, 299–310. doi: 10.1017/S1121189X00000257

Richter, D., Wall, A., Bruen, A., and Whittington, R. (2019). Is the global prevalence rate of adult mental illness increasing? Systematic review and meta-analysis. *Acta Psychiatr. Scand.* 140, 393–407. doi: 10.1111/acps.13083

Ross, R,G. (2014). Adolescents are like adults (sort of): psychosocial interventions for adolescents with or vulnerable to schizophrenia. *J. Am. Acad. Child Adolesc. Psychiatry* 53, 833–834. doi: 10.1016/j.jaac.2014.04.019

Rutten, B. P. F., Hammels, C., Geschwind, N., Menne-Lothmann, C., Pishva, E., Schruers, K., et al. (2013). Resilience in mental health: linking psychological and neurobiological perspectives. *Acta Psychiatr. Scand.* 128, 3–20. doi: 10.1111/acps.12095

Schäfer, I., and Fisher, H.L. (2011). Childhood trauma and psychosis - what is the evidence? *Dialogues in Clin. Neurosci.* 13, 360–365. doi: 10.31887/DCNS.2011.13.2/ischaefer

Schwarz, J., Geissler, M., Küsel, M., Müller, K., Unterlauf, C., Bechdolf, A., et al. (2020). Genesungsbegleitung und stationsäquivalente Behandlung. *Nervenheilkunde* 39, 731–738. doi: 10.1055/a-1193-8261

Seikkula, J., and Arnkil, T. (2016). *Dialogical Meetings in Social Networks*. London, Routledge

Shepherd, G., Boardman, J., and Slade, M. (2008). *Making Recovery a Reality*. Policy Paper. Sainsbury Centre for Mental Health. Available online at: https://www.centreformentalhealth.org.uk/publications/making-recovery-reality (accessed May 10).

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., et al. (2014). Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry* 13, 12–20. doi: 10.1002/wps.20084

Slaikeu, K. A. (1990). *Crisis Intervention: A Handbook for Practice and Research*. Boston: Allyn and Bacon.

Sullivan, P. F., Daly, M. J., and O'Donovan, M. (2012). Genetic architectures of psychiatric disorders: the emerging picture and its implications. *Nat. Rev. Genetics* 13, 537–551. doi: 10.1038/nrg3240

Thornicroft, G. (2007). Most people with mental illness are not treated. *Lancet* 370, 807–808. doi: 10.1016/S0140-6736(07)61392-0

Viswanath, B., and Chaturvedi, S. K. (2012). Cultural aspects of major mental disorders: a critical review from an Indian perspective. *Indian J. Psychol. Med.* 34, 306–312. doi: 10.4103/0253-7176.108193

von Peter, S., and Schwarz, J. (2021). Mutual support by people with lived experience of mental distress in crisis respites - a scoping review. *Psychiatr. Praxis* 48, 65–72. doi: 10.1055/a-1307-7160

Zubin, J., and Spring, B. (1977). Vulnerability: a new view of schizophrenia. *J. Abnorm. Psychol.* 86, 103. doi: 10.1037/0021-843X.86.2.103

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CONCEPTUAL ANALYSIS
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Dialogue as a Response to the Psychiatrization of Society? Potentials of the Open Dialogue Approach

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In recent decades, the use of psychosocial and psychiatric care systems has increased worldwide. A recent article proposed the concept of psychiatrization as an explanatory framework, describing multiple processes responsible for the spread of psychiatric concepts and forms of treatment. This article aims to explore the potentials of the Open Dialogue (OD) approach for engaging in less psychiatrizing forms of psychosocial support. While OD may not be an all-encompassing solution to de-psychiatrization, this paper refers to previous research showing that OD has the potential to 1) limit the use of neuroleptics, 2), reduce the incidences of mental health problems and 3) decrease the use of psychiatric services. It substantiates these potentials to de-psychiatrize psychosocial support by exploring the OD's internal logic, its use of language, its processes of meaning-making, its notion of professionalism, its promotion of dialogue and how OD is set up structurally. The conclusion touches upon the dangers of co-optation, formalization and universalization of the OD approach and stresses the need for more societal, layperson competencies in dealing with psychosocial crises.

Keywords: psychocentrism, psychiatrization, professionalism, need-adapted, dialogical, medicalization, psychologization, sanism

INTRODUCTION

In recent decades, the use of psychosocial and psychiatric care systems has increased worldwide, even though the incidence and prevalence of so-called "mental disorders" have remained relatively stable (Beeker et al., 2021). A recent article, to which this manuscript responds, proposed the concept of psychiatrization as an explanatory framework, describing multiple processes responsible for the spread of psychiatric concepts and forms of treatment (ibid): psychiatrization can be promoted by political or psychiatric actors themselves (top-down), as well as by citizens or users (bottom-up), and can lead to various negative social effects, such as an expansion of diagnostic categories, an increasing use of psychotropic drugs or the pathologization of life challenges. Accordingly, psychiatric concepts that prevent or at least curtail the processes of psychiatrization are of particular importance.

This article aims to introduce the Open Dialogue (OD) approach and explore its potential for engaging in less psychiatrizing forms of treatment or support in psychosocial crises. OD is a multi-professional, continuous, needs- and outpatient-oriented model of psychiatric support for crisis, developed initially in Finland and then applied in more than 30 countries. In OD, the social network and the user are involved in joint treatment planning and treatment engagement from the beginning and throughout the whole therapeutic process (sometimes for years if necessary). A central element is the use of network meetings, involving the service users and their social or professional environments to enable a mutual and deeper understanding of the current crisis, as well as draw on the creativity and resources of the network and make joint decisions for further courses of action. All additional treatment elements, such as individual psychotherapy, medication, nursing, social work and others, are provided and integrated as needed. In case of hospitalisation, the same team continues to work with the individual of concern and the network as a whole.

In Finland, where OD was developed, network meetings are embedded in a specific reorganization of the entire help system, according to the following basic organizational principles (Aaltonen et al., 2011; Seikkula et al., 2011; Beeker et al., 2021) immediate help in crises, ideally within 24 h (Aaltonen et al., 2011), involvement of the social network through network meetings from the beginning of the treatment (Seikkula et al., 2011), flexibility and mobility with regards to the needs of the network in terms of frequency, location and participants in network meetings (Bergström et al., 2021), responsibility for the organization and implementation of the entire treatment process by the treatment team and (von Peter et al., 2019) psychological continuity or ensuring the continuity of relationships and common understandings over the entire course of treatment. Thus, OD as an approach depends on structural principles that enable its implementation, which may require a substantial re-shaping of the mental health care system in which it is embedded.

Existing literature describes the many benefits and positive effects of OD in client outcomes (Aaltonen et al., 2011; Seikkula et al., 2011; Bergström et al., 2021). Among others, it has been shown that its largely non-institutional and non-medicalized approach fits well with contemporary human rights perspectives which suggests that its basic network perspective promotes a contextual and relational understanding of mental well-being (von Peter et al., 2019). OD opens a space in which all participants can express themselves equally, and aims to strengthen mutual respect, autonomy and self-determination. In this respect, it seems to be a suitable model to advance an urgently needed reform of the mental health care systems worldwide (Bartlett and Schulze, 2018; WHO, 2021).

Complementary to this idea, the present paper weighs the potential of the OD approach to implement support in a less psychiatrizing way. The manuscript to which we respond (Beeker et al., 2021) mentions the possibility of de-psychiatrization, which demonstrate that psychiatrization is not a deterministic one-way road. Accordingly, we will focus in the following on the potentials of the OD approach to de-psychiatrize mental health care by either reversing psychiatrization that has already occurred or prevent it from the beginning. Thereby, we will focus on top-down processes of de-psychiatrization, first, because OD is a support service that originated in psychiatry and, thus, operates top-down by definition, and second, because we as authors all offer OD rather than receive it which also implies a top-down perspective. In terms of interaction, the described top-down effects of OD can also trigger or reduce bottom-up processes, the potential effects of which are not explored here in detail in the following due to our roles as OD practitioners and researchers.

EFFECTS OF OPEN DIALOGUE

Since its development in Western Lapland, Open Dialogue has been studied in five cohort studies with first-episode psychotic disorders (Lehtinen et al., 2000; Seikkula et al., 2006; Seikkula et al., 2011; Bergstrøm et al., 2017), and currently a large cluster-randomized control trial (ODDESSI trial) is being conducted in the United Kingdom. These cohort studies show promising results even regarding OD's potential for de-psychiatrization, including a significant reduction of inpatient stays (i.e. hospital days and re-admissions) as well as lower relapse rates over time in all cohorts (Seikkula et al., 2006; Seikkula et al., 2011; Bergstrøm et al., 2018). In addition, the results show a re-integration into work and education of up to 84% of the participants and a considerably low and infrequent use of neuroleptic medication both initially (28–50%) and during the course of intervention (11–29%) (Seikkula et al., 2006; Bergstrøm et al., 2018). In the comparison between the individual cohorts, shorter and less severe psychotic episodes were described as well as a dramatic reduction (up to 82%) of clients with residual symptomatology. Additionally, a decrease in the use of psychiatric services and frequency of network meetings were reported (Seikkula et al., 2006; Aaltonen et al., 2011; Bergstrøm et al., 2017), and significantly fewer disability allowances were used compared with historical control groups (Seikkula et al., 2006; Bergstrøm et al., 2018). Overall, across all cohorts from 1992 to 2005, evidence showed that the treatment outcomes achieved in each case remained fairly stable over the entire period or even increased over time (Bergstrøm et al., 2018).

The results of the cohort studies in Western Lapland paint an alternative picture to that of traditional treatment for psychotic crises which relies heavily on drug treatment and is associated with high socioeconomic costs (Charlson et al., 2018; He et al., 2020). Moreover, the described effects of OD are an indication that this form of support has the potential to counteract and potentially prevent further expansion of psychiatric concepts and psychiatrized treatment services at several levels (Beeker et al., 2021): a limited use of neuroleptics (Aaltonen et al., 2011), reduced incidences of mental illness and a more restrained use of diagnostic categories and (Seikkula et al., 2011) an overall decrease in the use of psychiatric care services. Yet, it should be noted that these outcomes could only be achieved through the comprehensive structural changes in the participating Finnish catchment areas. The extent to which OD has a similar potential for de-psychiatrization without these structural changes remains unclear. Accordingly, the question arises in which way or through which therapeutic elements the de-psychiatrizing potentials of OD are mediated? In the following section, we investigate five potentially decisive aspects (Beeker et al., 2021): the use of language (Aaltonen et al., 2011), the processes of meaning-making (Seikkula et al., 2011), the notion of professionalism (Bergström et al., 2021), the promotion of dialogue and (von Peter et al., 2019) some structural aspects of OD.

USE OF LANGUAGE

Apart from treatment planning, a primary goal of network meetings in OD is to foster a shared, polyphonic (i.e. eliciting multiple perspectives) dialogue among participants by using a specific form of language (Seikkula et al., 2001; Seikkula and Trimble, 2005). As described in its principles (Olson et al., 2014), support within the framework of OD relies on the use of everyday terms and non-psychiatric language or terminology. Instead of primarily following a certain agenda (e.g. by asking diagnostic questions), the network meeting facilitators pay attention to the words and stories of the network participants, notice expressions and themes they perceive as important to the network and use them to further expand on ideas (e.g. by repeating individual utterances without paraphrasing or interpreting). Allowing for long silences and being curious about key words that seem significant, is also common. In this way, key words can become central subjective concepts for the communication between the network participants and action-guiding terms useful for planning further steps for support. In doing so, ambiguity is explicitly encouraged and valorized: different meanings and explanatory models of psychosocial crises are allowed to coexist and are essential for understanding and establishing relationships among network participants.

Instead of using a medicalizing language or psychiatric concepts and classifications, OD support focuses on elaborating individual meanings, bringing idiosyncratic narratives into exchange, and using contextual language anchored in everyday life. Behaviors and interactions are not explained by diagnoses or classificatory concepts (unless raised by members of the network) but are understood by contextualizing them as adaptations to stressful life situations or the life histories of individuals or the network. This way, a deeper understanding of the participants among themselves is made possible and solutions can be found collaboratively. Each network participant is supported in this process to contribute their own perspective and find their own terms and concepts. In this context, psychiatric or psychological explanatory approaches are usually dispensed with altogether or are provided–at most–as *one* perspective among many for understanding and explanation, while ideas by the clinical team are held lightly and offered tentatively.

Breaking the interpretive sovereignty of psychiatric language is an integral part of OD, which may explain a significant part of its de-psychiatrizing potential. Instead of using the often stigmatizing psychiatric language and concepts (Rose and Thornicroft, 2010) or using standardized treatments tailored for specific presentations rather than to the persons of concern, the participating networks gain a unique expertise about the explanation and/or solution to their own life situation. From a de-psychiatrizing perspective, the individual language is preserved as a tool for understanding and dealing with crises which can, in the long run, have the potential to de-psychiatrize as it fosters idioms that are grounded in the network's everyday life. In that sense, a bottom-up effect can also be assumed, resulting from the OD's cultivation of a diversity of language in relation to crises, fitting the multi-layered realities of those involved and thereby offering spaces for self-empowerment in dealing with them—a hypothesis that has been supported by recent research (Bergstøm et al., 2019).

PROCESSES OF MEANING-MAKING

OD evolved from the Finnish Need-Adapted Treatment approach, developed from the 1960s to the 1980s in Turku as part of the Finnish national schizophrenia project for first-time psychotically affected people over five phases (Alanen, 2009). This approach was developed as an integrative treatment model based on family therapy, network therapy and psychoanalytic concepts. This led to practices in which the participants are asked to find (new) meanings for the present crisis together during the network meetings. Crises are understood contextually as "natural" responses to challenging life events rather than explained by psychopathology or neurobiological correlates (Seikkula, 2019). They are always seen as meaningful and understandable in the context of an individual life if one only listens closely or asks carefully, thus being normalized as learned responses to a stressful situation.

Thus, during a network meeting the team listens for the meaningful and "logical" aspects of each person's response. The participants are supported to find meaningful explanations instead of framing or understanding a behavior as "wrong" or "crazy". In the form of a "conversational back-and-forth exchange" (Olson et al., 2014) a subtle process of understanding and responding takes place between the network participants and the team, from which meaningful stories gradually emerge that aim at grasping the frequently unspeakable dilemmas and experiences that are at the root of a given symptom. Thereby, during a phase of acute crisis, finding and discussing a single keyword may be more important than a complete story of explanation. This single word may be explored together to arrive at a shared understanding of the crisis at hand, making it more understandable to foster new possibilities to act and think for everyone.

From a methodological perspective, OD practitioners work as a team to support the process of generating and sharing meaning in two different ways related to outer and inner polyphony during the process of the network meeting (Haarakangas, 1997; Seikkula, 2008). Outer or horizontal polyphony happens when the practitioners assist the emergence of the different points of view of the members in the network by providing an opportunity for each participant to express themselves, paying attention to both what is said and to non-verbal expressions. The inner polyphony, also described as vertical polyphony, refers instead to the awareness and use of the different inner voices of both the practitioners and network participants during the network meeting. In this respect, OD meetings can be conceived places for sharing and co-producing knowledge, meanings, experiences and feelings where both professional and lay perspectives are valorized, thus leaving sufficient space for processes of de-psychiatrization.

Further, at times one or more network meeting participants may try to understand the crisis as resulting from a biological or medical problem or with the help of psychiatric nosology. These persons may react with disappointment when the dialogical engagement within the meeting also generates other explanations or attempts at meaning-making. These can be challenging moments in which psychiatric knowledge is needed as well as a profound sensitivity in order to more deeply understand the questions, thoughts and feelings that may lay behind this desire to understand a crisis in medical terms. Quite often, this understanding is simply the result of previous contact with the psychosocial system in which these types of explanations were given along the way. In this sense, OD can also be understood as a possibility to revise these bottom-up psychiatrization processes or at least question them and make them a topic for further exploration.

NOTION OF PROFESSIONALISM

It is obvious that this use of a non-psychiatric language, the promotion of dialogue and the associated (dialogic) attitude have profound implications for the role of those working in OD, including an impact on professional identity. This is especially true for psychiatrists who need to consider what kind of expertise, what competencies and what bodies of knowledge are needed for good implementation of a network meeting, topics that are the subject of recurrent discussion in the OD community (Holmesland et al., 2010; Borchers, 2014; Valtanen, 2019; Schubert et al., 2021). What is clear, however, is that the central expertise lies not in the transmission of knowledge by mental health workers but in their capacity to promote dialogue and the equal exchange of perspectives (Seikkula et al., 2001; Olson et al., 2014). Any treatment mandates or problem definitions do not come unidirectionally from the mental health professionals but primarily emerge from the dialogue among the network meeting participants. The network members should be allowed to decide the content of the exchange, the focus and frequency of the support and whether support is needed or not. On the other hand, the practitioners may offer tentative advice about these decisions, but their primary responsibility is to facilitate and moderate the dialogic processes. They provide the flexibility and mobility necessary to respond to the needs of the network with sufficient staff continuity throughout the treatment process.

When the network meeting practitioners contribute to the exchange, they often do so from a reflexive and personal perspective, drawing on their own private and professional experiences as needed. They certainly may also contribute with professional knowledge but primarily when this is requested by the network and then marked as only one of many possible perspectives. Furthermore, a large part of one's own contributions is offered in the form of an explicit reflective talk between professionals in the presence of the whole network about their experience of witnessing the network process ("reflecting team") (Andersen, 2007; Schriver et al., 2019). This kind of reflection, as a way of sharing professional expertise (Jacobsen et al., 2021), can be rejected by the network much more easily than a seemingly scientific or medicalized explanation that is often introduced with a more *de facto* stance. Thus, the practitioners contribute with their own thoughts, professional knowledge and life or work experiences in a questioning manner rather than dominating the network discussion with medical terminologies. From this point of view, the knowledge and expertise about the network are in the network itself, whereas the practitioners contribute by enabling a dialogic exchange.

This approach requires the practitioners to assume a position of "not knowing", assuming that each person involved in the network has their own view of the situation, which may not even be comprehensible at first (Anderson et al., 1992). A person's experience and understanding of a situation is not self-explanatory and must therefore be openly inquired about and exchanged in the network. Even if different perspectives have been shared in a network, one can never be sure whether a point of view or a problem has really been fully understood, grasped or recognized. Accordingly, hasty solutions or decisions are also to be avoided. Especially in crises, this is in stark contrast to the usual, risk-averse, security-seeking processes of psychiatric care. A central principle in the implementation of network talks is, therefore, a tolerance for uncertainty: while the facilitators have an inner openness for the processes described, they provide a framework that enables exchange and creating the opportunity for previously unheard ideas and explanations for the crises to be heard (Olson et al., 2014).

Thereby, a transparent and open way of communication (i.e. making their thoughts and feelings open to the network) is another principle of practicing OD. Since traumatic experiences and experiences of powerlessness are of great importance for developing psychosocial crises, this transparency on behalf of the practitioners can foster a sense of safety and security (Seikkula and Trimble, 2005; Seikkula et al., 2006). As such, professionalism in OD requires staff to be genuine, openly sharing fears, hopes and anxieties. Instead of "standing above" or distanced from a crisis-situation, they find themselves in the middle of it both metaphorically and concretely. As the network meetings often take place in private homes, OD practitioners are guests, adapting to the context and providing contextual responsiveness to the crisis.

Thus, the OD approach requires a strong redefinition of what counts as professionalism. In network meetings, the professionals primarily participate as human beings with feelings and emotions, who are fallible and justly uncertain about the complex, context-dependent and interactional nature of crises. As much as they may contribute with knowledge that they have accumulated through education or life and work experiences, the concrete solutions, explanations or answers must be given by the network participants themselves. From a de-psychiatrization perspective, one could argue that OD re-signifies the image of psychiatric professionals: instead of being mainly authoritative experts on the nature and management of disorders or diseases, they are now seen as specialists in facilitating dialogical conversations or interactions that also may be helpful to prevent or counteract the psychiatrization of other areas of life.

PROMOTING DIALOGUE

In addition to the use of language described above, further practices are used in OD to promote dialogic exchanges: reflection among the professionals on the content or the structure of a network meeting, relational questions or making sure that all participants have their equal say. Network meetings are always facilitated in team, making open reflections and exchanges (i.e. in the presence of the network) between practitioners possible. Practitioners understand themselves as a part of the dialogue, paying special attention to the actualization of the present encounter. What happens in the here and now of a network meeting is often more important than the details of a long case history or extensive descriptions of symptoms. As a result, this focus on dialogical engagement during a network meeting may allow for new meanings or explanations to emerge, resulting from the actual interactions and discussions between the network members and having the potential to find relational and context-bound instead of psychiatrized solutions.

Further, OD differs significantly from traditional psychiatric practices in its active involvement of the wider network of the persons of concern. Before the first meeting (and every session thereafter), clients are asked who they think is influential for or during a crisis and, thus, should be involved in a network meeting. Network members may be family members, friends, or even contacts in authorities, employers and other persons of support. Involving people from various backgrounds and life contexts fosters a rich exchange with multiple forms of knowledge and ways of being. Experiences of violence, power relations, inequality, exclusion, isolation are example topics that are frequently discussed and point to the social but also societal, micro-political (rather than only medical) focus of this approach. Thus, crises are no longer relegated to explicitly designated and segregated spaces. The boundaries of psychiatric action are less fixed and are not tied to specific institutions or limited to a small, medical or restricted professional framework. Instead, OD support in psychosocial crises means bringing different worlds together and into exchange, resulting in a changed reality for those involved. In this way, OD shifts the focus of crisis support away from external experts towards joint dialogues with multiple actors, reducing the risk that the psychiatric assessment is removed from the reality of the people concerned. Promoting dialogue could thereby prevent top-down processes of psychiatrization in the field of psychiatric assessment.

STRUCTURAL ASPECTS OF OPEN DIALOGUE

Structural aspects refer to how OD is implemented in daily practice and within the wider mental health care landscape. OD is not a manualized psychotherapeutic or medical intervention. However, it does follow a set of principles, identified for the purpose of training, research and implementation, that are put into use or recombined in various ways depending on the needs of the network (Olson et al., 2014). Openness is notwithstanding a central component of its implementation. OD is genuinely need-adapted, which is per definition at odds with top-down, psychiatrizing approaches commonly used in contemporary psychiatric care institutions.

Further, as mentioned above the implementation of OD in Finland was accompanied by a fundamental restructuring of the local health care structures. This involved a major reduction of hospital beds and inpatient facilities and prioritization of outpatient and outreach treatments (Seikkula et al., 2001). As a consequence, meetings were implemented in the living environment of the network: their homes or at school or work, if desired. In this respect, OD shares structural similarities to various approaches of integrated care, such as the work of FACT or ACT teams, many of which have a strong evidence base (Gühne et al., 2018).

Another important goal was developing an alternative form of support in case of psychotic crises able to reduce or dispense of a primarily psychopharmacological approach in psychiatry: A key outcome parameter was the extent to which OD helped to either eliminate the need for neuroleptic medication or to reduce it. This focus alone demonstrates how seriously OD has tried to find non-medicalizing responses to and ways of dealing with psychosocial crises. In that sense, OD can be seen as a tool for the de-medicalization of psychiatric services, a goal that seems to be central to de-psychiatrization (Beeker et al., 2021).

With network meetings at the center of support and having a contextual understanding of crises, OD can be understood as a systemic form of therapy. Psychosocial crises, the responsibility for their emergence and the way(s) out of them are distributed upon several shoulders. Thus, OD breaks with the deeply individualizing infrastructure of traditional psychiatric approaches which allow for psychiatrization processes to further expand. In fact, it may be understood as a means to de-pathologize an individual and instead contextualizing a crisis by creating an embedded understanding against the background of a wider social network. Thus, OD aims to return the responsibility for understanding, managing or overcoming crises to more than one person and, understood somewhat more broadly, to society itself. All people in the social network should be asked and feel empowered to communicate and work together to find solutions to extraordinary situations, whereas common psychiatric approaches tend to allocate this responsibility primarily to one person, the individual of concern.

At the same time, whether these structural aspects come into play depends heavily on the nature of the care context. In many countries, some of the principles mentioned can only be implemented to a limited extent because the mental care systems are highly fragmented and geared to the support of individuals, therefore hardly providing for any opportunities for continuous, systemic support work. Yet, if the OD is implemented in its full (Finnish) form, the structural aspects mentioned could contribute to its de-psychiatrizing potential.

ADVOCATUS DIABOLI

It is important for us not to present the OD as an all-encompassing solution to de-psychiatrize support in psychosocial crises. Certainly, dialogue may not be the primary solution to all problems at hand. Further, the OD is not free of some psychiatrizing effects and probably cannot entirely be. After all, it has been developed gradually, over many years, and primarily by psychiatric or mental health professionals. Thus, even though OD has undoubtedly been based on different and *trans*-disciplinarily anchored concepts and theories over the course of years it originates in psychiatric discourses and practices and cannot be separated from them in its origins, orientation and concepts.

To give a more concrete example, the psychiatrizing risk of OD may be transmitted by its outreach approach: Despite the undisputed positive effects of outreach forms of treatment, especially in comparison to classical inpatient care (Gühne et al., 2018), moving psychosocial support into the living environment of users is, first of all, a formally psychiatrizing process. When a psychiatric concept is brought into someone's home, it can potentially reach more people in their private living environment and thus shape the role of psychiatry in everyday life, quite independently of the type, orientation or quality of the support offered.

Secondly and argued from a somewhat broader perspective, OD is also based on the basic assumption, common at least in Western and individualistic countries, that the care of psychosocial crises requires an institutional response. Instead of dealing with these crises collectively within society, dealing with them has been delegated to staff members of an institution who are paid for it, trained for it, and consequently, always bring a limited range of response options.

Thirdly, OD both in its original application in Finland and in most cases at present is implemented within medical-psychiatric frameworks, i.e. within mental health care systems. This context of application powerfully shapes the way OD is implemented (Von Peter et al., n d). Legal regulations on professional recognition and prerequisites for care, possibilities of billing or recognition of work performed or the concrete organizational conditions of a care system are just a few examples of the many ways in which the concrete design of a health care system can influence the implementation of any mental health approach.

Fourthly, most of the staff of the institutions that currently offer OD internationally largely belong to psychiatric professions. They are mostly conventionally socialized in psychiatric or psychosocial institutions and receive OD training often only in a later stage of their career. In this respect, at least the development of Peer-Supported Open Dialogue (POD) is a promising development (Razzaque and Stockmann, 2016), which could promote the democratic and non-hierarchical orientation of OD (Bellingham et al., 2018). At the same time, the very inclusion of peer experts by experience in existing psychiatric services repeatedly raises questions about appropriation and alignment with psychiatric treatment routines and roles which are also closely related to the question of the psychiatrizing potential of OD.

These examples make it clear that the OD approach cannot be free from psychiatrizing effects either. Psychiatrization as a concept describes a development of society as a whole and is already strongly advanced in many Western societies and accordingly effective. OD is in most cases trained and applied within the existing mental health care systems, which limits its possibilities to respond to psychosocial crises in a de-psychiatrizing way, sometimes drastically, depending on the context. While adopted primarily within public mental health services (Pocobello et al., 2021), in some contexts OD is also implemented by independent associations such as "Offener Dialog e.V." in Leipzig, where it is offered on a voluntary basis and outside the logic of psychiatric care (i.e., without the need for a diagnosis, an obligation to document or prove the fulfilment of a medical treatment mandate and without the use of psychotropic drugs). However, such projects will remain an exception or could potentially sink before setting sail without an adequate funding base.

CONCLUSION

The goal of this paper was to weigh the de-psychiatrizing potential of supporting psychosocial crises with the OD approach. Although this need-adapted approach has its origins in psychiatric discourses and practices and is implemented in this setting in the majority of cases, OD holds some potential for de-psychiatrization. As shown, this potential has been demonstrated by the outcomes of the mentioned cohort studies. Further, it can be theoretically explained by the logic of the OD approach, in the way language is dealt with, the role of the staff within the network work and how this treatment approach is set up both structurally within the mental health care system and in its everyday application.

It must be said that the way OD is offered can differ significantly from the way users experience it. As described initially, we can only provide a top-down perspective due to our role as mental health professionals, OD practitioners and researchers. Thus, it is hard for us to wage whether OD can also bring about societal de-psychiatrizing change processes. This could be a subject for further investigation, as well as transdisciplinary research that critically examines, whether our more conceptual analysis of OD's de-psychiatrizing potentials holds up in practice. Empirical data on both a public health and local level are needed to confirm that the OD approach leads to treating mental suffering in a less psychiatrizing way than other treatment approaches.

In addition, the question arises if the described effects of the OD approach in Finland may require a temporal contextualization since at the time of these cohorts the psychiatrization of society was not so advanced compared to the present. Within the last few decades, psychiatry has increasingly adopted a reductionist neurobiological model (Bracken et al., 2012) which has also changed related disciplines, such as psychology, social work, etc., as much as society as a whole. So, can the de-psychiatrizing outcomes of OD be reproduced at present, despite this seemingly un-reversible process?

In this context, we currently see the danger that OD will be appropriated to serve as a pretty cloak to cover a medical-psychiatrizing treatment (and societal) system. This danger is even more pertinent, as calls for more democratic, human rights-based, empowering or recovery-oriented psychosocial support systems seem to expand, yet often without the willingness or sufficient reflexivity to change customary routines (Von Peter and Zinkler, 2021). In this context, the OD's primary principle of openness rather invites to fill and occupy the approach with own contents and ideologies, including medical concepts and procedures. Thus, whether the OD can have a de-psychiatrizing effect or not is not self-evident but depends on how it is implemented and whether the necessary context of care exists.

There have been and still are extensive discussions within the OD community about the extent to which OD should be formalized, also to be able to demonstrate and investigate its implementation fidelity. While some studies report resistance against standardization and replicable criteria for training and evaluation (Alvarez Monjaras, 2019; Florence et al., 2020; Hopper et al., 2020), different scales have been developed to assess organizational fidelity and clinical adherence (Olson et al., 2014; Alvarez-Monjaras et al., 2021; Lotmore et al., 2021). These scales operationalize the essential aspects of OD well and is being used in connection with the above-mentioned trial in England and upcoming studies. Yet, a more detailed description of the OD has also the disadvantage of limiting its need-adapted openness in implementation with all the dangers of its interventionist use, potentially too firmly prescribing which solutions are (or should be) found in which way for which problems.

Finally, OD is not a panacea. As stated, dialogue may not be the primary solution to all forms of mental health crisis. In an interview, psychiatrist Sandy Steingard pointed out the dangers of idealizing OD (Steingard, 2020), propagating it as the silver bullet for any psychosocial problem. OD is also man-made, error-prone and does not fit all situations of crisis. An overly dogmatic promotion does not do justice to these circumstances, and can lead to false hopes or expectations being raised among users, relatives, staff and other stakeholders. International cohort studies will try to clarify when, under which conditions and in which ways does the application of OD make sense. Indeed, OD can be considered as only one component to bring about the urgently needed changes in the mental health care system.

AUTHOR CONTRIBUTIONS

This Manuscript was written collaborative within the group of authors: Original conceptualization and the first draft by SV, KH, IN, and VA. Revision and additional parts by TB, MH, RP, MA-M, and JS. Editing by SV and KH. Proof—Reading by RP and MH.

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REFERENCES

Aaltonen, J., Seikkula, J., and Lehtinen, K. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: I. The Incidence of Non-affective Psychosis and Prodromal States. *Psychosis* 3, 179–191. doi:10.1080/17522439.2011.601750

Alanen, Y. O. (2009). Towards a More Humanistic Psychiatry: Development of Need-adapted Treatment of Schizophrenia Group Psychoses. *Psychosis* 1 (2), 156–166. doi:10.1080/17522430902795667

Alvarez Monjaras, M. (2019). *Fidelity Measurement for the Implementation of Social Networks Interventions in Complex Mental Health*. London: University College London DClinPsych thesis. Available at: https://discovery.ucl.ac.uk/id/eprint/10083112/ (Accessed August 12, 2021).

Alvarez-Monjaras, M., Lotmore, M., and Pilling, S. (2021). "Community Mental Health Fidelity Scale (COM-FIDE): ODDESSI Pilot Outcomes," in *3rd Meeting of the International Open Dialogue Research Collaboration – Book of Abstracts*. Editors R. Pocobello and F. Camilli (Italy: Institute of Cognitive Sciences and Technologies, National Research Council), 12.

Andersen, T. (2007). Reflecting Talks May Have many Versions: Here Is Mine. *Int. J. Psychother* 11 (2), 27–44. doi:10.1002/j.1467-8438.1992.tb00896

Anderson, H., and Goolishian, H. (1992). "The Client Is the Expert: A Not-knowing Approach to Therapy," in *Therapy as Social Construction*. Editors S. MacNamee and K. Gergen (London: Sage), 54–68.

Bartlett, P., and Schulze, M. (2018). Urgently Awaiting Implementation: The Right to Be Free from Exploitation, Violence and Abuse in Article 16 of the Convention on the Rights of Persons with Disabilities (CRPD). *Int. J. L. Psychiatry* 53, 2–14. doi:10.1016/j.ijlp.2017.05.007

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research. *Front. Psychiatry* 12, 645556. doi:10.3389/fpsyt.2021.645556

Bellingham, B., Buus, N., McCloughen, A., Dawson, L., Schweizer, R., Mikes-Liu, K., et al. (2018). Peer Work in Open Dialogue: A Discussion Paper. *Int. J. Ment. Health Nurs.* 27 (5), 1574–1583. doi:10.1111/inm.12457

Bergstøm, T., Seikkula, J., Holma, J., Mäki, P., and Köngäs-Saviaro, P. (2019). How Do People Talk Decades Later about Their Crisis that We Call Psychosis? A Qualitative Study of the Personal Meaning-Making Process. *Psychosis* 11 (2), 105–115. doi:10.1080/17522439.2019.1603320

Bergstrøm, T., Alakare, B., Aaltonen, J., Mäki, P., Köngäs-Saviaro, P., Taskila, J. J., et al. (2017). The Long-Term Use of Psychiatric Services within the Open Dialogue Treatment System after First-Episode Psychosis. *Psychosis* 9, 310–321. doi:10.1080/17522439.2017.1344295

Bergstrøm, T., Seikkula, J., Alakare, B., Mäki, P., Köngäs-Saviaro, P., Taskila, J. J., et al. (2018). The Family-Oriented Open Dialogue Approach in the Treatment of First-Episode Psychosis: Nineteen-Year Outcomes. *Psychiatry Res.* 270, 168–175. doi:10.1016/j.psychres.2018.09.039

Bergström, T., Seikkula, J., Holma, J., Köngäs-Saviaro, P., Taskila, J. J., and Alakare, B. (2021). Retrospective Experiences of First-Episode Psychosis Treatment Under Open Dialogue-Based Services: A Qualitative Study. *Community Ment. Health J.* Epub ahead of print. doi:10.1007/s10597-021-00895-6

Borchers, P. (2014). Issues like This Have an Impact: The Need-Adapted Treatment of Psychosis and the Psychiatrist's Inner Dialogue. Jyväskylä studies in education, psychology and Social Research. Available at: https://jyx.jyu.fi/bitstream/handle/123456789/44396/978-951-39-5861-9_vaitos25102014.pdf?sequence=1 (Accessed October 10, 2021)

Bracken, P., Thomas, P., Timimi, S., Asen, E., Behr, G., Beuster, C., et al. (2012). Psychiatry Beyond the Current Paradigm. *Br. J. Psychiatry* 201 (6), 430–434. doi:10.1192/bjp.bp.112.109447

Charlson, F. J., Ferrari, A. J., Santomauro, D. F., Diminic, S., Stockings, E., Scott, J. G., et al. (2018). Global Epidemiology and Burden of Schizophrenia: Findings from the Global Burden of Disease Study 2016. *Schizophr Bull.* 44 (6), 1195–1203. doi:10.1093/schbul/sby058

Florence, A. C., Jordan, G., Yasui, S., and Davidson, L. (2020). Implanting Rhizomes in Vermont: A Qualitative Study of How the Open Dialogue Approach Was Adapted and Implemented. *Psychiatr. Q.* 91 (3), 681–693. doi:10.1007/s11126-020-09732-7

Gühne, U., Weinmann, S., Riedel-Heller, S. G., and Becker, T. (2018). "S3-Leitlinie Psychosoziale Therapien bei schweren psychischen Erkrankungen: S3-Praxisleitlinien in Psychiatrie und Psychotherapie [German]," in *Herausgebende Fachgesellschaft: DGPPN* (Berlin: Springer).

Haarakangas, K. (1997). The Voices in Treatment Meeting. A Dialogical Analysis of the Treatment Meeting Conversations in Family-Centred Psychiatric Treatment Process in Regard to the Team Activity. *Stud. Educ. Psychol. Soc. Res.* 130, 119–126.

He, H., Liu, Q., Li, N., Guo, L., Gao, F., Bai, L., et al. (2020). Trends in the Incidence and DALYs of Schizophrenia at the Global, Regional and National Levels: Results from the Global Burden of Disease Study 2017. *Epidemiol. Psychiatr. Sci.* 29, e91. doi:10.1017/S2045796019000891

Holmesland, A. L., Seikkula, J., Nilsen, O., Hopfenbeck, M., and Erik Arnkil, T. (2010). Open Dialogues in Social Networks: Professional Identity and Transdisciplinary Collaboration. *Int. J. Integr. Care* 10 (3), e53. doi:10.5334/ijic.564

Hopper, K., Van Tiem, J., Cubellis, L., and Pope, L. (2020). Merging Intentional Peer Support and Dialogic Practice: Implementation Lessons from Parachute NYC. *Psychiatr. Serv.* 71 (2), 199–201. doi:10.1176/appi.ps.201900174

Jacobsen, R. K., Grov, E. K., Østefjells, T., and Karlsson, B. (2021). Open Dialogue Approach: Exploring and Describing Participants' Experiences in an Open Dialogue Training Program. *J. Psychosoc Nurs. Ment. Health Serv.* 59 (5), 38–47. doi:10.3928/02793695-20210107-03

Lehtinen, V., Aaltonen, J., Koffert, T., Räkköläinen, V., and Syvälahti, E. (2000). Two-Year Outcome in First-Episode Psychosis Treated According to an Integrated Model. Is Immediate Neuroleptisation Always Needed? *Eur. Psychiatry* 15, 312–320. doi:10.1016/s0924-9338(00)00400-4

Lotmore, M., Pilling, S., Alvarez-Monjaras, M., Wilson, E., and Ziedonis, D. (2021). "Development and Refinement of the Open Dialogue (OD) Adherence Protocol in Complex Mental Health Care," in *3rd Meeting of the International Open Dialogue Research Collaboration – Book of Abstracts*. Editors R. Pocobello and F. Camilli (Italy London: Institute of Cognitive Sciences and Technologies, National Research Council), 18–19.

Olson, M., Seikkula, J., and Ziedonis, D. (2014). The Key Elements of Dialogical Practice in Open Dialogue: Fidelity Criteria. Online verfügbar: http://umassmed.edu/psychiatry/globalinitiatives/opendialogue/ (Accessed May 25, 2021).

Pocobello, R. (2021). "Open Dialogue Teams in the World - Main Results of the International Survey," in *3rd Meeting of the International Open Dialogue Research Collaboration – Book of Abstracts*. Editors R. Pocobello and F. Camilli (Italy: Institute of Cognitive Sciences and Technologies, National Research Council), 2. doi:10.53247/MIODRC3

Razzaque, R., and Stockmann, T. (2016). An Introduction to Peer-Supported Open Dialogue in Mental Healthcare. *BJPsych Adv.* 22 (5), 348–356. doi:10.1192/apt.bp.115.015230

Rose, D., and Thornicroft, G. (2010). Service User Perspectives on the Impact of a Mental Illness Diagnosis. *Epidemiol. Psichiatr Soc.* 19 (2), 140–147. doi:10.1017/s1121189x00000841

Schriver, K. N., Buus, N., and Rossen, C. B. (2019). Reflective Practices in Open Dialogue Meetings: Reporting and Inferential 'My Side Tellings'. *J. Pragmatics* 146, 19–31. doi:10.1016/j.pragma.2019.03.007

Schubert, S., Rhodes, P., and Buus, N. (2021). Transformation of Professional Identity: An Exploration of Psychologists and Psychiatrists Implementing Open Dialogue. *J. Fam. Ther.* 43 (1), 143–164. doi:10.1111/1467-6427.12289

Seikkula, J. (2019). Psychosis Is Not Illness but a Survival Strategy in Severe Stress: A Proposal for an Addition to a Phenomenological Point of View. *Psychopathology* 52, 143–150. doi:10.1159/000500162

Seikkula, J., and Trimble, D. (2005). Healing Elements of Therapeutic Conversation: Dialogue as an Embodiment of Love. *Fam. Process.* 44, 461–475. doi:10.1111/j.1545-5300.2005.00072.x

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J., and Lehtinen, K. (2006). Five-Year Experience of First-Episode Nonaffective Psychosis in Open-Dialogue Approach: Treatment Principles, Follow-Up Outcomes, and Two Case Studies. *Psychotherapy Res.* 16 (2), 214–228. doi:10.1080/10503300500268490

Seikkula, J., Alakare, B., and Aaltonen, J. (2001). Open Dialogue in Psychosis I: An Introduction and Case Illustration. *J. Constr Psychol.* 14 (4), 247–265. doi:10.1080/107205301750433397

Seikkula, J., Alakare, B., and Aaltonen, J. (2011). The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-Term Stability of Acute Psychosis Outcomes in Advanced Community Care. *Psychosis* 3, 192–204. doi:10.1080/17522439.2011.595819

Seikkula, J. (2008). Inner and Outer Voices in the Present Moment of Family and Network Therapy. *J. Fam. Ther.* 30 (4), 478–491. doi:10.1111/j.1467-6427.2008.00439.x

Steingard, S. (2020). A Conversation with Nev Jones. Mad in America. Available at: https://www.madinamerica.com/2020/09/a-conversation-with-nev-jones/ (Accessed September 13, 2021).

Valtanen, K. (2019). The Psychiatrist's Role in Implementing an Open Dialogue Model of Care. *Aust. N. Z. J. Fam. Ther.* 40 (3), 319–329. doi:10.1002/anzf.1382

von Peter, S., Aderhold, V., Cubellis, L., Bergström, T., Stastny, P., Seikkula, J., et al. (2019). Open Dialogue as a Human Rights-Aligned Approach. *Front. Psychiatry* 10, 387. doi:10.3389/fpsyt.2019.00387

Von Peter, S., Aderhold, V., and Heumann, K. (n d). "Open Dialogue in German Psychiatric Care – Efforts, Challenges and Obstacles," in *3rd Meeting of the International Open Dialogue Research Collaboration – Book of Abstracts*. Editors R. Pocobello and F. Camilli (Italy: Institute of Cognitive Sciences and Technologies, National Research Council).

Von Peter, S., and Zinkler, M. (2021). Coping with Criticism and Embracing Change-Further Reflexions on the Debate on a Mental Health Care System without Coercion. *Laws* 10 (2), 22. doi:10.3390/laws10020022

WHO (2021). *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches*. Geneva: World Health Organization. Available at: https://www.who.int/publications/i/item/9789240025707 (Accessed September 13, 2021).

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Psychiatrization of Resistance: The Co-option of Consumer, Survivor, and Ex-patient Movements in the Global South

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This article examines contemporary examples of psychiatrization as a tool of disciplinary control and repression, focusing on new research on the co-option of consumer/survivor/ex-patient movements within the Global South. Here, we understand psychiatrization as (1) the process of imposing certain interpretive limits on states of difference and distress and (2) the conceptualization of treatment and recovery through the teleological notion of normalcy. By interpreting difference solely in psychiatric terms, psychiatrization functions as a tool of disciplinary control in both domestic and international contexts by reterritorializing efforts to resist hegemonic norms and political institutions of gendered and racialized oppression, colonialism, and imperialism. After setting out our understanding of psychiatrization as a political process in the sense that it enacts a particular "ontological politics", one that foregrounds psychiatric interpretations of difference and dissent to the exclusion of other possible meanings, we examine the reach and complexity of psychiatrization in the suppression of political and social movements that attempt to resist oppressive norms and institutions. We then present new research within the consumer/survivor/ex-patient and psychosocial disability movements in the Global South to show how psychiatrization can thwart activist's aims of transforming how we view both the end goals of mental health treatment and the political valence of mental distress.

Keywords: psychiatrization, sexual violence, consumer/survivor/ex-patient, discipline, MGMH

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INTRODUCTION

In the introduction to *Red*, *White*, and *Black*, Wilderson (2010) describes an Indigenous man who sits on Telegraph Avenue in Berkeley with a sign requesting payment for stolen land, and a Black woman who yells at students passing by her Harlem doorstep for stealing her couch and for selling her into slavery (p. 1). As Wilderson remarks, the Black woman and the Indigenous man must be constructed as "crazy" to support our continued avoidance of difficult questions about reparations, land, and justice. We argue that the psychiatrization of attempts to resist oppression and seek justice is a significant way in which "mental illness" is deployed to manage and control marginalized populations, including and especially people of color and people living in poverty. Here, we understand psychiatrization as (1) the process of imposing certain interpretive limits on states of difference and distress and (2) the conceptualization of treatment and recovery through the teleological notion of normalcy. By interpreting difference solely in psychiatric terms, psychiatrization can function as a tool of disciplinary power in both domestic and international contexts by reterritorializing efforts to resist hegemonic norms and political institutions of racial capitalism, colonialism, and imperialism.

Drawing upon Mol (1999)'s conception of ontological politics—which refers to practices of framing problems and producing bodies within the construction of a social problem—we understand the psychiatrization of difference from and resistance to hegemonic norms as a political-ontological process. This paper proceeds in three parts: first, we argue that psychiatrization can function as a process of disciplinary control by enacting an ontological politics that foregrounds psychiatric interpretations of difference and dissent to the exclusion of other possible meanings. Here, we use "disciplinary" in a Foucauldian sense to refer to the production and reproduction of subjects through tactics of control that serve the ends of power (Foucault, 2003). We are specifically concerned with psychiatrization as a disciplinary tactic insofar as it shores up the racialized, gendered, and ableist hierarchies intrinsic to global capitalism (Ben-Moshe, 2020).

Second, we examine several tension points between psychiatrization and political and social movements that attempt to express resistance to hegemonic norms and exploitative institutions, to give a sense of the complexity and global reach of processes of psychiatrization that function as a form of disciplinary control over participants in these movements. We then present new research on the institutional co-option of the consumer, survivor, and ex-patient movements within the Movement for Global Mental Health (MGMH), to show how processes of psychiatrization thwart activist's aims of transforming how we view both the end goals of mental health treatment and the political valence of mental distress caused by social and political conditions. We conclude that psychiatrization's disciplinary function constitutes an impediment to psychiatry's larger goal of alleviating suffering caused by mental difference and distress, insofar as psychiatrization neutralizes political resistance to the very institutions and norms that cause distress.

PSYCHIATRIZATION AS ONTOLOGICAL POLITICS

As Laclau (1981/2021) observed, politics is "the construction of the unthinkable;" it can also, as Foucault noted, constitute a continuation of war with "other means" (Foucault, 2003). The science of psychiatry attempts to diagnose, prevent, and treat mental disorders. Modern psychiatric classification systems such as the Diagnostic and Statistical Manual of Mental Disorders (DSM) were born of pragmatic needs: to meet the demands of the growing field of medical statistics in the 20th century, clinicians needed descriptive and operationalizable criteria for sorting patients (Aftab and Ryznar, 2021). The Movement for Global Mental Health, formed in 2007, represents a growing attempt to measure, prevent, and treat mental disorders worldwide, largely by importing the techniques and classificatory systems of Western psychiatry (Mills, 2014). While the MGMH contains a diversity of viewpoints on culture and mental health, with some acknowledgment of the need to adapt methods and interventions to specific contexts, the thrust of this movement assumes that the current conceptual, diagnostic, and treatment approaches of psychiatry can be applied without engaging ethnographic and anthropological work and without critical reflexive analysis of the evidence-base of the Western mental health field (Kirmayer and Pedersen, 2014; Beresford, 2018). Across the reports and publications produced by different players in the MGMH, including academic groups and large international development organizations, the framing of mental distress ranges from categories such as "mental health problems," "mental illness," and "mental disorders" (De Silva and Roland, 2014), to "behavioral, developmental, and neurological disorders" (United Nations General Assembly, 2015).

Like the processes of framing mental distress utilized within the MGMH, the psychiatrization of mental distress can be a political process in at least two senses: first, it constrains the ways in which we conceive of mental differences—it constructs what is "thinkable" with respect to symptoms of mental distress by limiting our interpretive apparatus to dysfunction and pathology. Acts of resistance, when conceived as pathology, force people with legitimate, counterhegemonic political and social claims—especially Black, Brown, and Indigenous peoples—into the Prison Industrial Complex and other carceral institutions (Ware et al., 2014, p. 166; Ben-Moshe, 2020). In Canada, for example, resistance to attempted assimilation and colonization forced many Indigenous people into psychiatric treatment facilities and prisons (Ware et al., 2014). Incarceration and its logic also extend beyond carceral institutions and into communities through, for example, chemical incarceration by forced medication and surveillance in state-mandated outpatient treatment (Ben-Moshe, 2020)[1].

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[1] The development of psychiatry as a medical science is strongly linked to capitalism, capitalist expansion, and colonialism (see Mills, 2014; Ben-Moshe, 2020). Because relations of capitalist accumulation and the exclusions necessitated by imperialist expansion also produce exploited, disabled, distressed, and disenfranchised peoples, capitalist states must find ways to manage these populations. Incarceration and institutionalization are two means of "population control" that are also generative of capital through, for example, private prisons, hospitals, and security contracts (Spade, 2013, p. 1031; Ben-Moshe, 2020). Pathologizing symptoms of mental distress also has a long history in the management of capitalism's crises, as it both produces new means of capitalist accumulation—through profitable institutions like psychiatry, mental hospitals, and prescription drug manufacturing—and reduces the chances of organized political and social responses to the mental suffering caused by capitalist exploitation and economic instability (Monbiot, 2018). In British East Africa, for example, "medicalized explanations for dissent" were "far preferable [for colonizers] to economic and political analyses that might find colonial practices to be culpable in African unrest" in the early 20th century (Mahone, 2006, p. 250). The DSM has even linked unsatisfactory job performance with mental dysfunction, and in the mid-1980s, government employee assistance programs expanded to cover mental distress as a means to increase worker productivity (Davies, 2017). Incarceration, institutionalization, and psychiatrization of mental distress can all be viewed as tactics of both public and private actors to manage capitalist exploitation and its discontents while also generating profits (Gilmore, 2007). It is worth noting that these tactics engender both top-down and bottom-up processes of psychiatrization, because populations are encouraged and even

Second, psychiatrization can be a political process insofar as it is influenced by both private and public actors who assert political power to define notions of normalcy and public order that are consistent with or promote their own interests and values. As Mills (2015) has pointed out, for example, the use of psychiatric diagnostic categories to classify the manifestation of "symptoms" of poverty and oppression can constrain our understandings of structural factors that contribute to inequality in the first place. The use of psychiatric definitions to label complex socioeconomic phenomena, in turn, constrains our notions of pathology and recovery in the mental health context. By defining abnormality and pathology in terms of economic burdens under a capitalist theory of human value, for example, political actors who shape mental health discourse uphold a particular political and economic ideology. Reports and publications produced by different players in the MGMH, including academic groups and large international development organizations, have framed mental disorders as "highly prevalent, accounting for a large burden of disease" (Mills, 2018, p. 849).

Claims that mental disorders account for "a large burden of disease" such as those made by the MGMH have their roots in attempts to utilize the measures and metrics of physical illnesses for the calculation of statistics related to mental disorders through epidemiological data (Bemme and D'souza, 2014). Starting in 1991, the World Bank and the World Health Organization (WHO) initiated the Global Burden of Disease studies (GBDs) in an attempt to quantify the role of medical interventions in economic development and to assess progress toward them (Murray and Lopez, 1996). One of the indicators utilized by the GBDs to compare different disease categories is the Disability-adjusted Life Year (DALY) metric, which calculates how many years of life are lost to a disease category due to early death or loss of functional abilities from disability. The 2010 GBD study included "mental, neurological, and substance use disorders," and a key finding was the rapid increase in non-communicable diseases in low- and middle-income countries (LMICs), with the proportion of the burden attributable to these diseases rising from 36% in 1990 to 49% in 2010 (Murray et al., 2012; Charlson et al., 2015). As alluded to earlier, these statistics assume (and reproduce the assumption) that categories of mental distress, such as depression, anxiety, schizophrenia, etc., apply universally across different cultures and locales.

Similarly, in a study for the World Economic Forum, Bloom et al. (2011) attempted to calculate the economic cost of mental disorders, finding that the global cost of these disorders would reach US$6 trillion by the year 2030, constituting a large percentage of all lost output and productivity worldwide. A 2016 study estimated that without the implementation of psychiatric treatments worldwide, depression, and anxiety disorders would cost the 36 largest companies in the world US$925 billion every year (Chisholm et al., 2016, p. 419). These framings of the problem of mental suffering in terms of monetary cost suggests that we conceptualize recovery only in terms of a state of affairs that restores the subject to her estimated potential for economic productivity. At the same time, institutions and disciplines devoted to treating mental health emerge as revenue-generating industries, which Ben-Moshe (2020) and others have described as the "carceral industrial complex."

Even when assuming the cross-cultural appropriateness of using Western diagnostic constructs in non-Western settings, epidemiological analyses have criticized the GBD studies for the value judgments inherent in DALY metrics, the low quality of data in LMICs without robust health surveillance systems, and the uncritical use of the GBD estimates in academic studies and policies (Brhlikova et al., 2011). In the case of depression estimates, the GBD data were generated using a wide range of different measures and scales, which often did not allow for the use of clinical judgement in screening or diagnosis. The most common depression measures used in the GBD study, the Diagnostic Interview Schedule (DIS) and the Composite Diagnostic Interview Schedule (CIDI), are highly standardized and structured interviews, often conducted by laypeople (Brhlikova et al., 2011). Almost the entirety of validation studies for the CIDI were completed in Western samples, and its cross-cultural reliability and validity have been challenged (Ferrari et al., 2013). Moreover, GBD data from LMICs in South-East Asia and Africa was often not based on nationally representative samples and was extrapolated from studies from a small area, or even a single village (Brhlikova et al., 2011).

Further, in a much more straightforward way, members of the psychiatric profession contribute to disciplinary efforts by participating in policing. Policing refers to activities performed by "an institution that is empowered by the state to inflict social control and reinforce oppressive social and economic relationships" (Klukoff et al., 2021, p. 460). Psychiatrists participate in policing in a number of ways: conducting evaluations in civil commitment hearings that constitute evidence needed by state prosecutors to meet the "clear and convincing" standard for conservatorships, involuntary hospitalizations, and forced medication treatment [see, e.g., Addington v. Texas, 441 U.S. 418 (1979)]; making findings regarding a patient's medication compliance that can justify rejection of an applicant's petition for social security or disability benefits (see Social Security Regulation 18-3p, 2018); and performing risk assessments that are used to justify both immigration detention and incarceration for individuals awaiting trial, often using metrics that are racially biased or, at best, lacking in validity with non-white populations (see Murray and Lopez, 1996, pp. 261–62).

Both government policy and industry funding shape the discourse and practice of diagnostic psychiatry domestically and in rising initiatives in the MGMH. This private-public partnership between industry and state power, as Obert (2018) observes, continues to shape both organized violence and criminal justice in the U.S. (p. 5). Such partnerships "characterize contemporary forms of governance following the neoliberal turn" (Mulla, 2014, p. 225, citing Bumiller, 2008) and shape the delivery of psychiatric services in private hospitals, which become designated agents of the state. In this paper we show how politically and institutionally led GMH interventions

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required to translate their symptoms of distress into psychiatric language and new forms of psychiatric knowledge (see Lancaster, 2011).

such as widespread and mandated depression screening frame mental suffering as an economic burden while downplaying "concerns about neocolonialism and the ethnocentric quality of the instruments" used to measure mental health (Cosgrove and Karter, 2018, p. 674).

In the U.S., we argue, neoliberal capitalist politics inform and shape public health discourse and practice that frequently result in pro-industry policies with only passing regard to public health effects. As Jill Fisher observes, the logic of neoliberalism dictates that "What's good for the industry is good for America" (Fisher, 2007, p. 65). Here, businesses are political actors, and concentrations of market power essentially privatize political power to serve the interests of increasing market share for a few global corporations. Corporations are also political in the sense that they are products of state actions whereby the state grants certain privileges, which the Supreme Court recognized as early as 1837 in the Charles River Bridge v. Warren Bridge decision. Markets and market actors are therefore not "natural" but constructed by law, and the construction of markets by law is always political. The current economic and political order, which privileges economic "efficiency," is also not neutral: it enacts a principle of accession that increasingly concentrates economic power through, for example, the operation of credit markets, legal rules regarding inheritance, and tax policies that favor the wealthy. Economic power is, in turn, inextricably connected to systems of unequal power that produce racialized, gendered, and ableist hierarchies (Ben-Moshe, 2020).

Whether funded by government, non-profit foundations, or pharmaceutical companies, psychiatric research is inflected with financial bias, and financial relationships with industry create "pro-industry... habits of thought" (Lexchin and O'Donovan, 2010, p. 643). Indeed, in addition to lobbying and providing direct "user fee" payments to the Food and Drug Administration in the US, pharmaceutical companies contribute funding to individual psychiatrists, medical schools, research institutions, patient advocacy groups, and politicians (see also Rose et al., 2017; Butler and Fugh-Berman, 2020). The legal and market structures that sustain this flow of capital and influence are distinctly political; as Tarek Younis succinctly puts it, "[p]olitics cannot be disassociated from public health" (Younis, 2021a,b, p. 2).

As Beeker et al. (2021) note, psychiatrization can be "top-down" in the sense that industry, governments, and other "experts" can initiate and help to normalize processes of psychiatric classification and diagnosis. While the political nature of top-down processes of psychiatrization are the most visible, bottom-up psychiatrization—psychiatrization led by individuals and group struggles for recognition of their subjective experiences of suffering in terms of psychiatric classification—is also political in the sense that it constrains how forms of mental suffering is "thinkable," and in the sense that it is influenced by political actors both public and private. For example as Davis (2021) explains in his recent work, *Chemically Imbalanced*, private actors experiencing mental challenges often adopt medicalized explanations of their own suffering in order to avert both real and perceived allocations of blame for non-normative or "excessive" emotional responses to life events. The impulse to categorize suffering in terms of what Davis calls the "neurobiological imaginary" of modern psychiatric discourse in order to achieve a hegemonic notion of viable selfhood works to naturalize the social norms of racial capitalism. As Davis writes, these norms "are built directly into the medicalized language, [and therefore] any recourse to that language [of psychiatry] cannot but reify the social norms as the natural and inevitable yardsticks of health" (2020, p. 181).

As Fisher (2008) and Spade (2020) have argued, when forms of mental suffering have political and economic causes, collective movements to understanding those causes can lead to revolutionary action. In other words, some forms of mental suffering can engender dissent; yet both top-down and bottom-up psychiatrization processes drain suffering of its political and social contents by converting it into an intra-individual problem. The understandable impulse to eradicate feelings of sadness, loneliness, or discontent through psychiatric interventions simultaneously legitimizes valuations of mental differences in terms of economic costs and costs to productivity. As Sara Ahmed (2007/2008) has argued, "it is the very assumption that good feelings are open and bad feelings are closed that allows historical forms of injustice to disappear" (p. 135). In "treating" the suffering patient, psychiatry converts "bad" feelings into "good" ones, and these "conversions function as displacements of injury from public view" (id., p. 134). Further, the neoliberal focus on individualization effectively de-genders and de-racializes social problems (see Barad, 2007). This is not to suggest that people experiencing mental distress are not in need of care—rather, it means that viewing mental distress solely through the lens of psychiatry functions to first silo and then resignify symptoms of distress, effectively neutralizing resistance and maintaining legitimacy of the current political-economic order. To highlight the complexity and global reach of processes of psychiatrization, we provide three examples in which processes of psychiatrization territorialize distress as apolitical in the US, UK, and international contexts, before turning to new research on consumer, survivor, and ex-patient movements in the Global South and their attempts to resist processes of psychiatrization within the MGMH.

EXAMPLE 1: PROTEST, RAPE, AND SEXUAL VIOLENCE IN THE US

The construction of Black men as psychotic for speaking out against racial injustice during Civil Rights movement, and the subsequent overdiagnosis of Black men with schizophrenia, is a clear example of the repressive and disciplinary potential of psychiatrization (Metzl, 2009). As Metzl writes, "diagnostic terminology [for mental illness] is inherently politicized," incorporating racially and politically inflected terminology (Metzl, 2009, p. 197). He continues:

> "Race impacts medical communication because racial tensions are structured into clinical interactions long before doctors or patients enter examination rooms. To a remarkable extent, anxieties about racial difference shape diagnostic criteria, health-care policies, medical, and popular attitudes about mentally ill

> persons, the structures of treatment facilities, and, ultimately, the conversations that take place there within" (p. xii).

Top-down and bottom-up processes of psychiatrization of survivors of rape and sexual violence provides another pertinent example of the potential depoliticizing and disciplinary function of psychiatrization in the US. Anti-violence movements spearheaded by feminists of color in the 1960's and '70s linked gender-based violence to state violence and harms caused by public policy, structural inequality, institutionalized racism, and patriarchal power (Richie, 2012; Taylor, 2017). Movements like the Combahee River Collective in Boston, for example, recognized sexual violence and patriarchal domination within the Black community as stemming from white imperialist culture (Bryan et al., 2018). Similarly, Davis (1983) linked practices of slavery and the abuse of Black women and girls with the rape of white women:

> "Once white men were persuaded that they could commit sexual assaults against Black women with impunity, their conduct toward women of their own race could not have remained unmarred. Racism has always served as a provocation to rape, and white women in the United States have necessarily suffered the ricochet fire of these attacks" (p. 177).

Understanding our shared histories of racialized violence, and our respective roles within it, is thus a crucial step in the task of interrogating the cyclical reproduction of rape and sexual abuse in America.

Yet as Bumiller (2008) has carefully documented, the feminist movement against sexual violence was gradually co-opted by the neoliberal state and used to legitimize and expand state surveillance and mass incarceration. Processes of psychiatrization have been central to this process, both in processes of converting perpetrators into pathological subjects in need of reform and deserving of criminal punishment—the "homosexual," for example, and later the "pedophile" (see Lancaster, 2011; Harkins, 2020)—and by converting the suffering caused by sexual violence into intra-individual pathology or dysfunction. These processes have served to further legitimize both the carceral state—which disproportionately harms people of color and non-gender-conforming peoples—and the pharmaceutical industry. Psychiatrization of both victims and perpetrators of sexual violence also leaves socially marginalized women more vulnerable to violence, because women of color tend to be further harmed by psychiatric institutions[2] (Bumiller, 2008; Metzl, 2009). Further, an essential part of the depoliticization of sexual violence was psychiatry's conceptualization of the "sex offender" as a pathological individual divorced from social and political logics. This trope has been used to rationalize expansion of state systems of surveillance and punishment, which disproportionately affect people of color.

As Harkins (2009) and Serisier (2018) have observed, individual experiences of sexual abuse have been commodified within an industry of survivor narratives that interprets these experiences as apolitical personal stories. Psychiatrically informed discourses of wellness, mental health, and self-help have played an important role in restricting the scope of meaning of sexual violence narratives to the realm of the personal, rather than the political (Serisier, 2018). Processes of psychiatrization have thus come to constitute "boundary-drawing practices" that refigure sexual violence as an apolitical phenomenon (Beres et al., 2009, p. 206), function as a disciplinary tactic by legitimizing state violence in the form of heightened surveillance and expansion the carceral state, and providing an industry solution to suffering caused by what for many activists and feminist of color can be read as a social and political problem (see Serisier, 2018).

EXAMPLE 2: REFUGEES, SOLDIERS, AND THE INTERNATIONAL "WAR ON TERROR"

As Howell (2011) argues, psychiatrization can have distinctly political functions in the global context as well, informing everything from the treatment of refugees and military troops to the discipline of "anti-terrorism." Efforts of the World Health Organization and the United Nations to marshal the mental health of refugees, for example, are "aimed not only at alleviating trauma, but also at restoring order" (Howell, 2011, p. 3). The design and implementation of programs specifically for "refugees" also relies on and "reproduce[s] the notion of a system of discrete sovereign states—a system that produces statelessness and the category of refugees in the first place" (id.). Psy disciplines are increasingly implicated in the functioning and maintenance of Western militaries for the management of traumatized soldiers (id., 4). This is evidenced by steep increases in psychiatric prescription practices for soldiers and military veterans after 2001, despite simultaneous denials by the US military to confirm diagnoses and provide care to soldiers and veterans. Finally, the psy disciplines are marshaled in rendering intelligible the West's "enemies" in the war on terror, to characterize suicide bombers in terms of psychological states as opposed to political demands and motivations (id., p. 7). Kolb (2020) has traced the characterization of terror and terrorism in apolitical language—as an epidemic, for example—to the Indian Mutiny of 1857. Contemporary constructions of "terrorism" after 9/11, as Stampnitzky (2013) argues, enact a "politics of anti-knowledge" constituted by concerted efforts to deny any political understanding or rationale could be ascribed to terrorism.

EXAMPLE 3: "RADICALIZATION" IN THE UK

Further, as Younis (2021a) has argued, psychologization functions as a foil that allows nation-states to evade charges of institutional racism in their management and policing of Muslims. In the UK, the human rights organization Medact.org

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[2] As Dean Spade argues, well-intentioned legal reform movements often leave behind the most vulnerable, centering a universal (white, female) subject of rights at the expense of others (Spade, 2013). These movements "tend[] to provide just enough transformation to stabilize and preserve status quo conditions" of racial neoliberalism (2013, p. 5).

(2021) has shown that mental health professionals collude with counterterrorism police officers to create "Vulnerability Support Hubs" to evaluate individuals suspected of "extremism." As Medact reports, these "Hubs" "use sub-diagnostic thresholds and risk pathologizing people based on political expression or socioeconomic vulnerability" (id.). Here, psychologization's purported colorblindness effectively disguises the nation-state's racialization of Muslim populations. Further, it diverts attention from what is essentially an effort to manage of anti-hegemonic political expression by constructing racialized Muslim individuals as "at risk" or vulnerable to "radicalization." An additional example is PREVENT, a national policy directed against radicalization in the UK, which mandates that certain public bodies evaluate individual risk factors in the "war on terror." Like the psychiatrization of suicide bombers, the use of psychiatric discourses to justify racist policies also rules out larger political questions connected to resistance, dissent, and discontent. Indeed, as Kundnani has argued, the rise of discriminatory and racialized "risk management" practices targeting asylum seekers, "radicals," and "Islamic terrorists" are a function of the fact that "the great well of human despair, rooted in poverty and powerlessness, can no longer be contained within national boundaries" (Kundnani, 2007, p. 1). Yet these expressions of discontent are refigured as apolitical within psychiatric discourse.

Just as top-down psychiatrization policies like PREVENT can preserve the legitimacy of a political and economic order while deploying racialized tropes and surveillance tactics against minorities, bottom-up processes of psychiatrization, as in the treatment of rape survivors described above, can also function as repressive, disciplinary tactics insofar as the language of psychiatry constrains our interpretations of violence and suffering. Indeed, as the following example from research within the consumer, survivor, and ex-patient and psychosocial disability movements show, C/S/X activists in the Global South have attempted to push back against psychiatrization but are actively discouraged and coopted by powerful actors in the MGMH.

CO-OPTION OF CONSUMER, SURVIVOR, EX-PATIENT, AND PSYCHOSOCIAL DISABILITY MOVEMENTS

Scholars and activists with lived experience of mental distress, broadly organized under the consumer, survivor, and ex-patient (C/S/X) movement, have acted as a force against psychiatrization by opposing the medicalization of their experiences (Jones and Brown, 2012). Following the adoption of the Convention on the Rights of Persons with Disabilities (CRPD), regional groups of people with lived experience have begun to organize politically to contest psychiatrization and its effects on persons with psychosocial disability (Davar, 2008). As a recent study of the experiences of psychosocial disability advocates in the Global South (Karter, 2021) demonstrates, however, these efforts are often co-opted by powerful actors in the movement for global mental health (MGMH).

As Mills (2014) and others (see, e.g., Bhatia and Priya, 2021) have shown, the MGMH as facilitated through the World Health Organization and an assortment of NGOs has functioned as a pathway to psychiatrization of more and more populations throughout the Global South, imposing concepts of Western psychiatry upon diverse groups of people including refugees and victims of religious persecution, without regard for the nuanced regional and ethnic contexts and histories that contribute to war, violence, and mental distress. Following the ratification of the CRPD and the development of regional groups organizing under the psychosocial disability framework, psychosocial disability organizations began to be invited to participate in global mental health projects throughout the Global South. People with lived experience have often found, however, that this participation or representation was not the same as the "meaningful and authentic engagement" they were seeking (see, e.g., Russo and Wooley, 2020).

A recent qualitative study of interviews with psychosocial disability advocates in the Global South (Karter, 2021) shows how discourses of psychiatrization can operate through structural and interpersonal power dynamics to stifle resistance. Participants that were interviewed described a number of practices by MGMH groups that created barriers to the full inclusion of people with psychosocial disabilities in decision-making processes. These ranged from subtle put-downs to what appeared to be deliberate attempts to "tokenize" and "co-opt" their contributions (p. 91–96). Several activist participants described having the experience of feeling stuck when deciding between whether to engage in certain projects or to remove themselves and their organizations entirely. Participants feared that participating risked lending a sort of legitimacy to a project they did not agree with, by giving the appearance that it included lived-experience perspectives, but it could also allow them to have some influence on removing the parts they found most dangerous. On the other hand, if they refused to participate, it could send a message that these projects need to be more inclusive from the start, but it risked allowing a project to move forward that would perpetuate psychiatrization without regard to psychosocial disability advocates' political concerns (p. 93–94). One participant is quoted, describing this experience as "tokenism," saying that "in these institutionalized spaces people with psychosocial disabilities are seen only as an endorsement. They care about our testimony, not our participation in any active way that could lead to transformation." He added, however, that "the lack of alternatives forces us to take advantage of any space that is open to make change, to transform" (Karter, 2021, pp. 94).

While the opportunity to collaborate on new projects within the MGMH risked tokenization, C/S/X participants who had developed alternative interventions to psychiatric and psychiatrizing systems found that allowing professional psychiatrists to collaborate on these interventions risked "co-option" (Russo and Wooley, 2020). In response to these attempts to maintain the original psychiatrization approach of the MGMH, organizations of people with psychosocial disabilities and C/S/X scholar-activists have explicitly addressed the risks inherent in collaboration unless the power of the psychiatric narrative is upended. In an open letter, several such advocacy organizations—European Network of (Ex-)Users and Survivors of Psychiatry (ENUSP), Absolute Prohibition Campaign, Center for the Human Rights of Users and Survivors of Psychiatry (CHRUSP), Red Esfera Latinoamericana de la Diversidad Psicosocial, TCI Asia Pacific, and World Network of Users and Survivors of Psychiatry (WNUSP)—declared that the paradigm shift necessitated by the CRPD meant diminishing the social power of psychiatry.

Based on a social model of disability, the UN CRPD and the CRPD Committee's guidance offer us an important prospect to shift away from the biomedical paradigm when approaching madness and distress and explore not only dignified but also socially responsible and good-quality responses to human crises. This requires the relinquishment of power by the psychiatric profession and a re-definition of psychiatry's role in society. At times of such a significant historical turn, rather than admit its many failures and join efforts to collaboratively develop different and better responses, the [World Psychiatric Association] has chosen to expand its "expertise" into the field of lawmaking in order to "save the CRPD from itself" [European Network of (Ex-) Users Survivors of Psychiatry (ENUSP), 2019, p. 5].

The World Psychiatric Association (WPA) is psychiatry's global association and has taken an oppositional stance to rights-based approaches to psychiatric treatment. In the context of the MGMH debates, they have issued public statements challenging the call for rights-based approaches. The tension between proponents of the CRPD and rights-based approaches on one side and entrenched psychiatric and pharmaceutical interests on the other, has also played out through public statements and in medical journals. For example, the Australian and New Zealand Journal of Psychiatry, featured a point/counterpoint between researchers who supported the rights-based focus in mental health policy and practice, including Gill (2018) and Cosgrove and Jureidini (2019), and those who dismissed the approach as "anti-psychiatry" (see e.g., Dharmawardene and Menkes, 2018). In addition, when a special issue of the journal World Psychiatry (the official journal of the WPA) featured several articles calling for the CRPD to be amended, particularly to preserve forced treatment (see e.g., Appelbaum, 2019), six organizations of people with psychosocial disabilities issued the open letter quoted above [European Network of (Ex-) Users Survivors of Psychiatry (ENUSP), 2019].

Due to the inherent power imbalances at play in the MGMH, Russo and Wooley argue that survivor-advocates cannot join alliances or work toward change with psychiatrists: "In our view, the CRPD came about not as a demand to change psychiatry but rather as a clear call to change policies, practices, and mindsets that create psychiatry" (Russo and Wooley, 2020, p. 155). To their point, the framing of "experts and patients" inherent in psychiatric discourse can serve to undermine the rights of service-users. An analysis of the 2007 Mental Health Act in the UK, for instance, found that experts and doctors were seen as trustworthy while patients were seen as dangerous and non-compliant, severely limiting their ability to have their testimony heard and believed (Kent et al., 2020).

To move away from psychiatry's historical connection to maintaining social control in the interest of colonial powers (Hickling, 2020) that preserves and expands the global system of racialized capitalism, scholars have argued that the MGMH should adopt "a 'pluralistic view of knowledge' that recognizes multiple voices and sources of knowledge and avoids the 'epistemic injustice' that occurs when the knowledge of one group is validated while others are denied legitimacy" (Bemme and Kirmayer, 2020, p. 8). Given the principles of full and effective inclusion supported by the CRPD, psychosocial disability advocates may be well-positioned to contribute to this pluralistic view of knowledge, drawing upon their lived experience to bring attention to the nuances of cultural experience and contextual factors. Psychiatrization, as we have explored here, can be antagonistic to such a pluralist view of knowledge because it imposes limits on the ways in which consumers, survivors, and ex-patients are permitted to interpret their own lived experiences.

CONCLUSION: DECODING PSYCHIATRIC "ILLNESS"

> *We must convert widespread mental health problems from medicalized conditions into effective antagonisms. Affective disorders are forms of captured discontent; this disaffection can and must be channeled outwards, directed toward its real cause, Capital.*—Fisher (2008, p. 80).

Psychiatrization, as we have argued, can function as an apparatus of disciplinary control that produces resistant subjects as aberrant and in need of psychiatric treatment. While some mental differences have the potential to rupture and dislocate political ideologies of gendered, ableist, and racialized oppression, exposing their contradictions and cruel logics of exploitation, psychiatrization functions to neutralize this potential. As we have argued, processes of psychiatrization can and do thwart revolutionary possibilities through the exercise of disciplinary power: through categorization, institutionalization, and chemical incarceration, and by constructing mental suffering as thinkable only in the limited ontology of the neurobiological imaginary.

As Gherovici (2003) argues in her work on the so-called "Puerto Rican syndrome," a culture-bound diagnosis that affected working-class Puerto Rican soldiers conscripted into the U.S. military, symptom profiles that come to be understood as psychiatric illness may in fact be complex, somaticized forms of communication (see also Leader, 2011). Remarking on the often dramatic and shocking symptom profile of Puerto Rican syndrome, she writes:

> "It is as if those extravagant manifestations that entered medical records were in fact messages, at times opaque, neither comprehended nor controlled by the subject" (Gherovici, 2003).

Psychiatrization limits how we read these messages; it provides a decoding key of sorts that privileges a particular kind of interpretation, one that is always already political in that it is informed by economic and ideological forces beyond the control of the well-intentioned clinician.

An ontological politics that instead affords a reading of at least some mental suffering as "forms of captured discontent" (Fisher, 2008) in addition to apolitical or irreducible distress allows us to imagine more than one modality of explanation, treatment, and recovery. This affordance can refocus our attention onto the sociopolitical conditions elided and excluded by psychiatric discourse; restore the political valence of mental difference as a challenge to the legitimacy of dominant economic, political, and social orderings; and turn our attention to the facets of political and social life that require collective action and transformation. As such, mental suffering read as manifestations of dissent might "hint at and embody aspirations that are wildly utopian, derelict to capitalism, and antithetical to its attendant discourse of Man" (Hartman, 2008, p. 12). A properly ethical interpretation of these manifestations sees "both a reconstruction and a manifestation … staged as a provocation, a call for attention, still awaiting the right decoding: … 'Here I am, without my understanding of what it means" (Gherovici, 2003).

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article/supplementary material, further inquiries can be directed to the corresponding author/s.

AUTHOR CONTRIBUTIONS

JL conceived the idea for the paper and wrote the first draft. JK added the section on consumer/survivor/ex-patients and contributed to both writing and editing of the finished version. All authors contributed to the article and approved the submitted version.

REFERENCES

Aftab, A., and Ryznar, E. (2021). Conceptual and historical evolution of psychiatric nosology. *Int. Rev. Psychiatry* 33, 486–499. doi: 10.1080/09540261.2020.1828306

Ahmed, S. (2007/2008). Multiculturalism and the promise of happiness. *New Formations* 63, 121–137. Available online at: link.gale.com/apps/doc/A175632735/AONE?u=anon~8112d0bc&sid=googleScholar&xid=5698d728

Appelbaum, P. S. (2019). Saving the UN Convention on the Rights of Persons with Disabilities-from itself. *World Psychiatry* 18:1. doi: 10.1002/wps.20583

Barad, K. (2007). *Meeting the Universe Halfway*. Durham, NC: Duke University Press.

Beeker, T., Mills, C., Meerman, S., Thoma, S., Heinze, M., and von Peter, S. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 20:645556. doi: 10.3389/fpsyt.2021.645556

Bemme, D., and D'souza, N. A. (2014). Global mental health and its discontents: an inquiry into the making of global and local scale. *Transcult. Psychiatry* 51, 850–874. doi: 10.1177/1363461514539830

Bemme, D., and Kirmayer, L. J. (2020). Global mental health: interdisciplinary challenges for a field in motion. *Transcult. Psychiatry* 57, 3–18. doi: 10.1177/1363461519898035

Ben-Moshe, L. (2020). *Decarcerating Disability: Deinstitutionalization and Prison Abolition*. Minneapolis, MN: University of Minnesota Press.

Beres, M., Crow, B., and Gotell, L. (2009). The perils of deinstitutionalization in neoliberal times. *Can. J. Sociol.* 34, 135–163.

Beresford, P. (2018). A failure of national mental health policy and the failure of a Global Summit. *Br. J. Ment. Health Nurs.* 7, 198–199. doi: 10.12968/bjmh.2018.7.5.198

Bhatia, S., and Priya, K. R. (2021). Coloniality and psychology: from silencing to re-centering marginalized voices in postcolonial times. *Rev. Gen. Psychol.* 25, 422–436. doi: 10.1177/10892680211046507

Bloom, D. E., Cafiero, E. T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L. R., and Fathima, S. (2011). *The Global Economic Burden of Non-Communicable Diseases: Report by the World Economic Forum and the Harvard School of Public Health*. World Economic Forum.

Brhlikova, P., Pollock, A. M., and Manners, R. (2011). Global Burden of Disease estimates of depression-how reliable is the epidemiological evidence? *J. R. Soc. Med.* 104, 25–34. doi: 10.1258/jrsm.2010.100080

Bryan, B., Dadzie, S., and Scafe, S. (2018). *The Heart of the Race*. London: Virago Press.

Bumiller, K. (2008). *In an Abusive State: How Neoliberalism Appropriated the Feminist Movement against Sexual Violence*. Durham, NC: Duke University Press.

Butler, J., and Fugh-Berman, A. (2020). Patient influencers paid by pharmaceutical companies should be required to disclose industry ties. *Health Affairs Blog.* doi: 10.1377/hblog20200109.985594

Charlson, F. J., Baxter, A. J., Dua, T., Degenhardt, L., Whiteford, H. A., and Vos, T. (2015). Excess mortality from mental, neurological and substance use disorders in the Global Burden of Disease Study 2010. *Epidemiol. Psychiatr. Sci.* 24, 121–140. doi: 10.1017/S2045796014000687

Chisholm, D., Sweeny, K., Sheehan, P., Rasmussen, B., Smit, F., Cuijpers, P., et al. (2016). Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry* 3, 415–424. doi: 10.1016/S2215-0366(16)30024-4

Cosgrove, L., and Jureidini, J. (2019). Why a rights-based approach is not anti-psychiatry. *Aust. N. Zeal. J. Psychiatry* 53, 503–504. doi: 10.1177/0004867419833450

Cosgrove, L., and Karter, J. (2018). The poison in the cure: Neoliberalism and contemporary movements in mental health. *Theory Psychol.* 28, 669–683. doi: 10.1177/0959354318796307

Davar, B. V. (2008). From mental illness to disability: choices for women users/survivors of psychiatry in self and identity constructions. *Indian J. Gender Stud.* 15, 261–290. doi: 10.1177/097152150801500204

Davies, J. (2017). *The Sedated Society: The Causes and Harms of Our Psychiatric Drug Epidemic*. New York, NY: Palgrave Macmillan.

Davis, A. (1983). *Women, Race, and Class*. New York, NY: Vintage.

Davis, J. (2021). *Chemically Imbalanced: Everyday Suffering, Medication, and our Troubled Quest for Self-Mastery*. Chicago, IL: Chicago University Press.

De Silva, M., and Roland, J. (2014). *Mental Health for Sustainable Development*. London: All Party Parliamentary Groups on Global Health and Mental Health.

Dharmawardene, V., and Menkes, D. B. (2018). Responding to the UN Special Rapporteur's anti-psychiatry bias. *Aust. N. Zeal. J. Psychiatry* 53, 282–283. doi: 10.1177/0004867418818359

European Network of (Ex-) Users and Survivors of Psychiatry (ENUSP). (2019). *Open Letter to WPA*. Available online at: http://enusp.org/wp-content/uploads/2019/03/Open-Letter-to-WPA-1.pdf (accessed December 01, 2021).

Ferrari, A. J., Charlson, F. J., Norman, R. E., Flaxman, A. D., Patten, S. B., Vos, T., et al. (2013). The epidemiological modelling of major depressive disorder: application for the Global Burden of Disease Study 2010. *PLoS One* 8:e69637. doi: 10.1371/journal.pone.0069637

Fisher, M. (2007). *Capitalist Realism*. London: Zero Books.

Fisher, M. (2008). *Capitalist Realism: Is There No Alternative?* Winchester: Zero Books.

Foucault, M. (2003). 14 January 1976. *Society Must Be Defended: Lectures at the Collège de France, 1975-76*, eds. M. Bertani, and A. Fontana, trans. D. Macey (New York, NY: Picador), p. 23–42.

Gherovici, P. (2003). *The Puerto Rican Syndrome*. New York, NY: Other Press.

Gill, N. S. (2018). Human rights framework: an ethical imperative for psychiatry. *Aust. N. Z. J. Psychiatry* 53, 8–10. doi: 10.1177/0004867418810179

Gilmore, R. W. (2007). *Golden Gulag: Prisons, Surplus, Crisis, and Opposition in Globalizing California*. Berkeley, CA: University of California Press.

Harkins, G. (2009). *Everybody's Family Romance: Reading Incest in Neoliberal America*. Minneapolis, MN: Minnessota University Press.

Harkins, G. (2020). *Virtual Pedophilia: Sex Offender Profiling and U.S. Security Culture*. Durham, NC: Duke University Press.

Hartman, S. (2008). Venus in two acts. *Small Axe* 12, 1–14. doi: 10.1215/-12-2-1

Hickling, F. W. (2020). Owning our madness: contributions of Jamaican psychiatry to decolonizing Global Mental Health. *Transcult. Psychiatry* 57, 19–31. doi: 10.1177/1363461519893142

Howell, A. (2011). *Madness in International Relations: Psychology, Security, and the Global Governance of Mental Health*. New York, NY: Routledge.

Jones, N., and Brown, R. (2012). The absence of psychiatric C/S/X perspectives in academic discourse: consequences and implications. *Disabil. Stud. Q.* 33. doi: 10.18061/dsq.v33i1.3433

Karter, J. M. (2021). *Inclusion Toward Transformation: Psychosocial Disability Advocacy and Global Mental Health.* Doctoral dissertation, University of Massachusetts Boston.

Kent, T., Cooke, A., and Marsh, I. (2020). "The expert and the patient": a discourse analysis of the House of Commons' debates regarding the 2007 Mental Health Act. *J. Mental Health* 15, 1–6. doi: 10.1080/09638237.2020.1818706

Kirmayer, L. J., and Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcult. Psychiatry* 51, 759–776. doi: 10.1177/1363461514557202

Klukoff, H., Kanani, H., Gaglione, C., and Alexander, A. (2021). Toward an abolitionist practice of psychology: Reimagining psychology's relationship with the criminal justice system. *J. Humanist. Psychol.* 61, 451–469. doi: 10.1177/00221678211015755

Kolb, R. (2020). *Epidemic Empire: Colonialism, Contagion, and Terror, 1817-2020*. Chicago, IL: University of Chicago Press.

Kundnani, A. (2007). *The End of Tolerance: Racism in 21st Century Britain*. London: Pluto Press.

Laclau, E. (1981/2021). Politics as construction of the unthinkable. *J. Lang. Politics* 20, 10–21. doi: 10.1075/jlp.20078.lac

Lancaster, R. (2011). *Sex Panic and the Punitive State*. Berkeley, CA: University of California Press.

Leader, D. (2011). *What is Madness?*. London: Penguin Books.

Lexchin, J., and O'Donovan, O. (2010). Prohibiting or 'managing' conflict of interest? A review of policies and procedures in three european drug regulation agencies. *Soc Sci Med.* 70, 643–647. doi: 10.1016/j.socscimed.2009.09.002

Medact.org (2021). *Racism, Mental Health and Pre-crime Policing: The Ethics of Vulnerability Support Hubs*. Available online at: https://www.medact.org/2021/resources/reports/racism-mental-health-and-pre-crime-policing-the-ethics-of-vulnerability-support-hubs/ (accessed December 01, 2021).

Metzl, J. (2009). *Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston, MA: Beacon Press.

Mills, C. (2014). *Decolonizing Global Mental Health: The Psychiatrisation of the Majority World.* London: Routledge. doi: 10.4324/9780203796757

Mills, C. (2015). The psychiatrization of poverty: rethinking the mental health-poverty nexus. *Soc. Pers. Psychol. Compass* 9, 213–222. doi: 10.1111/spc3.12168

Mills, C. (2018). From 'invisible problem' to global priority: the inclusion of mental health in the Sustainable Development Goals. *Dev. Change* 49, 843–866. doi: 10.1111/dech.12397

Mol, A. (1999). "Ontological politics: a word and some questions," in *Actor Network Theory and After*, eds. J. Law, and J. Hassard (Oxford; Malden: Blackwell), 74–89.

Monbiot, G. (2018). *Out of the Wreckage: A New Politics in an Age of Crisis*. New York, NY: Verso Books.

Mulla, S. (2014). *The Violence of Care.* New York, NY: NYU Press.

Murray, C. J. L., and Lopez, A. D. (1996). The Global Burden of Disease: A Comprehensive Assessment of Mortality and Disability from Diseases, Injuries and Risk Factors in 1990 and Projected to 2020. Boston, MA: Harvard School of Public Health. Available online at: https://apps.who.int/iris/bitstream/handle/10665/41864/0965546608_eng.pdf?sequence=1&isAllowed=y

Murray, C. J. L., Vos, T., Lozano, R., Naghavi, M., Flaxman, A. D., Michaud, C., et al. (2012). Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990-2010: a systematic analysis for the Global Burden of Disease Study 2010. *Lancet* 380, 2197–2223. doi: 10.1016/S0140-6736(12)62134-5

Obert, J. (2018). *The Six-Shooter State: Public and Private Violence in American Politics*. Cambridge: Cambridge University Press.

Richie, B. E. (2012). *Arrested Justice: Black Women, Violence, and American's Prison Nation*. New York, NY: NYU Press.

Rose, S. L., Highland, J., Karafa, M. T., and Joffe, S. (2017). Patient advocacy organizations, industry funding, and conflicts of interest. *JAMA Intern. Med.* 177, 344–350. doi: 10.1001/jamainternmed.2016.8443

Russo, J., and Wooley, S. (2020). The implementation of the convention on the rights of persons with disabilities: more than just another reform of psychiatry. *Health Human Rights* 22, 151–161.

Serisier, T. (2018). *Speaking Out: Feminism, Rape, and Narrative Politics*. London: Palgrave Macmillan.

Spade, D. (2013). Intersectional resistance and law reform. *Signs* 38, 1031–1055. doi: 10.1086/669574

Spade, D. (2020). *Mutual Aid: Building Solidarity Through This Crisis (and the Next)*. London; New York, NY: Verso Press.

Stampnitzky, L. (2013). *Disciplining Terror: How Experts Invented "Terrorism"*. Cambridge: Cambridge University Press.

Taylor, K.-Y. (2017). *How We Get Free: Black Feminism and the Combahee River Collective*. Chicago, IL: Haymarket Books.

United Nations General Assembly (2015). *Transforming Our World: The 2030 Agenda for Sustainable Development*. A/RES/70/1.

Ware, S., Ruzsa, J., and Dias, G. (2014). "It can't be fixed because it's not broken: racism and disability in the prison industrial complex," in *Disability Incarcerated: Imprisonment and Disability in the United States and Canada*, eds. L. Ben-Moshe, C. Chapman, and A. C. Carey (New York, NY: Palgrave Macmillan), 163–184.

Wilderson, F. B. (2010). *Red, White and Black: Cinema and the Structure of U.S. Antagonisms*. Durham, NC: Duke University Press.

Younis, T. (2021a). The muddle of Institutional Racism in Mental Health. *Sociol. Health Illn* (2021) 43:1831–1839. doi: 10.1111/1467-9566.13286

Younis, T. (2021b). The psychologisation of counter-extremism: unpacking PREVENT. *Race Class* 62, 37–60. doi: 10.1177/0306396820951055

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CONCEPTUAL ANALYSIS
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The Political Economy of the Mental Health System: A Marxist Analysis

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The present paper analyses the functions of the mental health system in relation to the economic organisation of society, using concepts derived from Marx's work on political economy and building on previous critiques. The analysis starts from the position that mental health problems are not equivalent to physical, medical conditions and are more fruitfully viewed as problems of communities or societies. Using the example of the United Kingdom, it traces how a public mental health system evolved alongside capitalism in order to manage the problems posed by people whose behaviour was too chaotic, disruptive or inefficient to participate in a labour market based on exploitation. The system provided a mixture of care and control, and under recent, Neoliberal regimes, these functions have been increasingly transferred to the private sector and provided in a capitalistic manner. Welfare payments are also part of the system and support those less seriously affected but unable to work productively enough to generate surplus value and profit. The increased intensity and precarity of work under Neoliberalism has driven up benefit claims at the same time as the Neoliberal state is trying to reduce them. These social responses are legitimised by the idea that mental disorders are medical conditions, and this idea also has a hegemonic function by construing the adverse consequences of social and economic structures as individual problems, an approach that has been particularly important during the rise of Neoliberalism. The concept of mental illness has a strategic role in modern societies, therefore, enabling certain contentious social activities by obscuring their political nature, and diverting attention from the failings of the underlying economic system. The analysis suggests the medical view is driven by political imperatives rather than science and reveals the need for a system that is more transparent and democratic. While the mental health system has some consistent functions across all modern societies, this account highlights one of the endemic contradictions of the capitalist system in the way that it marginalises large groups of people by narrowing the opportunities to make an economic contribution to society.

Keywords: Marxism, mental disorder, history of psychiatry, neoliberalism, political economy

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INTRODUCTION

The subject of mental health has perhaps never been more widely discussed than today, and mental health problems more widely accepted as "proper" medical conditions. There has been a huge escalation in the diagnosis and treatment of such problems across western societies in the past few decades. A quarter of the English population report that they have suffered from a mental illness at some point in their lives (Health and Social Care Information Centre, 2015), and even larger numbers have been persuaded that many instances of unhappiness and discontent arise from biochemical abnormalities and require medical interventions (Pilkington et al., 2013). This phenomenon has been referred to as "psychiatrization" (Beeker et al., 2021), and also as widening medicalisation or "disease-mongering", since psychiatric disorders are classified as a subset of medical disorders and often subject to medical-style interventions like pharmaceuticals (Conrad and Potter, 2000; Moynihan et al., 2002). In the meantime, there has been a profound reorganisation of provision for the seriously mentally unwell, with care provided by large state institutions transferred to smaller facilities and organisations, many run by the private sector on a "for-profit" basis.

The works of Marx and Engels are recognised to provide important insights into the nature and workings of many contemporary institutions, and systems for addressing mental health problems, particularly psychiatry, are no exception. Several scholars within a broadly defined Marxist tradition have examined mental institutions and treatments, building on the analysis of social deviance, and focusing on the way psychiatric interventions serve as mechanisms of social control, developed to manage behaviour that threatens to destabilise the capitalist system (Conrad, 1992; Scull, 1993; Cohen, 2016). Other authors have documented how, over recent decades, Neoliberal capitalism has coincided with the trend to medicalise and "commodify" more and more aspects of human feelings and behaviour, in the process turning them into a source of profit for the pharmaceutical and healthcare industries (Fisher, 2009; Davies, 2017). The ideological consequences of reframing social problems as individual pathology have also been highlighted, in the way this process diverts attention from the structural inequality and injustice that make life difficult for people in the first place (Fisher, 2009; Davies, 2011; Cohen, 2016).

Marxist analyses overlap with the "antipsychiatry" position, which argues that mental illness is a strategic, political concept, rather than a scientific one (Szasz, 1970; Szasz, 1989). There is also a wealth of Marxist literature on the welfare state that is relevant to understanding the role and functions of the mental health system (Gough, 1979; Higgs, 1993).

In the following article, I set out an analysis of how the mental health system relates to the economy, particularly a capitalist economy, making use of Marxist concepts such as use value, exchange value, exploitation, productive labour and ideology (see **Table 1**). I trace the evolution of the English system, revealing its social functions, which include social control, but also functions that have received little previous attention, such as the provision of care, and the way in which the biomedical ideology of psychiatry facilitates the capitalist welfare system, and promotes capitalist hegemony. I attempt to distinguish those aspects of the system that are specific to capitalism from those that are more general features of modern societies, and describe how understanding the mental health system in this way reveals some of the contradictions of capitalism. Since industrial capitalism is generally acknowledged to have started in England, the analysis provides a paradigmatic case of the relationship between economic development and social responses to mental disturbance in advanced capitalist economies, but it is not necessarily applicable to parts of the world where economic development has taken a different course.

As a practising psychiatrist, I have experienced the situations that mental health services are required to address, and the frequent disjunction between the official diagnostic framework for explaining these situations, and the problems individuals, families and communities actually experience. Yet, I have also been socialised by the system, in particular by the language it employs. The terminology of "mental health," "mental illness" and "mental disorder" is premised on the existence of a material entity or disease, located in the individual, a view that is challenged in this article. However, since there are no widely accepted alternative ways to describe the problems in question, I have used current terms.

THE NATURE OF MENTAL HEALTH PROBLEMS

In contrast to the mainstream position, I and other critics suggest that mental health problems are not equivalent to general medical conditions (Valenstein, 1998; Szasz, 2000; Whitaker, 2002; Moncrieff, 2020). Although human beings are embodied creatures, and all human activity depends on biology, none of the situations we call mental disorders have been convincingly shown to arise from a biological disease, or, putting it another way, from a specific dysfunction of physiological or biochemical processes.

The abundance of research into the biological basis of mental disorders means it is difficult to challenge every new claim or theory, yet fundamental flaws have been identified in key areas of

TABLE 1 | Marxist concepts.

Concept	
Use value	The value of a product in terms of the use it can be put to
Exchange value	The value of a product in terms of the money or other goods it can be exchanged for
Surplus value	The additional exchange value generated by labour over and above its own cost
Productive labour	Labour that generates surplus value
Exploitation	The accumulation of wealth through paying workers less than the value generated by their labour
Base/superstructure	The economic (or productive) system/social, political and cultural institutions and activities
Ideology	Ideas that support dominant class interests by obscuring the nature of reality

research. For example, genetic research with families and twins has overlooked important confounders and positive findings have been highlighted while negative ones have been buried (Rose et al., 1984; Joseph, 2003). More recent genome wide studies produce negligible evidence for any relevant genetic effects (Latham and Wilson, 2010; Moncrieff, 2014). The most consistent finding in biological psychiatry is that people diagnosed with schizophrenia have smaller brains and larger brain cavities than people without, and this has recently been shown to be due, at least in part, to the effects of antipsychotic treatment (Fusar-Poli et al., 2013). Any remaining differences are likely accounted for by intellectual ability and other uncontrolled factors (Moncrieff and Middleton, 2015). Biochemical research also fails to support widely held beliefs that mental disorders are caused by abnormalities of specific neurotransmitters (Valenstein, 1998). The hypothesis that depression is caused by serotonin deficiency is not supported by evidence from any of the principle areas of research into depression and the serotonin system (Moncrieff et al.). Evidence on dopamine also fails to confirm the dopamine hypothesis of schizophrenia or psychosis, though dopamine is known to be involved in arousal mechanisms that are likely to be awry in someone who is acutely psychotic (Moncrieff, 2009; Kendler and Schaffner, 2011).

Instead of viewing mental disorders as biological conditions that are inherent in individuals, I suggest we need to understand them as problems of communities or societies. If we do this, we will see from the following account of the evolution and functions of the mental health system, the principal problems we refer to as mental disorders consist, from a societal point of view, of dependency and disruptive behaviour. It is true that these problems can be caused by medical conditions. Occasionally, brain diseases, such as dementia and Huntingdon's chorea produce behaviour that is aggressive or socially undesirable, and many physical diseases reduce people's ability to maintain themselves. Indeed, for centuries, the institutions that developed to accommodate the mentally disturbed, also provided for people with neurological conditions, and sometimes still do (Rehling and Moncrieff, 2020). Moreover, in most countries, people with dementia, a neurological disease, are treated by psychiatrists rather than neurologists.

However, in the situations we routinely refer to as "mental disorders", no disease can reliably be found. It is in the nature of human beings to react to their environment in different ways. Some people behave in ways that are bizarre, difficult to understand and sometimes troublesome for others, and some people are more productive and efficient than others. Rather than representing these problems as the manifestations of as yet undiscovered brain diseases, I suggest that "mental illness" is simply the collection of challenging situations that remain when those that are amenable to the criminal justice system and those that are caused by a specific, medical condition are taken out of the picture (Moncrieff, 2020).

In what follows I accept the view that many of our current mental troubles are consequences of the particular socio-economic conditions of late capitalism, and the way in which these consequences are construed (Davies, 2011; Cohen, 2016; Davies, 2017). However, in contrast to the purely social constructionist view, I also assume that some are perennial features of human life and occur across different sorts of societies with varying economic bases.

MENTAL HEALTH PROBLEMS FROM A SOCIAL AND ECONOMIC PERSPECTIVE

In line with this view, the mental health system can be viewed as a social response to the set of problems we refer to as "mental disorder" or "illness". Some of these are problems for any modern society, whether capitalist, socialist or something else. Some are specific to capitalism. Though much debated, Marxist theory suggests that social institutions (the superstructure) reflect the need to support the prevailing economic system (the base) of each society and historical era (Harman, 1986). Therefore, institutional functions need to be understood in the context of the economic system in which they are embedded.

One of the functions of mental health services is to provide support and care for people when they are unable to look after themselves. Just like people with a severe physical disability, learning difficulties or neurological disease, people who have a serious mental disorder that would nowadays be referred to as schizophrenia, bipolar disorder or severe depression, are sometimes unable to wash or dress themselves, to manage money, shop, cook or maintain their environment in a habitable condition. The disability may be temporary, and many recover or improve, but for some it is long-term.

Serious mental disorder can also involve people behaving in ways that are disruptive or dangerous to the lives of others. Managing this behaviour to ensure social harmony is something societies have endeavoured to address long before the advent of capitalism, and is one of the principle functions of the mental health system. As legal scholar (and subsequently notorious lawyer), Alan Dershowitz, commented: "it is a fairly constant phenomenon in most societies that dangerous and bothersome people will be isolated by one means or another" (Dershowitz, 1974) (P 58). English history records how local, informal procedures aimed at managing dangerous and disruptive behaviour evolved to address lacunae in the criminal law, which included the difficulty of convicting people who were too confused, distracted or deluded to understand the justice system or respond to punishment. These informal procedures were gradually codified into formal law regarding the care and control of the "insane" (Dershowitz, 1974).

Disturbed and disruptive behaviour is not just a social nuisance, however, it potentially affects the processes of production that form the basis of modern societies. The individual who is acutely paranoid or severely depressed, for example, is unlikely to be able to work, or at least to work efficiently, and family members, too, may be prevented from working because of the disruption caused to their lives. Moreover, someone who is severely mentally disturbed may frighten and upset those around them, preventing people from feeling secure and motivated enough to satisfy the requirements of labour, and potentially jeopardising the whole system of modern production.

The more common, yet less visible social consequence of mental health problems that is specific to capitalist societies is not being able to support oneself financially. Capitalism depends on the majority of people earning their living through wage labour, and to be of use to capitalists, workers have to generate more wealth or value than they earn–what is known as "surplus value". If an individual falls below a certain level of productivity, it is no longer worth the expense of employing them. However, people who are unable to participate in productive labour that generates "exchange value" may nevertheless be able to engage in other useful activities and create "use value". They are not incapable of work, just incapable of doing the sort of work that is available in an advanced capitalist economy. Some of these people are part of the "industrial reserve army", who are recruited into work at times of labour shortage, and who help capitalists to keep wages down to maximise profit, but others, whom Marx referred to as the "demoralised, the ragged"; are unable to perform capitalist work on any terms (Marx, 1990) (p. 797).

The inability to earn associated with mental health problems may be temporary, lasting for the few weeks or months that the episode of madness, depression or stress endures, or it may be longer-lasting. Even if it is temporary, it may be recurrent, and the occurrence and duration of episodes is highly individual and unpredictable, making it difficult for those without highly supportive employers to sustain employment. There is no mechanism integral to capitalism to provide for people who are not employed, but capitalist economies have developed systems of welfare through the course of the last century, including the provision of financial support to the those who are classified as medically sick or disabled (Matthews, 2018).

THE MENTAL HEALTH SYSTEM AND THE WELFARE STATE

The mental health system, along with physical health services, education and the criminal justice system, fulfil certain social needs and thereby produce "use values" in the Marxist sense. If these services are provided capitalistically, that is by private firms that generate and accumulate capital through the extraction of surplus value, they also produce "exchange value". In modern capitalist societies of all political hues, a large part of these services are funded and coordinated by the state, both because a significant section of the population cannot afford them, and because of the level of organisation required. They may be provided by state enterprises or by private firms or charitable organisations, and they are often referred to collectively as the Welfare State.

Marxist commentators on the Welfare State highlight how it contributes to the social reproduction of the capitalist system by ensuring that there is a supply of healthy, educated and disciplined workers (Gough, 1979; O'Connor, 1973). These activities indirectly facilitate productive labour and the process of capital accumulation. The welfare state also ensures social harmony, by providing for the old and sick and sustaining those who will never enter the workforce, for example. These expenses are what Marx referred to as the "*faux frais* [incidental expenses] of capitalist production" (Marx, 1990) (p. 797). They are not associated with capitalist production *per se*, but can be viewed as a means of legitimation of the system, since, by preventing people from dying on the streets, they ensure the continuation of capitalist relations of exploitation and domination through hegemony rather than force (Higgs, 1993). Other Marxists highlight how the welfare state resulted from class struggle, and represents a concession to the working class inspired by the threat of revolution (Ferguson et al., 2002; Matthews, 2018), and others have pointed out how many functions of the welfare state are necessary for social reproduction in any modern economic system, and are not specific to capitalism (Cowling, 1985).

Most welfare state spending is not directly productive as it is provided either by public enterprises, which do not generate surplus value, or, if provided by the private sector, capital accumulation is constrained by the limits of public funding and taxation. Welfare services embody a contradiction, therefore, and represent both a pre-requisite for the continued existence of capitalism, and, at the same time, a drain on the surplus; "both a condition of capital accumulation and a subtraction from it" (Pierson, 1996) (p. 581) (O'Connor, 1973). This has led some to argue that the welfare state potentially undermines capitalism in the long-run (Gough, 1979; Bennett et al., 2009).

The philosophy behind the creation of the welfare state in the mid 20th century, as espoused by Keynes and the social democratic regimes that took up his ideas, was that it was the duty of the state to intervene and alleviate problems such as poverty and unemployment. It was the state's responsibility to ensure there were employment opportunities, education, housing and healthcare available to all (Higgs, 1993). During the 1970s, however, the welfare state came to be seen as contributing to or even causing the economic crisis of capitalism, and regimes all over the world started to bring in measures to reduce its costs. This commonly involved the privatisation of state services, since the private sector could employ people at lowers costs due to longer hours, worse pay and conditions. It also involved a reorientation of the philosophy behind the welfare state, which involved shifting responsibility from the government to the individual. Relatively generous and automatic unemployment or social security benefits were phased out, for example, and in their place individuals had to prove their entitlement, which involved demonstrating either a willingness to work, or an incapacity for work (Higgs, 1993).

Much of the mental health system predates the creation of the welfare state; indeed it prefigures other aspects of the welfare state in its role in producing a social environment conducive to the accumulation of capital. However, as a state-subsidised enterprise, it can usefully be considered as part of the welfare state, and as with other sectors, the provision of services for the seriously mentally ill has been increasingly transferred from the state to the private sector over recent decades.

THE FUNCTIONS OF THE MENTAL HEALTH SYSTEM

Maintaining Order and Providing Care

The mental health system in England evolved out of the Poor Laws that were enacted from the Tudor period in order to manage the problems created by the expropriation of the agricultural population, which was the first step necessary to provide the labour needed for capitalism, as depicted by Marx in Das Capital (Marx, 1990). The Poor Laws provided material and financial assistance or "relief", raised through local taxes, to families who could not provide for themselves, including in those instances in which a member of the family was mentally incapacitated. Poor Law officials also helped to keep the community safe and secure, and could use the money at their disposal to pay for the confinement of local people felt to be dangerous in various settings, such as a neighbouring household or, if necessary, a prison or prison-like establishment such as a "House of Correction" (Fessler, 1956; Rushton, 1988).

Public mental institutions, known as "asylums", arose in the context of an austerity drive in the early 19th century. This was intended to reduce the welfare burden by ending the system of "outdoor relief" that supported people in their own homes, and making state support contingent on entering the forbidding and highly stigmatised Workhouse, a policy encapsulated in the 1834 Poor Law Amendment Act [although some local authorities continued to pay "outdoor relief" (Forsythe et al., 1996)]. With the rise of the Workhouse, the "deserving" poor, who could not work by dint of mental derangement or impairment among other causes, needed to be separated from the "undeserving" poor - those deemed capable of work. The former were diverted to the new system of public asylums for treatment and cure that were constructed all over England during the middle of the 19th century, while the latter were made to do hard labour in exchange for their upkeep in the Workhouse (Scull, 1993).

The system was publicly funded because the costs of care and confinement were way beyond the majority of families, and because, as historian, Andrew Scull, suggests, building on the work of Michel Foucault, it was part of the means of establishing a disciplined workforce that had the requisite motivation to be put to work as wage labourers in the service of Capital (Foucault, 1965; Scull, 1993). Asylums provided a secluded place where people whose behaviour was socially disruptive but not obviously criminal could be contained, but they also provided care and sustenance for those who were too confused, chaotic or apathetic to be put to work in the Workhouse or driven out to scrape a living together in the harsh world of Victorian England. Despite widespread myths to the contrary, people who were simply eccentric or socially deviant (e.g. unmarried mothers) were not routinely admitted to the public asylums unless their behaviour posed significant problems (Rehling and Moncrieff, 2020).

The need for the State to provide care and containment arose partly because the capitalist system of wage labour meant there was little spare capacity within the family or community to look after someone who could not look after themselves (Wright, 1997). All modern societies that rely on industrial production and a large workforce have similar requirements and allowing the disturbed and confused to roam the streets or rot away due to lack of care would quickly undermine the legitimacy of any system. Persuading people to work in a capitalist manner towards the enrichment of others arguably requires greater motivation and discipline, however, especially if, as was the case at the beginning of the capitalist era, people are not used to doing so. Early capitalism, therefore, produced a particular imperative for the management of the seriously mentally ill, which is manifested in the vast amount of public resources expended on the asylum system in the 19th century.

Although the roots of this system are political and social - "moral" according to Foucault - since the 19th century it has presented itself as a medical endeavour directed at medical problems. Foucault suggested that the medical framework was superimposed onto the system in order to give it the legitimacy associated with science. He referred to psychiatry as a "moral enterprise overlaid by the myths of positivism" (Foucault, 1965) (p. 276). In a modern liberal society where the rights of the individual are pre-eminent, psychiatry can only fulfil its functions by presenting itself as a technical activity that is immune to political considerations. The medical nature of psychiatric terminology and knowledge obscures the values and judgements that are embedded in its practical execution (Ingelby, 1981). It enables interventions that are designed to curb or control unwanted behaviour to be conceptualized as medical treatments intended to benefit the recipient rather than the people who are disturbed by the individual's behaviour. It also extends the prerogative of the sick role, with its entitlement to care, to those who are unable to care for themselves, but where no obvious physical disease can account for their incapacity, and where the entitlement might, therefore, be questioned.

Modern Developments

The large public asylums were scaled down and finally closed from the 1980s onwards, and the official story declares that this process of deinstitutionalisation, as it was known, demonstrates the efficacy of modern drug treatments and confirms the validity of the medical view of mental disorder (Cookson et al., 2005). A Marxist analysis, on the other hand, suggests that the institutions were closed because of the desire to reduce public spending (Scull, 1977). It is now apparent that although the new drugs may render some people more subdued, they rarely enable people to become fully independent. A study published in 2005, for example, found that in 1998, more people were dependent on state and private services due to mental health problems than in 1898 (Healy et al., 2005). Instead, long-term psychiatric patients are now placed in other institutions - smaller, privately-run but state funded residential and nursing homes, for example, as well as private psychiatric hospitals, secure units and prisons, and many rely on the care and support of family members or paid carers (Priebe et al., 2005). Many subsist on financial support from the state, the new version of "outdoor relief".

Deinstitutionalisation was, therefore, partly an exercise in transferring provision for the long-term mentally disabled from the state to the private sector. The income still largely derives from the state, but the organisation of these services into private companies has enabled them to become a potential source of capital accumulation through the exploitation of employees.

Welfare

The vast majority of people who are currently diagnosed with a mental disorder cause no trouble for other people and have no difficulty looking after themselves on a day-to-day basis but are not able to work and so rely on financial support provided through the state welfare system. Welfare payments have become an important part of the mental health system and illustrate how conceptualising certain problems as mental illness or disorder disguises the flaws of the capitalist system, thus helping to suppress resistance to it.

Marxist analysts of disability have pointed out how capitalism constructs disability or dependency as a social problem. In pre-capitalist societies, the distinction between the dependent and independent was not clear-cut. Most people could produce "use value", contributing to the maintenance of the family and community in some fashion. In a capitalist society, in contrast, people are either fit to be exploited or they are unemployable (Finkelstein et al., 1981; Oliver, 1999; Slorach, 2011; Bengtsson, 2017). One of the major roles of the welfare state is the provision of financial or material support for those who cannot work intensively and productively enough to generate surplus value.

Sickness and disability payments were introduced in most western countries in the middle of the 20th century and have been rising rapidly since the 1980s, despite efforts to curb them (Kemp et al., 2006; Niemietz, 2016). Much of this rise is accounted for by the increase in people claiming benefits for mental health problems, particularly those classified as depression or anxiety (Waddell and Aylward, 2005; Kemp et al., 2006; Brown et al., 2009; Danziger et al., 2009). In the United Kingdom in 2008, it was estimated that the total cost of sickness and disability-related worklessness among the working age population was more than the cost of the whole of the National Health Service (Black, 2008). By 2014, almost half of United Kingdom claimants were classified as having a mental disorder as the reason for their claim, which was by far the largest category of causal medical conditions. Claims made due to a mental disorder doubled between 1995 and 2014, while claims made for most other types of medical conditions fell. These claims were predominantly long-term (Viola and Moncrieff, 2016). Similarly in the United States, claims for disability payments due to mental health problems have increased at a faster rate than claims for other medical conditions, and by 2005 they accounted for around a third of claims made to the major disability benefit schemes (Danziger et al., 2009). Again, once on disability benefits, people rarely go off them (Joffe-Walt, 2013).

The rise in disability payments to people with common mental disorders like anxiety and depression is paralleled by the phenomenal rise in antidepressant prescribing that has occurred since the early 1990s throughout the world. Consumption of antidepressants more than doubled in the United Kingdom between 1998 and 2010, for example (Ilyas and Moncrieff, 2012), having previously risen by more than three times from 1988 to 1998 (Middleton et al., 2001). There have been similar rises in many OECD countries (Organisation for Economic Development, 2020). Over the past few decades, an increasing proportion of people have been prescribed these drugs on a long-term basis (Mars et al., 2017; Taylor et al., 2019).

Studies of employment have also shown that receiving treatment for a mental health problem is associated with people taking more time off and being less likely to return to work than people who do not receive treatment (Dewa et al., 2003). It appears, therefore, that in many high income countries, including the United Kingdom and US, large numbers of people become economically inactive and are classified as being long-term mentally ill. They receive financial benefits and prescriptions for psychiatric drugs, and some may receive psychological therapy.

These recent trends illustrate the relationship between welfare and capital accumulation. During the period of Neoliberalism the ruling class has pushed back against the concessions that workers won during the mid 20th century in order to increase or maintain profit margins (Harvey, 2005; Glynn, 2006; Boltanski and Chiapello, 2018). This has been achieved by relocating many manual industries to countries where labour costs are cheaper, and by increasing the intensity or productivity of the work that remains (Office for National Statistics, 2018).

People have to work harder than they did in the past, their output and performance is constantly scrutinsed, and there is the constant threat of losing one's jobaltogether, especially for the increasing number of people employed on a casual or "self-employed" basis. The work environment requires workers to be more and more robust, efficient and compliant (Dardot and Laval, 2017). This applies to the public sector too, which has been remodelled on the private sector since the 1990s (Ironside and Seifert, 2004). Whereas previously there may have been a niche for the less productive in state enterprises, such as the UK's National Health Service (NHS), these now engage in intense performance monitoring and take a more disciplinarian approach to the workforce, resulting in a culture of "fear and blame" and a "demotivated workforce with low morale" (Stevenson and Moore, 2019) (p. 1). It is not surprising, therefore, that increasing numbers find they cannot tolerate the demands of work as it is currently organised.

Neoliberal capitalism increases the need or demand for disability benefits, therefore, but at the same time it attempts to restrain those benefits, which represent a drain on the overall surplus. In the United Kingdom, for example, the government has introduced more stringent criteria for qualifying as sick or disabled, abolished certain allowances, capped others, and set benefit rises below inflation (UNISON, 2013). Such measures are in constant tension with the fact that the alternative of working on the open market is less achievable for many, and hence attempts to restrain spending are barely successful (Office for Budget responsibility, 2019).

Capitalism creates redundant workers out of those people who can work, but are not productive enough to produce the desired amount of surplus value due to physical or mental disability (Finkelstein et al., 1981; Oliver and Flynn RJL, 1999). State-funded sickness and disability benefits disguise this structural unemployment–unemployment that is inherent to the current stage of capitalism (Beatty et al., 2000; Roberts and Taylor, 2019). In the US, this activity has become a new industry, with states paying businesses to help move people from state-funded social security to federally funded disability programmes (Joffe-Walt, 2013).

This process of exclusion from the productive workforce deprives people of a feeling of connection with and investment in their community, thus contributing to people becoming marginalised and demoralised, which is then labelled as mental illness. In this way, unemployment and low productivity are constructed as the fault of the individual (albeit a biological rather than a moral fault), rather than a systemic problem that reflects the prioritisation of profit over participation (Davies, 2017). The welfare system also solidifies people's identity as "spoiled" or damaged; as being incapable. Like the asylums of the 19th century, it keeps the non-working population quiet and secluded so the rest can be effectively exploited.

The Promotion of Hegemony

Underpinning the previously described functions of the mental health system is the idea that the situations concerned are medical conditions, with the implication that they originate in the body and thus absolve individuals of responsibility for their behaviour, and justify the forcible modification of that behaviour by others (Moncrieff, 2020). Although we have seen that this position is not supported by scientific evidence, it is widely embraced and its acceptance helps to legitimise the social and political status quo.

Construing life difficulties as an illness in what Nikolas Rose has called "the psychiatric re-shaping of discontent" (Rose, 2006) (p. 479) has long been recognised as a political strategy that silences protest and inhibits change. This was pointed out in the 1960s and 1970s by social scientists who explored the creeping medicalisation of society (Zola, 1972; Illich, 1976; Conrad and Schneider, 1980), along with "antipsychiatry" thinkers (Laing, 1967) and has been explored more recently by critics of neoliberalism (Fisher, 2009; Cohen, 2016; Davies, 2017). This strategy has been employed in socialist as well as capitalist countries. As William Davies points out, unhappiness has "political and sociological qualities that lend it critical potential" (Davies, 2011). To construe it as an illness, to label it as "clinical depression" as it is in neoliberal, western societies, as anxiety as it was for much of the 20th century (Healy, 2004), or neurasthaenia as it was in the Soviet bloc and communist China (Kleinman, 1982; Skultans, 2003), is to declare that it is not reasonable, to see it as something to be eradicated, rather than understood. Viewing worry, distress and misery as a medical condition isolates the individual as a patient who needs to be cured of their internal flaws. It cuts them off from understanding the social implications of their feelings, and it prevents society from understanding epidemics of mental health problems as "commentaries on social life" (Davies, 2017) (P 205).

As already noted, there has been a huge expansion in the numbers of people receiving mental health diagnoses and treatments in high income countries over recent decades with dramatic increases in the use of antidepressants, in particular, but also of stimulants (commonly prescribed for a diagnosis of ADHD), new anti-anxiety agents and drugs usually associated with the treatment of more severe disorders, such as antipsychotics (Ilyas and Moncrieff, 2012). Seventeen per cent of the population of England are now prescribed an antidepressant alone (Taylor et al., 2019).

There are some obvious drivers of this trend, such as the pharmaceutical industry, whose marketing activities have been facilitated both by the arrival of the Internet, and by political deregulation, including the repeal of the prohibition on advertising to consumers in the US and some other countries in the 1990s (Davies, 2017). Despite the fact that there is no evidence of an imbalance or abnormality of brain chemicals or any other biological abnormality in people with depression (Kennis et al., 2020; Moncrieff et al., 2021), the industry, aided and abetted by professional organisations such as the American Psychiatric Organisation and the UK's Royal College of Psychiatrists (APA, 2018; Royal College of Psychiat, 2009), has succeeded in persuading the general public that unhappiness and discontent arise from a faulty brain. Surveys conducted in the US and Australia in the 2000s, for example, showed that 85 and 88% of respondents respectively endorsed the idea that depression is caused by a chemical imbalance (France et al., 2007; Pilkington et al., 2013).

Political institutions have also embraced the idea that human reactions to difficult circumstances can be understood as mental health problems. The United Kingdom government's initiative on "transforming children and young people's mental health" for example (NHS, 2021), is premised on the idea that the source of stress, anxiety and behaviour problems among the young is not the conditions they grow up in or the highly competitive nature of the modern educational system, but individual flaws or weaknesses that can be addressed through treatment designed to help the individual to adjust and assimilate. Mental health support teams have been introduced into schools to "provide early intervention on some mental health and emotional wellbeing issues, such as mild to moderate anxiety" and referrals to NHS services for more severe problems. Inevitably, this will lead to increasing numbers of pupils being given a potentially stigmatising diagnostic label and pharmaceutical treatments, which are unlikely to have net benefits for most of them but certainly have risks and dangers (Kazda et al., 2021).

Capitalism requires a certain level of dissatisfaction in order to operate smoothly and maintain consumption. People need to be persuaded that their lives are lacking in some way, and neoliberalism, with its rolling back of state responsibilities, has exaggerated this tendency (Davies, 2011). The "privatisation of public troubles and the requirement to make competitive choices at every turn" (Hall et al., 2013) (p. 12) breed perpetual feelings of insecurity and inadequacy that establish the demand necessary to stoke capital accumulation. The construction of the ideal neoliberal subject as an informed and intelligent consumer, who is fully responsible for their own wellbeing, both creates the conditions for increasing personal stress, in what has been called a "malady of responsibility" (Dardot and Laval, 2017) (P 292), and encourages people to look for solutions in the consumption of pharmaceuticals and other easily marketable products, such as short-term therapy (Davies, 2017).

Competition, the basis of the capitalist system, creates winners and losers. Fear of failure is therefore a constant source of anxiety for the modern individual, and failure itself so often the precipitant of the demoralisation and hopelessness that is called depression (Ehrenberg, 2010; Dardot and Laval, 2017). "Depression is the shadow side of entrepreneurial culture," said Marxist author Mark Fisher, "what happens when magical voluntarism confronts limited opportunities" (Fisher, 2012).

Presenting this situation as individual deficiencies rather than a systemic by-product helps obscure its political and economic origins. The language of mental health and mental illness or disorder can be thought of, therefore, as an "ideology", in the Marxist sense that these concepts help to obscure real underlying tensions and conflicts, and render the population amenable to viewing them as relatively simple, technical problems that should be left to experts. As Bruce Cohen points out, "biomedical ideology has become the dominant "solution" to what are social and economic conditions of late capitalism" (Cohen, 2016) (p. 91). Authors who have described this phenomenon as "psychiatrization" highlight how it leads to numerous personal and social consequences from the creation of individual dependency to the diversion of needed resources from other areas of health and social services (Beeker et al., 2021), but most importantly, from the Marxist point of view, it disguises "failed policies" (Conrad, 1992) (p. 7).

The current "mental health movement", with its encouragement to conceive of our understandable reactions to an increasing array of social problems, including unemployment, school failure, child abuse, domestic violence and loneliness as individual pathology requiring expert, professional treatment, promotes an ideology that helps legitimise existing social and economic relations by diverting attention from the problems themselves. In this way, it acts as a hegemonic tool for the capitalist system that now dominates most of the globe. It has been successful in moulding public attitudes and gaining political support, despite efforts of some mental health campaigners, professionals and academics to expose its political implications and to present other ways of understanding the difficulties we currently refer to as mental disorders (Johnstone et al., 2018; Guy et al., 2019).

SOCIAL RESPONSES TO MENTAL HEALTH PROBLEMS

As this analysis illustrates, how society responds to the problems posed by dependency and troublesome behaviour is potentially contentious. For Foucault, and medical sociologists, such as Peter Conrad, one of the important consequences of the medicalisation of such problems is to render them morally and politically neutral (Foucault, 1965; Conrad, 1992). The concept of mental illness provides a justification for using force against people whose behaviour is antisocial or dangerous, but who are too confused or irrational to be appropriate for the criminal justice system. It also authorises support for people who do not qualify for care or welfare by virtue of being old or physically sick or disabled. Presenting these responses as medical activities that are the rightful and exclusive terrain of qualified, medical specialists shields them from being questioned or challenged. As the psychiatrist and critic, Thomas Szasz pointed out, the psychiatric system performs its functions "in a manner that pleases and pacifies the consciences of politicians, professionals and the majority of the people" (Szasz, 1994) (p. 200). It also has a wider hegemonic role in the maintenance of capitalism, along with other socio-economic systems, by locating the sources of individuals' unhappiness and discontent within their own brains, rather than in their external circumstances, individualising "what might otherwise be seen as collective social problems" and thereby letting the political and economic system off the hook (Conrad, 1992) (p. 224).

On the other hand, some left-wing analysts, notably Peter Sedgewick, point out that this position enables capitalist governments to cut disability benefits and reduce other resources available for people affected by mental health problems (Sedgewick, 1982). While this may be theoretically possible, it depends on Sedgewick accepting the view that mental disorders are essentially equivalent to neurological diseases.

Apart from the lack of evidence that this is the case, it is difficult to accept that all dependency and disruptive behaviour is caused by a physical disease. If it is not, (Moncrieff, 2020)? then surely we need a more transparent system of control and care, that acknowledges the ethical and political dilemmas involved and is based on widespread democratic debate informed particularly by the voice of the system's recipients. Such a system would have to balance the need to restrict people's behaviour when it becomes a nuisance or danger to other people, with the individual's legitimate interests to live in the way they want to live (19). We also need an alternative to the sick role in order to fairly and transparently distribute resources and care to people who are unable to be financially or practically independent, without having to deem them as being biologically flawed (Cresswell and Spandler, 2009).

REFLECTIONS ON CAPITALISM

This analysis suggests that the mental health system can be understood as part of a wider system of social reproduction through which modern societies produce a fit, capable and amenable workforce and ensure social harmony. The particular means of social reproduction depend on the economic and social form that each society takes. Some aspects of the mental health system are an enduring response to perennial social problems that cut across different epochs, political systems and cultures. These have not been fundamentally changed by the introduction of modern medical perspectives and interventions. For hundreds of years, English Poor Law officials grappled with how to help a family whose breadwinner had become mentally incapable, or how to protect the community from someone who was behaving irrationally and unpredictably (Rushton, 1988). Supporting the chronically dependent and controlling chaotic and disruptive behaviour remain the main functions of the modern mental health system.

On the other hand, some trends are distinctive of capitalism in general and neoliberal capitalism in particular. The modern welfare state emerged, in part, to compensate those who cannot work intensively and productively enough to earn a living through wage labour. The concept of mental illness enables a system that is justified by the nature of physical sickness and disability to incorporate people who are disorganised, demoralised, slow, antisocial, chaotic or unmotivated–factors whose significance clearly varies according to the nature of the work that is available. Some of these people may be recruited into the work force during an economic boom, and in the mid 20th century, when conditions for labour were more favourable, even those people diagnosed with severe mental conditions such as 'schizophrenia' had a reasonable chance of employment (Warner, 2004).

During the decades of neoliberal capitalism, however, as labour entitlements have been rolled back and work has become more competitive and exploitative, increasing numbers of people have become economically inactive for long periods. It is patently absurd to imagine that the quarter of the population who have been diagnosed with a mental illness (Health and Social Care Information Centre, 2015), or the fifth who take antidepressants (Taylor et al., 2019) have an as yet unidentified brain disease. Instead, this situation reflects the changing structure of contemporary capitalism. Disability support disguises the way in which capitalism narrows the opportunities for people to contribute to the productive efforts of society, thereby relegating large numbers of people into a surplus population that has no investment in its own community. The transformation of post-industrial populations into mental patients represents the economic and social marginalisation of a large segment of society. Rejecting the medicalisation of so-called mental health problems is a necessary step in revealing some of the fundamental contradictions of capitalism and laying the groundwork for political change.

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The author confirms being the sole contributor of this work and has approved it for publication.

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REFERENCES

APA (2018). *What Is Depression?American Psychiatric Association*. Available from: https://www.psychiatry.org/patients-families/depression/what-is-depression.

Beatty, C., Fothergill, S., and Macmillan, R. (2000). A Theory of Employment, Unemployment and Sickness. *Reg. Stud.* 34, 617–630. doi:10.1080/00343400050178429

Beeker, T., Mills, C., Bhugra, D., Te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of Society: A Conceptual Framework and Call for Transdisciplinary Research. *Front. Psychiatry* 12, 645556. doi:10.3389/fpsyt.2021.645556

Bengtsson, S. (2017). Out of the Frame: Disability and the Body in the Writings of Karl Marx. *Scand. J. Disabil. Res.* 19 (2), 151–160. doi:10.1080/15017419.2016.1263972

Bennett, C., Graham, I. D., Kristjansson, E., Kearing, S. A., Clay, K. F., and O'Connor, A. M. (2009). Validation of a Preparation for Decision Making Scale. *PatientEducCouns* 78 (1), 130–133. doi:10.1016/j.pec.2009.05.012

Black, C. (2008). *Dame Carol Black's Review of the Health of Britain's Working Age Population: Working for a Healthier Tomorrow*. London: The Stationery Office.

Boltanski, L., and Chiapello, E. (2018). *The New Spirit of Capitalism*. London: Verso.

Brown, J., Hanlon, P., Turok, I., Webster, D., Arnott, J., and Macdonald, E. B. (2009). Mental Health as a Reason for Claiming Incapacity Benefit-Aa Comparison of National and Local Trends. *J. Public Health (Oxf)* 31 (1), 74–80. doi:10.1093/pubmed/fdn098

Cohen BMZ. Psychiatric Hegemony (2016). *A Marxist Theory of Mental Illness*. London: Palgrave Macmillan.

Conrad, P. (1992). Medicalization and Social Control. *Annu. Rev. Sociol.* 18, 209–232. doi:10.1146/annurev.so.18.080192.001233

Conrad, P., and Schneider, W. (1980). *Deviance and Medicalization: From Badness to Sickness*. St Louis: The C.V. Mosby company.

Conrad, P., and Potter, D. (2000). From Hyperactive Children to ADHD Adults: Observations on the Expansion of Medical Categories. *Soc. Probl.* 47 (4), 559–582. doi:10.2307/3097135

Cookson, J. (2005). "A Brief History of Psychiatry," in *Core Psychiatry*. Editors P. Wright, J. Stern, and M. Phelan. Second (Edinburgh: Elsevier Saunders), 1–12.

Cowling, M. (1985). The Welfare State as a Reproduction Condition of Capitalism: what Does This Explanation Tell Us? *Int. J. Soc. Soc. Pol.* 5 (1), 68–78. doi:10.1108/eb012979

Cresswell, M., and Spandler, H. (2009). Psychopolitics: Peter Sedgwick's Legacy for the Politics of Mental Health. *Soc. Theor. Health* 7 (2), 129–147. doi:10.1057/sth.2009.7

Danziger, S., Frank, R. G., and Meara, E. (2009). Mental Illness, Work, and Income Support Programs. *Am. J. Psychiatry* 166 (4), 398–404. doi:10.1176/appi.ajp.2008.08020297

Dardot, P., and Laval, C. (2017). *The New Way of the World: On Neoliberal Society*. London: Verso.

Davies, J. (2017). "Political Pills: Psychopharmaceuticals and Neoliberalism as Mutually Supporting," in *The Sedated Society* (London: Palgrave Macmillan), 189–225. doi:10.1007/978-3-319-44911-1_8

Davies, W. (2011). The Political Economy of Unhappiness. *New Left Rev.* 71 (Sept/Oct).

Dershowitz, A. (1974). The Origins of Preventive Confinement in Anglo-American Law- Part 1: The English Experience*University of Cincinnati Law Review*, 43, 1–60.

Dewa, C. S., Hoch, J. S., Lin, E., Paterson, M., and Goering, P. (2003). Pattern of Antidepressant Use and Duration of Depression-Related Absence from Work. *Br. J. Psychiatry* 183, 507–513. doi:10.1192/bjp.183.6.507

Ehrenberg, A. (2010). *The Weariness of the Self.* Montreal: McGill-Queens University Press.

Ferguson, I., Lavalette, M., and Mooney, G. (2002). *Rethinking Welfare: A Critical Perspective*. London: Sage.

Fessler, A. (1956). The Management of Lunacy in Seventeenth century England; an Investigation of Quarter-Sessions Records. *Proc. R. Soc. Med.* 49 (11), 901–907. doi:10.1177/003591575604901107

Finkelstein, V. (1981). "Disability and the Helper/Helped Relationship. An Historical View," in *Handicap in a Social World*. Editors A. Brechin, P. Liddiard, and J. Swain (London: Hodder Arnold).

Fisher, M. (2009). *Capitalist Realism: Is There No Alternative?* London: Zero Books.

Fisher, M. (2012). *Why Mental Health Is a Political Issue*. Manchester, UK: The Guardian. 16th July 2012.

Forsythe, B., Melling, J., and Adair, R. (1996). The New Poor Law and the County Pauper Lunatic Asylum-Tthe Devon Experience 1834-1884. *Soc. Hist. Med.* 9, 335–355. doi:10.1093/shm/9.3.335

Foucault, M. (1965). *Madness and Civilisation*. New York: Random House.

France, C. M., Lysaker, P. H., and Robinson, R. P. (2007). The "Chemical Imbalance" Explanation for Depression: Origins, Lay Endorsement, and Clinical Implications. *Prof. Psychol. Res. Pract.* 38, 411–420. doi:10.1037/0735-7028.38.4.411

Fusar-Poli, P., Smieskova, R., Kempton, M. J., Ho, B. C., Andreasen, N. C., and Borgwardt, S. (2013). Progressive Brain Changes in Schizophrenia Related to

Antipsychotic Treatment? A Meta-Analysis of Longitudinal Mri Studies. *NeurosciBiobehavRev* 37 (8), 1680–1691. doi:10.1016/j.neubiorev.2013.06.001

Glynn, A. (2006). *Capitalism Unleashed*. Oxford: Oxford University Press.

Gough, I. (1979). *The Political Economy of the Welfare State*. London: Macmillan.

Guy, A., Davies, J., and Rizq, R. (2019). in *Guidance for Psychological Therapists: Enabling Conversations with Clients Taking or Withdrawing from Prescribed Psychiatric Drugs* (London: APPG for Prescribed Drug Dependence).

Hall, S., Massey, D., and Rustin, M. (2013). After Neoliberalism: Analysing the Present. *Soundings* 53, 8–22. doi:10.3898/136266213806045656

Harman, C. (1986). Base and Superstructure. *Int. Socialism* 2, 3–44.

Harvey, D. (2005). *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Health and Social Care Information Centre (2015). *Health Survey for England 2014*. London.

Healy, D., Harris, M., Michael, P., Cattell, D., Savage, M., Chalasani, P., et al. (2005). Service Utilization in 1896 and 1996: Morbidity and Mortality Data from North Wales. *Hist. Psychiatry* 16 (61 Pt 1), 27–42. doi:10.1177/0957154X05044604

Healy, D. (2004). Shaping the Intimate: Influences on the Experience of Everyday Nerves. *Soc. Stud. Sci.* 34 (2), 219–245. doi:10.1177/0306312704042620

Higgs, P. (1993). *The NHS and Ideological Conflict*. Aldershot, UK: Avebury.

Illich, I. (1976). *Limits to Medicine. Medical Nemesis: The Expropriation of Health*. London: Marion Boyers.

Ilyas, S., and Moncrieff, J. (2012). Trends in Prescriptions and Costs of Drugs for Mental Disorders in England, 1998-2010, 1998-2010. *Br. J. Psychiatry* 200 (5), 393–398. doi:10.1192/bjp.bp.111.104257

Ingelby, D. (1981). “Understanding ’mental Illness,” in *Critical Psychiatry: The Politics of Mental Health*. Editor D. Ingelby (London: Penguin Books), 23–71.

Ironside, M., and Seifert, R. The Impact of Privatisation and the Marketisation on Employment Conditions in the Public Services Radical Statistics. 2004;86:57–71.

Joffe-Walt, C.(2013). Unfit for Work The Startling Rise of Disability in America: NPR. [Available from: https://apps.npr.org/unfit-for-work/.

Johnstone, L., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., et al. (2018). *The Power Threat Meaning Framework: Towards the Identification of Patterns in Emotional Distress, Unusual Experiences and Troubled or Troubling Behaviour, as an Alternative to Functional Psychiatric Diagnosis*. Leicester: British Psychological Society.

Joseph, J. (2003). *The Gene Illusion: Genetic Research in Psychiatry and Psychology under the Microscope*. Monmouth, UK: PCCS Books.

Kazda, L., Bell, K., Thomas, R., McGeechan, K., Sims, R., and Barratt, A. (2021). Overdiagnosis of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents: A Systematic Scoping Review. *JAMA Netw. Open* 4 (4), e215335. doi:10.1001/jamanetworkopen.2021.5335

Kemp, P. A., Sunden, A., and Bakker Tauritz, B. (2006). *Sick Societies: Trends in Disability Benefits in post-industrial Welfare States*. Geneva: International Social Security Association.

Kendler, K. S., and Schaffner, K. F. (2011). The Dopamine Hypothesis of Schizophrenia: an Historical and Philosophical Analysis. *Philos. Psychiatry Psychol.* 18 (1), 41–63. doi:10.1353/ppp.2011.0005

Kennis, M., Gerritsen, L., van Dalen, M., Williams, A., Cuijpers, P., and Bockting, C. (2020). Prospective Biomarkers of Major Depressive Disorder: a Systematic Review and Meta-Analysis. *Mol. Psychiatry* 25 (2), 321–338. doi:10.1038/s41380-019-0585-z

Kleinman, A. (1982). Neurasthenia and Depression: a Study of Somatization and Culture in China. *Cult. Med. Psychiatry* 6 (2), 117–190. doi:10.1007/BF00051427

Laing, R. D. (1967). *The Politics of Experience and the Bird of Paradise*. Harmondsworth: Penguin Books.

Latham, J., and Wilson, A. (2010). *The Great DNA Data Deficit: Are Genes for Disease a Mirage?* 1st Dec 2021. Available from: https://www.independentsciencenews.org/health/the-great-dna-data-deficit/.

Mars, B., Heron, J., Kessler, D., Davies, N. M., Martin, R. M., Thomas, K. H., et al. (2017). Influences on Antidepressant Prescribing Trends in the UK: 1995-2011. *Soc. Psychiatry Psychiatr. Epidemiol.* 52 (2), 193–200. doi:10.1007/s00127-016-1306-4

Marx, K. (1990). *Capital Volume 1*. London: Penguin Books.

Matthews, D. (2018). The Working Class Struggle for Welfare in Britain. *Montly Rev.* 69 (9), 33. doi:10.14452/mr-069-09-2018-02_3

Middleton, N., Gunnell, D., Whitley, E., Dorling, D., and Frankel, S. (2001). Secular Trends in Antidepressant Prescribing in the UK, 1975-1998. *J. Public Health Med.* 23 (4), 262–267. doi:10.1093/pubmed/23.4.262

Moncrieff, J. (2020). "It Was the Brain Tumor that Done it!": Szasz and Wittgenstein on the Importance of Distinguishing Disease from Behavior and Implications for the Nature of Mental Disorder. *Philos. Psychiatry Psychol.* 27, 169–181. doi:10.1353/ppp.2020.0017

Moncrieff, J. A Critique of Genetic Research on Schizophrenia – Expensive Castles in the Air2014 1st Dec 2021. Available from: https://joannamoncrieff.com/2014/09/01/a-critique-of-genetic-research-on-schizophrenia-expensive-castles-in-the-air/.

Moncrieff, J. (2009). A Critique of the Dopamine Hypothesis of Schizophrenia and Psychosis. *Harv. Rev. Psychiatry* 17 (3), 214–225. doi:10.1080/10673220902979896

Moncrieff, J., Cooper, R., Stockmann, T., Amendola, S., Hengartner, M. P., and Horowitz, M. A. (2021). *The Serotonin Theory of Depression: An Umbrella Review of the Evidence Molecular Psychiatry*. submitted.

Moncrieff, J., and Middleton, H. (2015). Schizophrenia: a Critical Psychiatry Perspective. *Curr. Opin. Psychiatry* 28 (3), 264–268. doi:10.1097/YCO.0000000000000151

Moncrieff Jc, R., Stockmann, T., Amendola, S., Hengartner, M. P., and Horowitz, M. A. The Serotonin Theory of Depression: a Systematic Umbrella Review of the Evidence. submitted to Molecular Psychiatry.

Moynihan, R., Heath, I., and Henry, D. (2002). Selling Sickness: the Pharmaceutical Industry and Disease Mongering. *BMJ* 324 (7342), 886–891. doi:10.1136/bmj.324.7342.886

NHS (2021). *New Mental Health Support in Schools and Colleges and Faster Access to NHS Care: NHS*. uk. [Available from: https://www.england.nhs.uk/mental-health/cyp/trailblazers/.

Niemietz, K. (2016). *A Briefing: Disability Benefits*. London.

O’Connor, J. (1973). *The Fiscal Crisis of the State*. New York: St Martin’s Press.

Office for Budget Responsibility. Welfare trends report. London; 2019.

Office for National Statistics (2018). UK Whole Economy: Output Per Hour Worked: Office for National Statistics. [Available from: https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity/timeseries/lzvb/prdy.

Oliver, M. (1999). “Capitalism, Disability, and Ideology: A Materialist Critique of the Normalization Principle,” in *A Quarter-century of Normalization and Social Role Valorization: Evolution and Impact*. Editor R.J. Flynn and R.A. Lemay (Ottowa: University of Ottowa Press), 163–173.

Organisation for Economic Co-Operation and Development (2020). *Statistics Health Status*. Paris, France: OECD. [Available from: https://stats.oecd.org/index.aspx?DataSetCode=HEALTH_STAT#.

Pierson, P. (1996). The New Politics of the Welfare State. *World Pol.* 48, 143–179. doi:10.1353/wp.1996.0004

Pilkington, P. D., Reavley, N. J., and Jorm, A. F. (2013). The Australian Public’s Beliefs about the Causes of Depression: Associated Factors and Changes over 16 Years. *J. Affect Disord.* 150 (2), 356–362. doi:10.1016/j.jad.2013.04.019

Priebe, S., Badesconyi, A., Fioritti, A., Hansson, L., Kilian, R., Torres-Gonzales, F., et al. (2005). Reinstitutionalisation in Mental Health Care: Comparison of Data on Service Provision from Six European Countries. *BMJ* 330 (7483), 123–126. doi:10.1136/bmj.38296.611215.AE

Rehling, J., and Moncrieff, J. (2020). The Functions of an Asylum: an Analysis of Male and Female Admissions to Essex County Asylum in 1904. *Psychol. Med.*, 1–7. doi:10.1017/S0033291719004021

Roberts, J., and Taylor, K. (2019). *New Evidence on Disability Benefit Claims in the UK: The Role of Health and the Local Labour Market*. Bonn: IZA Institute of Labour Economics, 12825. Contract No.: IZA DP No.

Rose, N. (2006). Disorders without Borders? the Expanding Scope of Psychiatric Practice. *BioSocieties* 1 (4), 465–484. doi:10.1017/s1745855206004078

Rose, S., Lewontin, R. C., and Kamin, L. J. (1984). *Not in Our Genes. Biology, Ideology and Human Nature*. Pantheon Books.

Royal College of Psychiatrists (2009). *Antidepressants London*. London, UK: Royal College of Psychiatrists. Available from: http://www.rcpsych.ac.uk/mentalhealthinfoforall/problems/depression/antidepressants.aspx.

Rushton, P. (1988). Lunatics and Idiots: Mental Disability, the Community, and the Poor Law in North-East England, 1600-1800. *Med. Hist.* 32, 34–50. doi:10.1017/s0025727300047591

Scull, A. (1977). *Decarceration: Community Treatment and the Deviant- a Radical View*. Englewood Cliffs, NJ: Prentice-Hall.

Scull, A. (1993). *The Most Solitary of Afflictions*. New Haven: Yale University Press.

Sedgewick, P. (1982). *Psychopolitics*. London: Pluto Press.

Skultans, V. (2003). From Damaged Nerves to Masked Depression: Inevitability and hope in Latvian Psychiatric Narratives. *Soc. Sci. Med.* 56 (12), 2421–2431. doi:10.1016/s0277-9536(02)00245-9

Slorach, R. (2011). Marxism and Disability. *Int. Socialism* 129 (4th January).

Stevenson, R. D., and Moore, D. E. (2019). A Culture of Learning for the NHS. *J. Eur. CME* 8 (1), 1613862. doi:10.1080/21614083.2019.1613862

Szasz, T. (1994). *Cruel Compassion. Psychiatric Control of Society's Unwanted*. New York: John Wiley & Sons.

Szasz, T. (1970). *Ideology and Insanity; Essays on the Psychiatric Dehumanization of Man*. New York: Anchor Books.

Szasz, T. (1989). *Law, Liberty and Psychiatry: An Inquiry into the Social Uses of Mental Health*. SyracuseNew York: Syracuse University Press.

Szasz, T. (2000). *Mental Disorders Are Not Diseases*. Tysons, VA: USA Today. [Jaunary 2000]. Available from: http://www.szasz.com/usatoday.html.

Taylor, S., Annand, F., Burkinshaw, P., Greaves, F., Kelleher, M., Knight, J., et al. (2019). *Dependence and Withdrawal Associated with Some Prescribed Medicines: An Evidence Review*. London.

UNISON (2013). *Welfare Reform Changes Affecting Disabled People*. London, UK: UNISON.

Valenstein, E. (1998). *Blaming the Brain*. New York: Free Press.

Viola, S., and Moncrieff, J. (2016). Claims for Sickness and Disability Benefits Owing to Mental Disorders in the UK: Trends from 1995 to 2014. *BJPsych Open* 2, 18–24. doi:10.1192/bjpo.bp.115.002246

Waddell, G., and Aylward, M. (2005). *The Scientific and Conceptual Basis of Incapacity Benefits*. London: The Stationery Office.

Warner, R. (2004). *Recovery from Schizophrenia: Psychiatry and Political Economy. Hove*. East Sussex.: Brunner-Routledge.

Whitaker, R. (2002). *Mad in America*. Cambridge, MA: Perseus Publishing.

Wright, D. (1997). Getting Out of the Asylum: Understanding the Confinement of the Insane in the Nineteenth century. *Soc. Hist. Med.* 10 (1), 137–155. doi:10.1093/shm/10.1.137

Zola, I. K. (1972). Medicine as an Institution of Social Control. *Sociol. Rev.* 20 (4), 487–504. doi:10.1111/j.1467-954x.1972.tb00220.x

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PERSPECTIVE
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Not in Their Right Mind? Right-Wing Extremism Is Not a Mental Illness, but Still a Challenge for Psychiatry

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Most research in psychiatry on extremism focuses on the question whether there is a connection between extremism and psychiatric diagnoses. In addition, practitioners are increasingly asked to take part in programs aimed at preventing and countering violent extremism by assessing risk for radicalization. However, an issue that remains largely unaddressed is that the rise of the far right in many countries during the last years poses a challenge for psychiatric services as working with right-wing patients can be a source of conflict for practitioners and patients alike. In this article, we assert that the narrow conceptual scope on psychological vulnerabilities and the practical focus on risk assessment contribute to processes of psychiatrization and limit the scope of research on right-wing extremism in psychiatry. By giving a brief overview of social research into right-wing extremism, the article argues that right wing beliefs should not be conceptualized as an expression of psychological vulnerabilities but rather as attempts to deal with conflict-laden social reality. Thus, a shift of perspective in psychiatric research on extremism is needed. On a conceptional level, the scope needs to be broadened to grasp the interplay of individual and social factors in radicalization with sufficient complexity. On a practical level, it is necessary to further investigate challenges for practitioners and institutions working with right-wing extremist patients.

Keywords: psychiatry, right-wing extremism, radicalization, psychiatrization, right-wing populism, mental health, prevention

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INTRODUCTION

In the last 10 years, right-wing populism[1] has established itself as a stable force within the political spectrum of many countries, in some even as part of the government (Mudde, 2019). This led to intense debates not only in the public sphere, but also in research on the causes and consequences of right-wing extremism. After radicalization prevention had focused mainly on Islamism in the years after the September 11 attacks, the recent developments brought right-wing extremism back into focus.

As with many sectors of public life, the popularity of the far right, and the accompanying public focus on it, also affect psychiatric services. As public health care institutions,

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[1] As terminological discussions would go beyond the scope of the article, we chose to use the most well-known terms. However, it should be noted that there is considerable debate on the analytical value of terms like right-wing populism and extremism.

psychiatric institutions must offer services to right-wing extremists just as to other patients. This results in various challenges. For example, the presence of right-wing extremists can be a burden for other patients or staff, especially if they have experienced discrimination related to racism and right-wing extremism. On the other hand, and unlike other health care institutions, psychiatric clinics and services are increasingly confronted with a particular set of questions: Are right wing extremist orientations and violence connected to psychiatric diagnoses? What role should psychiatry play in prevention of radicalization and violence?

The assumption of a connection between psychopathology and extremist violence has a long history (Gilman and Thomas, 2016) and is found particularly in media and public debate (DeFoster and Swalve, 2018). In psychiatry and criminology, the notion of a psychopathology of extremists has been discussed controversially since the 1970's (Cooper, 1978; Tanay, 1987; Victoroff, 2005). Lack of empirical evidence was a source of repeated criticism over the years and led most researchers in the field of radicalization to reject the assumption of mental illness having a causal influence on radicalization processes. In recent years, however, psychiatric institutions have increasingly been included in programs aimed at preventing and countering violent extremism (P/CVE), most prominently in the US and the UK. This resulted in a certain revival of research on mental illness and extremism as evidenced by a growing corpus of empirical studies.

Although research into how extremism challenges psychiatric and psychotherapeutic institutions has become highly relevant in recent times, current approaches suffer conceptually from a one-sided focus on mental health problems. This conceptual reductionism is accompanied by a prevention perspective that combines public health and security agendas and thus drives a psychiatrization of a phenomenon that should rather be understood as a complex interplay of individual, social and societal factors. The article argues for a research perspective that can integrate social as well as societal context and is able to address practical challenges of public health care institutions in working with extremist patients. This is done by (1) giving a concise summary of the conceptual and practical shortcomings in psychiatric research on extremism and (2) contrasting psychiatric approaches with current social research on right-wing extremism. The shift in research perspective encouraged by the article comprises both violent as well as non-violent forms of extremism.

RIGHT-WING EXTREMISM AND PSYCHIATRY

The Conceptual Perspective: Mental Health as a Risk Factor for Radicalization

For a long time, the psychiatric literature put forward the thesis of a psychopathology of extremists mostly based on conceptual considerations (Cooper, 1978; Tanay, 1987). However, during the last 10 years, an increasing number of studies were published that empirically investigate the presumed connection of extremism and mental illnesses (Gill and Corner, 2017). These studies report elevated prevalence rates for psychiatric diagnoses among extremists, particularly for depression (Bhui et al., 2014; Bhui, 2016; Campelo et al., 2018a; Rousseau et al., 2019; Morris and Meloy, 2020) but also for schizophrenia (Weenink, 2019), and personality disorders (Coid et al., 2016). Especially "lone wolf"-terrorists are more likely to fulfill the criteria for a psychiatric diagnosis (Gruenewald et al., 2013; Corner and Gill, 2015; Corner et al., 2016). Most studies follow a tendency noticeable in radicalization studies in general, namely, to focus primarily on Islamism, whereas right-wing extremism tends to play a minor role (Bjørgo and Aasland, 2019). Isolated studies, however, can be found claiming that right-wing violent offenders are more likely to have had traumatic experiences during childhood (Baron, 1997; Simi et al., 2016).

Although studies seem to point toward a connection of psychiatric diagnoses and radicalization, findings are inconsistent and do not allow for a clear conclusion. Meta-studies report considerable variation in prevalence rates between individual studies (Trimbur et al., 2021) and note that many studies have a weak diagnostic basis (Corner et al., 2021; Gill et al., 2021). The heterogenous findings do not come as a surprise, since radicalization is usually seen as a complex process with a wide range of pathways (Borum, 2012). As such, many factors do play a role in radicalization processes, for example, the presence of social adversities, availability of radical ideology, and proximity to radical political groups. In addition, radicalization is a highly dynamic process that encompasses personality changes (Bjørgo, 2011) and represents an independent source of psychological stress that must be dealt with (Koehler, 2020). Studies on the correlation of psychiatric diagnoses and extremism can neither account for the complexity nor for the dynamism of radicalization processes. It thus remains unclear, how elevated prevalence rates for psychiatric diagnoses among extremist populations are to be interpreted. Based on the available data, a causal connection of mental illness and radicalization cannot be established.

Nevertheless, psychiatric literature maintains that psychic vulnerabilities can help to explain extremism (Corner et al., 2021; Gill et al., 2021), if social and societal aspects are factored in (McCauley and Moskalenko, 2008; Simi et al., 2016; Decety et al., 2018; de Ridder et al., 2019; Gill et al., 2021; Harpviken, 2021). This is usually done by situating individual risk factors within a multilevel model that includes the social micro level (family, friends), meso level (communities, social class), and macro level (societal and political developments) (Doosje et al., 2016; Eisenman and Flavahan, 2017; Campelo et al., 2018b), often mirroring the ecological model for violence prevention by the World Health Organization (WHO, 2004).

Although, at first glance, paying closer attention to social context seems to increase the explanatory power of the model, central problems remain. Firstly, the model does not clarify how individual and social factors interact in radicalization processes (Smith et al., 2020). Instead, it is implied that individual, social, and societal risk factors just add up to an overall radicalization risk, neglecting the dynamism of radicalization processes and leaving open why, under otherwise similar conditions, some individuals develop extremist orientations and others do not.

Secondly, adding social context does not solve the initial problem plaguing the explanatory model, namely, that there is little evidence for a causal connection between psychiatric diagnoses and extremism.

The Practical Perspective: Mental Health Practices in the Context of Counterterrorism

In 2015, the United Kingdom Government revised the Prevent Strategy Policy that now requires psychiatrists among other professions to identify and report people at risk of being drawn into terrorism (HM Government., 2015; Weine et al., 2017; Chivers, 2018). Community-based programs aiming at preventing and countering violent extremism have also been launched in the United States (Ellis and Abdi, 2017). In the European Union, the Radicalization Awareness Network (RAN) encourages mental health practitioners to assess risks for radicalization (Al-Attar, 2019; RAN Practitioners., 2021a,b).

The prevention approach is often laid out within a public health framework (Bhui et al., 2012; McGilloway et al., 2015; Alcalá et al., 2017; Bhui and Jones, 2017; Bhui, 2018; Aggarwal, 2019; Weine and Kansal, 2019). Following Caplan (1964), these approaches usually make a distinction between primary, secondary, and tertiary prevention (Weine and Kansal, 2019). While primary prevention aims at anticipating radicalization processes before they occur, for example, by working with communities to increase social cohesion and access to social services (Ellis and Abdi, 2017), secondary prevention aims at identifying and intervening in radicalization processes at an early stage, and tertiary prevention seeks to rehabilitate extremists. Psychiatrists are usually asked to work in all three areas as part of a multidisciplinary team that also involves community work (Weine et al., 2017). Thus, the prevention approach contributes to an expansion of psychiatric tasks and structures.

However, the prevention approach goes beyond the public health field and is part of national security programs, some of which have already been mentioned. Within these programs, psychiatric structures are assigned the task of assessing risks for violent radicalization of patients as part of an early warning system and thereby contributing to preventing terrorist attacks (Eisenman and Flavahan, 2017; Weine et al., 2017). In some states, as Denmark for example, institutional structures have been created to coordinate collaboration between psychiatry, intelligence, police, and social work (Freestone, 2017; Sestoft et al., 2017). As such, psychiatry becomes part of a national security agenda. This point has been hotly debated among psychiatrists, especially in the UK. While some argue that psychiatrists are responsible to protect society from "violence resulting from mental illness" (Hurlow et al., 2016, p. 162) and therefore should cooperate with security agencies to prevent radicalization, many are skeptical about the scientific foundations of risk assessment procedures (Bhui, 2016; Royal College of Psychiatrists., 2016; Khoshnood, 2017) and point toward ethical issues such as negative stereotyping of Muslim communities and breaching medical confidentiality (Middleton, 2016; Summerfield, 2016).

Based on the dual perspective of public health and security agendas, practical recommendations for psychiatrists focus primarily on the question of what specific roles psychiatrists should play in P/CVE (Al-Attar, 2019; Dom et al., 2020) and how they can contribute to risk assessment (Eisenman and Flavahan, 2017; Logan and Lloyd, 2019; Bhui et al., 2020; Logan and Sellers, 2021). Several tools now exist to assist psychiatrists in risk assessment, such as Trap-18 (Meloy, 2018) and the VERA-2R (Pressman et al., 2016). The focus on safety issues and the tendency to view Muslim communities and psychiatric patients as "dangerous people" (McSherry and Patrick, 2011) has been the subject of repeated criticism (Coppock and MacGovern, 2014; Open Society Justice Initiative., 2016; Rizq, 2017; Abbas, 2019).

THE ROLE OF SOCIETY: RIGHT-WING EXTREMISM AS REACTION TO SOCIAL CONFLICT

It is widely assumed in radicalization literature that grievances within the social lifeworld of individuals work as a push factor in radicalization (Borum, 2012; Hafez and Mullins, 2015). Despite acknowledging that social factors play a role in radicalization, most studies on extremism in psychiatry still focus mainly on individual risk factors such as psychological vulnerabilities and do not go into much detail how these vulnerabilities interact with social and societal factors. In contrast, explanations developed in social research give a more nuanced account of societal developments leading to right-wing support. Although explanations differ, most of them agree on a crucial point: right-wing orientations need to be explained as a reaction to a social reality that is perceived to be in crisis.

One of the oldest explanations for right-wing extremism, the theory of the authoritarian personality developed by Adorno et al. (2019) during World War II, views right-wing extremism as an expression of a personality structure that formed in reaction to feelings of powerlessness caused by strict and punishing parents. If similar feelings of powerlessness are reexperienced later in life, for example during personal or social crises, authoritarian personalities are likely to turn toward right-wing political groups. While the original concept of authoritarianism was complemented by a social theory developed by Adorno, later social psychological reformulations, such as Right-Wing Authoritarianism (Altemeyer, 1981), pay less attention to societal conditions of authoritarianism. However, newer research again emphasizes social roots of right-wing extremist orientations by combining the concept with a theory of perceived threat (Onraet et al., 2013).

Recent social research on the popularity of the far right builds less on theories of authoritarianism and instead describes the turn to radical and extreme right-wing positions within the conceptual framework of status threat. It is an ongoing debate whether it is predominantly economic or cultural change that threatens social status. Socioeconomic explanations (Manow, 2018; Rodrik, 2018) highlight the role of economic insecurity following the transformation of economy and labor market due to globalization, while sociocultural approaches argue that a change of conventional values and norms is responsible for feelings of threat (de Wilde et al., 2019; Inglehard and Norris, 2019). Despite the differences, both explanations assume that a threat to social status drives right-wing support. Research on supporters of the German right-wing populist party Alternative für Deutschland (AfD) found that it is a combination of both socioeconomic and sociocultural threat that predicts support for the right-wing party (Lengfeld and Dilger, 2018).

Although less popular in recent years, another explanation for radicalization can be found in approaches that focus on anomie. These emphasize the dissolution of social cohesion and security following societal processes of individualization as an important factor for the development of right-wing extremist orientations (Anhut and Heitmeyer, 2009). Evidence for the anomie-theoretical explanation can also be found in the electorate of far-right parties such as the AfD. The impression of being increasingly socially isolated is widespread among AfD supporters (Müller-Hilmer and Gagné, 2018).

DISCUSSION

Even though studies report higher prevalence rates of psychiatric diagnoses among extremists, there is no clear evidence for a causal influence of mental health issues on extremism. Rather, as social research shows, right-wing extremist orientations form through a complex interaction of individual and social factors and can be understood as an attempt to come to terms with a social reality that is perceived to be in crisis. Psychiatric research into right-wing extremism should, therefore, be able take the interplay of individual and social factors within the biography of extremists into account. Against this background, current research on right-wing extremism in psychiatry has several weaknesses:

- The focus on individual risk factors found in psychiatric literature restricts the conceptual scope to psychiatric phenomena and ignores the fact that right-wing extremist orientations develop as a way to deal with social challenges. Although current approaches often propose multilevel models of radicalization that include social and societal factors, it remains unclear how individual and social factors interact in the formation of right-wing extremist orientations. Often, social aspects are conceptualized simply in terms of bad influence by peers or lack of social support that add to individual mental health risks.
- Despite little evidence for psychological causes of radicalization, psychiatric treatment is part of P/CVE programs such as the EU's Radicalization Awareness Network (Al-Attar, 2019). However, treatment recommendations often do not go beyond standard psychiatric treatment, such as medication and psychotherapy (RAN Practitioners., 2021a). That suggests that by treating mental health symptoms it is also possible to treat extremism. Moreover, the P/CVE approach also suggests that extremism is manageable through closer psychiatric screening and risk assessment, thus expanding the reach and tasks of psychiatric structures. The combination of psychiatric treatment of right-wing extremism and expansion of security policy tasks to psychiatry can be described as a form of top-down psychiatrization (Beeker et al., 2021). Top-down psychiatrization is a process driven by institutional and political agents in which an increasing number of people and areas of life become subject to psychiatric knowledge and practices.
- Difficulties and challenges for practitioners working with right-wing extremist patients have received little attention so far. Not only do right-wing extremist orientations conflict with ethical principles of the medical profession like, for example, treatment regardless of ethnicity, sexual orientation, or gender, but treatment of right-wing patients may also lead to tensions and conflicts with patients and staff who have experienced discrimination related to right-wing extremism.
- The conceptual focus in psychiatric literature lies almost exclusively on radicalization into violent extremism. As a result, radicalization processes that do not lead to violent acts do not receive sufficient attention.
- Often, right-wing extremism is subsumed under the label extremism, neglecting the specifics of right-wing extremism. Despite sharing some characteristics with, for example, Islamism, right-wing extremism develops in different social contexts and manifests in different ways (Bjørgo and Aasland, 2019).

To conclude, a research perspective is needed that can conceptually integrate psychological and social factors so that right-wing extremism becomes visible as a relationship persons form toward their social environment. Research should also be able to grasp the specifics of right-wing extremism in its violent as well as non-violent forms. Conceptually, a promising starting point can be found, for example, in the concept of orientation as it was developed within the German research on right-wing extremism among youth in the 1990's (Held et al., 1996; Marvakis, 1996, 2020). That approach understands right-wing extremism as an orientation aid for leading one's life in a complex and challenging social environment.

Since the trajectories into right-wing extremism are diverse, a qualitative methodology would be best suited to explore the interplay of individual, social, and societal aspects within the biography of right-wing extremists. If it is better understood how right-wing orientations develop during life course, it should be possible to work out if and how these orientations relate to psychiatric diagnoses and whether treatments are needed that take the specifics of right-wing orientations into account. The few studies that exist on therapeutic work with right-wing extremist patients understand right-wing extremism primarily as affinity toward violence (Ebrecht-Laermann et al., 2017; Hardtmann, 2017; Henkel et al., 2019). Instead, a broader scope that also includes right-wing extremism as an ideological orientation is needed. In this context, approaches from psychoanalytic social psychology, which emphasize the importance of far-right ideology for maintaining a psychological balance may be helpful (Busch et al., 2016; Lohl, 2021).

However, shifting the focus of research from psychological risk factors to processes of orientation in social contexts does not mean that psychiatry would not benefit from a better understanding of right-wing extremism. But instead of trying to cure right-wing extremism by psychiatric means, psychiatry needs to concentrate on the practical challenges of working with persons belonging to the far-right political spectrum. Research-based concepts and appropriately trained personnel are needed to deal professionally with these challenges. Understanding the limitations of psychiatry in this manner can potentially contribute to an effective and just use of resources in psychiatric institutions.

DATA AVAILABILITY STATEMENT

The original contributions presented in the study are included in the article, further inquiries can be directed to the corresponding author.

AUTHOR CONTRIBUTIONS

FS and PB developed the initial idea for the article, conducted literature search, and interpreted literature. FS wrote the first draft. All authors contributed to preparing the final version of the manuscript, approve the final version to be published, and agree to be accountable for all aspects of the work.

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REFERENCES

Abbas, M. S. (2019). Producing internal suspect bodies: divisive effects of UK counter-terrorism measures on Muslim communities in Leeds and Bradford. *Br. J. Sociol* 70, 261–282. doi: 10.1111/1468-4446.12366

Adorno, T. W., Frenkel-Brunswik, E., Levinson, D. J., and Sanford, R. N. (2019). *The Authoritarian Personality*. New York: Verso.

Aggarwal, N. K. (2019). Questioning the current public health approach to countering violent extremism. *Glob. Public Health* 14, 309–317. doi: 10.1080/17441692.2018.1474936

Al-Attar, Z. (2019). *Extremism, Radicalisation and Mental Health: Handbook for Practitioners*. Available online at: https://ec.europa.eu/home-affairs/system/files/2019-11/ran_h-sc_handbook-for-practitioners_extremism-radicalisation-mental-health_112019_en.pdf (accessed November 28, 2021).

Alcalá, H. E., Sharif, M. Z., and Samari, G. (2017). Social determinants of health, violent radicalization, and terrorism: a public health perspective. *Health Equity* 1, 87–95. doi: 10.1089/heq.2016.0016

Altemeyer, B. (1981). *Right-Wing Authoritarianism*. Winnipeg: University of Manitoba Press.

Anhut, R., and Heitmeyer, W. (2009). "Desintegration, Anerkennungsbilanzen und die Rolle sozialer Vergleichsprozesse für unterschiedliche Verarbeitungsmuster," in *Neuer Mensch und kollektive Identität in der Kommunikationsgesellschaft*, ed. P. Gerhard (Wiesbaden: VS Verlag für Sozialwissenschaften), 212–236.

Baron, S. W. (1997). Canadian male street skinheads: street gang or street terrorists? *Can. Rev. Sociol.* 34, 125–154. doi: 10.1111/j.1755-618X.1997.tb00204.x

Beeker, T., Mills, C., Bhugra, D., te Meerman, S., Thoma, S., Heinze, M., et al. (2021). Psychiatrization of society: a conceptual framework and call for transdisciplinary research. *Front. Psychiatry* 12:859. doi: 10.3389/fpsyt.2021.645556

Bhui, K. (2016). Flash, the emperor and policies without evidence: counter-terrorism measures destined for failure and societally divisive. *BJPsych Bull*. 40, 82–84. doi: 10.1192/pb.bp.116.053603

Bhui, K. (2018). Radicalisation and mental health. *Nord. J. Psychiatry* 72, 16–19. doi: 10.1080/08039488.2018.1525640

Bhui, K., Everitt, B., and Jones, E. (2014). Might depression, psychosocial adversity, and limited social assets explain vulnerability to and resistance against violent radicalisation? *PLoS ONE* 9:9. doi: 10.1371/journal.pone.0105918

Bhui, K., and Jones, E. (2017). The challenge of radicalisation: a public health approach to understanding and intervention. *Psychoanal. Psychother.* 31, 401–410. doi: 10.1080/02668734.2017.1354908

Bhui, K., Otis, M., Halvorsrud, K., Freestone, M., and Jones, E. (2020). Assessing risks of violent extremism in depressive disorders: developing and validating a new measure of sympathies for violent protest and terrorism. *Aust. N. Z. J. Psychiatry* 54, 1078–1085. doi: 10.1177/0004867420944520

Bhui, K. S., Hicks, M. H., Lashley, M., and Jones, E. (2012). A public health approach to understanding and preventing violent radicalization. *BMC Med.* 10, 16. doi: 10.1186/1741-7015-10-16

Bjørgo, T. (2011). Dreams and disillusionment: engagement in and disengagement from militant extremist groups. *Crime Law Soc. Chang.* 55, 277–285. doi: 10.1007/s10611-011-9282-9

Bjørgo, T., and Aasland, R. (2019). *Extreme-Right Violence and Terrorism: Concepts, Patterns, and Responses*. Available online at: https://icct.nl/app/uploads/2019/09/Extreme-Right-Violence-and-Terrorism-Concepts-Patterns-and-Responses-4.pdf (accessed November 28, 2021).

Borum, R. (2012). Radicalization into violent extremism II: a review of conceptual models and empirical research. *J. Strateg. Secur.* 4, 37–62. doi: 10.5038/1944-0472.4.4.2

Busch, C., Gehrlein, M., and Uhlig, T.D. (2016). *Schiefheilungen. Zeitgenössische Betrachtung über Antisemitismus*. Wiesbaden: Springer.

Campelo, N., Bouzar, L., Oppetit, A., Pellerin, H., Hefez, S., Bronsard, G., et al. (2018a). Joining the Islamic State from France between 2014 and 2016: an observational follow-up study. *Palgrave Commun.* 4:137. doi: 10.1057/s41599-018-0191-8

Campelo, N., Oppetit, A., Neau, F., Cohen, D., and Bronsard, G. (2018b). Who are the European youths willing to engage in radicalisation? a multidisciplinary review of their psychological and social profiles. *Eur. Psychiatry* 52, 1–14. doi: 10.1016/j.eurpsy.2018.03.001

Caplan, G. (1964). *Principles of Preventive Psychiatry*. New York, NY: Basic Books.

Chivers, C. (2018). What is the headspace they are in when they are making those referrals? Exploring the lifeworlds and experiences of health and social care practitioners undertaking risk work within the Prevent Strategy. *Health Risk Soc.* 20, 81–103. doi: 10.1080/13698575.2018.1437121

Coid, J. W., Bhui, K., MacManus, D., Kallis, C., Bebbington, P., and Ullrich, S. (2016). Extremism, religion and psychiatric morbidity in a population-based sample of young men. *BJPsych.* 209, 491–497. doi: 10.1192/bjp.bp.116.186510

Cooper, H. H. A. (1978). Psychopath as terrorist. *MLegal Medical Quarterly* 2, 253–262.

Coppock, V., and MacGovern, M. (2014). Dangerous minds? deconstructing counter-terrorism discourse, radicalisation and the 'psychological vulnerability' of muslim children and young people in britain. *Child. Soc.* 28, 242–256. doi: 10.1111/chso.12060

Corner, E., and Gill, P. (2015). A false dichotomy? Mental illness and lone-actor terrorism. *Law Hum. Behav.* 39, 23–34. doi: 10.1037/lhb0000102

Corner, E., Gill, P., and Mason, O. (2016). Mental health disorders and the terrorist: a research note probing selection effects and disorder prevalence. *Stud. Confl. Terror.* 39, 560–568. doi: 10.1080/1057610X.2015.1120099

Corner, E., Taylor, H., Van der Vegt, I., Salman, N., Rottweiler, B., Hetzel, F., et al. (2021). Reviewing the links between violent extremism and personality, personality disorders, and psychopathy. *J. Forens. Psychiatry Psychol.* 32, 378–407. doi: 10.1080/14789949.2021.1884736

de Ridder, B., Fassaert, T., and Grimbergen, C. (2019). Radicalisering en psychiatrie: pleidooi voor een brede blik. *Tijdschr. Psychiatr*. 61, 554–562. Available online at: https://www.tijdschriftvoorpsychiatrie.nl/assets/articles/61-2019-8-artikel-deridder.pdf (accessed April 26, 2022).

de Wilde, P., Koopmans, R., Merkel, W., Strijbis, O., and Zürn, M. (2019). *The Struggle Over Borders: Cosmopolitanism and Communitarianism*. Cambridge: Cambridge University Press.

Decety, J., Pape, R., and Workman, C. I. (2018). A multilevel social neuroscience perspective on radicalization and terrorism. *Soc Neurosci.* 13, 511–529. doi: 10.1080/17470919.2017.1400462

DeFoster, R., and Swalve, N. (2018). Guns, culture or mental health? Framing mass shootings as a public health crisis. *Health Commun.* 33, 1211–1222. doi: 10.1080/10410236.2017.1350907

Dom, G., Schouler-Ocak, M., Bhui, K., Demunter, H., Kuey, L., Raballo, A., et al. (2020). Mass violence, radicalization and terrorism: a role for psychiatric profession? *Eur. Psychiatry.* 49, 78–80. doi: 10.1016/j.eurpsy.2018.01.001

Doosje, B., Moghaddam, F. M., Kruglanski, A. W., de Wolf, A., Mann, L., and Feddes, A. R. (2016). Terrorism, radicalization and de-radicalization. *Curr. Opin. Psychol.* 11, 79–84. doi: 10.1016/j.copsyc.2016.06.008

Ebrecht-Laermann, A., Bialluch, C., and Sischka, K. (2017). "Analyse im Extrem. Transgressive Dynamiken in der Arbeit mit Menschen aus rechtsextremen und salafistischen Milieus," in *Grenzen*, eds. B. Unruh, I. Moeslein-Teising, and S. Walz-Pawlita. (Gießen: Psychosozial) 250–258.

Eisenman, D. P., and Flavahan, L. (2017). Canaries in the coal mine: interpersonal violence, gang violence, and violent extremism through a public health prevention lens. *Int. Rev. Psychiatry* 29, 341–349. doi: 10.1080/09540261.2017.1343527

Ellis, B. H., and Abdi, S. (2017). Building community resilience to violent extremism through genuine partnerships. *Am. Psychol.* 72, 289–300. doi: 10.1037/amp0000065

Freestone, M. (2017). Personality, identity, risk and radicalisation. *Int. Rev. Psychiatry* 29, 310–312. doi: 10.1080/09540261.2017.1344395

Gill, P., Clemmow, C., Hetzel, F., Rottweiler, B., Salman, N., Van der Vegt, I., et al. (2021). Systematic review of mental health problems and violent extremism. *J. Forens. Psychiatry Psychol.* 32, 51–78. doi: 10.1080/14789949.2020.1820067

Gill, P., and Corner, E. (2017). There and back again: the study of mental disorder and terrorist involvement. *Am. Psychol.* 72, 231–241. doi: 10.1037/amp0000090

Gilman, S. J., and Thomas, J. M. (2016). *Are Racists Crazy? How Prejudice, Racism, and Antisemitism Became Markers of Insanity.* New York: NYU Press.

Gruenewald, J., Chermak, S., and Freilich, J. D. (2013). Distinguishing "loner" attacks from other domestic extremist violence. *Criminol. Public Policy* 12, 65–91. doi: 10.1111/1745-9133.12008

Hafez, M., and Mullins, C. (2015). The radicalization puzzle: a theoretical synthesis of empirical approaches to homegrown extremism. *Stud. Confl. Terror.* 38, 958–975. doi: 10.1080/1057610X.2015.1051375

Hardtmann, G. (2017). ""Wer hier etwas gegen meinen Großvater sagt, den bringe ich um...". Gespräche mit rechtsradikalen Jugendlichen aus psychoanalytischer Perspektive," *in Aggression, Gewalt und Radikalisierung. Psychodynamisches Verständnis und therapeutisches Arbeiten mit Kindern und Jugendlichen,* ed. B. Traxl. (Frankfurt a. M.: Brandes and Apsel) 191–218.

Harpviken, A. N. (2021). Psychological vulnerabilities and extremism among Norwegian youth: a structural equation model using a large-n sample. *Peace. Confl.* 27, 212–224. doi: 10.1037/pac0000562

Held, J., Horn, H.-W., and Marvakis, A. (1996). *Gespaltene Jugend. Politische Orientierungen jugendlicher ArbeitnehmerInnen*. Opladen: Leske/Budrich.

Henkel, M., Michel, S., Gaubatz, S., Keymer, A., Brakemeier, E.-L., and Benecke, C. (2019). Schwierige situationen in der psychotherapie und wie therapeuten mit ihnen umgehen. *Z. Psychosom. Med. Psychother.* 65, 372–383. doi: 10.13109/zptm.2019.65.4.372

HM Government. (2015). *Revised Prevent Duty Guidance for England and Wales.* Available online at: https://www.gov.uk/government/publications/prevent-duty-guidance/revised-prevent-duty-guidance-for-england-and-wales (accessed February 21, 2022).

Hurlow, J., Wilson, S., and James, D. V. (2016). Protesting loudly about prevent is popular but is it informed and sensible? *BJPsych Bulletin* 40, 162–163. doi: 10.1192/pb.40.3.162

Inglehard, R., and Norris, P. (2019). *Cultural Backlash. Trump, Brexit, and Authoritarian Populism.* Cambridge: Cambridge University Press.

Khoshnood, A. (2017). The correlation between mental disorders and terrorism is weak. *BJPsych Bulletin* 41, 56–56. doi: 10.1192/pb.41.1.56

Koehler, D. (2020). Violent extremism, mental health and substance abuse among adolescents: towards a trauma psychological perspective on violent radicalization and deradicalization. *J. Forens. Psychiatry Psychol*. 31, 455–472. doi: 10.1080/14789949.2020.1758752

Lengfeld, H., and Dilger, C. (2018). Kulturelle und ökonomische Bedrohung. Eine Analyse der Ursachen der Parteiidentifikation mit der "Alternative für Deutschland" mit dem Sozio-oekonomischen Panel 2016. *Zeitschrift für Soziologie* 47, 181–199. doi: 10.1515/zfsoz-2018-1012

Logan, C., and Lloyd, M. (2019). Violent extremism: a comparison of approaches to assessing and managing risk. *Legal Criminol. Psychol.* 24, 141–161. doi: 10.1111/lcrp.12140

Logan, C., and Sellers, R. (2021). Risk assessment and management in violent extremism: a primer for mental health practitioners. *J. Forens. Psychiatry Psychol.* 32, 355–377. doi: 10.1080/14789949.2020.1859591

Lohl, J. (2021). "Über den Abgrund": Tiefenhermeneutische Analysen rechter Sozialisationsprozesse. *Sozialer Sinn* 22, 25–48. doi: 10.1515/sosi-2021-0003

Manow, P. (2018). *Die politische Ökonomie des Populismus.* Berlin: Suhrkamp.

Marvakis, A. (1996). *Orientierung und Gesellschaft. Gesellschaftstheoretische und individuelwissenschaftliche Grundlagen politischer Orientierungen Jugendlicher in Strukturen sozialer Ungleichheit.* Frankfurt: Peter Lang.

Marvakis, A. (2020). "Nationalism and/or Developing Understanding of Society?," in *Cultural-Historical and Critical Psychology: Common Ground, Divergences and Future Pathways*, eds. M. Fleer, F. González Rey, and P.E. Jones. (Singapore: Springer Singapore), 155–171.

McCauley, C., and Moskalenko, S. (2008). Mechanisms of political radicalization: pathways toward terrorism. *Terror. Polit. Violenc.* 20, 415–433. doi: 10.1080/09546550802073367

McGilloway, A., Ghosh, P., and Bhui, K. (2015). A systematic review of pathways to and processes associated with radicalization and extremism amongst Muslims in Western societies. *Int. Rev. Psychiatry* 27, 39–50. doi: 10.3109/09540261.2014.992008

McSherry, B., and Patrick, K. (2011). *Dangerous people. Policy, Prediction, and Practice.* New York, NY: Routledge.

Meloy, J. R. (2018). The Operational development and empirical testing of the terrorist radicalization assessment protocol (TRAP−18). *J. Pers. Assess.* 100, 483–492. doi: 10.1080/00223891.2018.1481077

Middleton, J. (2016). Preventing violent extremism: the role of doctors. *Lancet* 388, 2219–2221. doi: 10.1016/S0140-6736(16)31902-X

Morris, A., and Meloy, J. R. (2020). A preliminary report of psychiatric diagnoses in a scottish county sample of persons of national security concern. J. *Forensic Sci.* 65, 1638–1645. doi: 10.1111/1556-4029.14471

Mudde, C. (2019). *The Far Right Today*. Cambridge: Polity Press.

Müller-Hilmer, R., and Gagné, J. (2018). "Was verbindet, was trennt die Deutschen? Werte und Konfliktlinien in der deutschen Wählerschaft im Jahr 2017", in: *Forschungsförderungs report Nr. 2.* Available online at: https://www.boeckler.de/fpdf/HBS-006793/p_fofoe_report_002_2018.pdf (accessed April 26, 2022).

Onraet, E., Van Hiel, A., Dhont, K., and Pattyn, S. (2013). Internal and external threat in relationship with right-wing attitudes. *J. Pers.* 81, 233–248. doi: 10.1111/jopy.12011

Open Society Justice Initiative. (2016). *Eroding Trust The UK's Prevent Counter-Extremism Strategy in Health and Education. New* York, NY: Open Society Foundations.

Pressman, E., Duits, N., Rinne, T., and Flockton, J. (2016). *VERA-2R Violent Extremism Risk Assessment Version 2 Revised: A Structured Professional Judgement Approach.* Utrecht: N. I. F. P./D. J. I.

RAN Practitioners. (2021a). *Conclusion Paper: Mental Health Practices and Interventions in P/CVE*. Available online at: https://ec.europa.eu/home-affairs/document/download/ac5728a7-ac30-45dc-b823-4f5fcf7acc9c_en (accessed November 28, 2021).

RAN Practitioners. (2021b). *RAN Activities on Mental Health*. Available online at: https://ec.europa.eu/home-affairs/networks/radicalisation-awareness-network-ran/topics-and-working-groups/ran-mental-health-working-group-ran-health_en (accessed November 28, 2021).

Rizq, R. (2017). 'Pre-crime', prevent, and practices of exceptionalism: psychotherapy and the new norm in the NHS. *Psychodyn. Pract.* 23, 336–356. doi: 10.1080/14753634.2017.1365005

Rodrik, D. (2018). Populism and the Economics of Globalization. *J Int Busin Pol.* 1, 12–33. doi: 10.1057/s42214-018-0001-4

Rousseau, C., Hassan, G., Miconi, D., Lecompte, V., Mekki-Berrada, A., El Hage, H., et al. (2019). From social adversity to sympathy for violent radicalization:

the role of depression, religiosity and social support. *Arch. Public Health* 77, 45. doi: 10.1186/s13690-019-0372-y

Royal College of Psychiatrists. (2016). *Counter-Terrorism and Psychiatry. Position Statement PS04/16*. Available online at: https://www.rcpsych.ac.uk/pdf/PS04_16.pdf (accessed February 18, 2022).

Sestoft, D., Hansen, S. M., and Christensen, D. M. (2017). The police, social services, and psychiatry (PSP) cooperation as a platform for dealing with concerns of radicalization. *Int. Rev. Psychiatry* 29, 350–354. doi: 10.1080/09540261.2017.1343526

Simi, P., Sporer, K., and Bubolz, B. F. (2016). Narratives of childhood adversity and adolescent misconduct as precursors to violent extremism: a life-course criminological approach. *J. Res. Crime Delinquency* 53, 536–563. doi: 10.1177/0022427815627312

Smith, L. G. E., Blackwood, L., and Thomas, E. F. (2020). The need to refocus on the group as the site of radicalization. *Perspect. Psychol. Sci.* 15, 327–352. doi: 10.1177/1745691619885870

Summerfield, D. (2016). Mandating doctors to attend counter-terrorism workshops is medically unethical. *BJPsych Bull* 40, 87–88. doi: 10.1192/pb.bp.115.053173

Tanay, E. (1987). Pseudo-Political Terrorism. *J. Forensic Sci.* 32, 192–200. doi: 10.1520/JFS12342J

Trimbur, M., Amad, A., Horn, M., Thomas, P., and Fovet, T. (2021). Are radicalization and terrorism associated with psychiatric disorders? A systematic review. *J. Psychiatr. Res.* 141, 214–222. doi: 10.1016/j.jpsychires.2021.07.002

Victoroff, J. (2005). The mind of the terrorist: a review and critique of psychological approaches. *J. Conflict. Resolut.* 49, 3–42. doi: 10.1177/0022002704272040

Weenink, A. W. (2019). Adversity, criminality, and mental health problems in jihadis in dutch police files. *Perspect. Terror.* 13, 130–142. Available online at: https://www.universiteitleiden.nl/binaries/content/assets/customsites/perspectives-on-terrorism/2019/issue-5/9--weenink.pdf (accessed April 26, 2022).

Weine, S., Eisenman, D. P., Jackson, L. T., Kinsler, J., and Polutnik, C. (2017). Utilizing mental health professionals to help prevent the next attacks. *Int. Rev. Psychiatry* 29, 334–340. doi: 10.1080/09540261.2017.1343533

Weine, S., and Kansal, S. (2019). What should global mental health do about violent extremism? *Glob Ment Health* 6, e14. doi: 10.1017/gmh.2019.12

WHO (2004). *Preventing violence: a guide to implementing the recommendations of the World Report on Violence and Health.* Available online at: https://apps.who.int/iris/bitstream/handle/10665/43014/9241592079.pdf;sequence=1 (accessed November 5, 2021).

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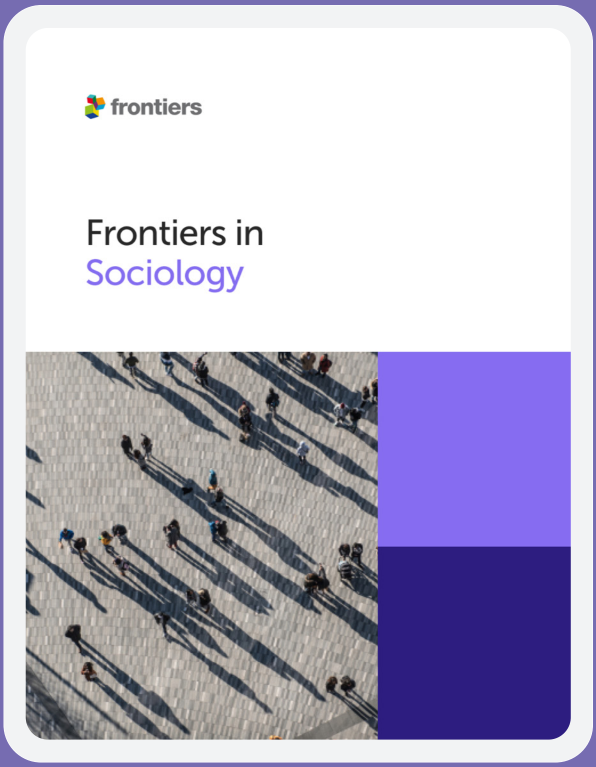

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