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# Diagnostic Cultures

A Cultural Approach to the Pathologization  
of Modern Life

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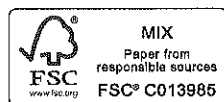
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nominalism), and then I argue that the concept of mental disorder or illness is not held together by necessary and sufficient conditions, but by what Wittgenstein called family resemblance. Following from this, the chapter moves on to articulate an approach to the idea of mental disorder from a cultural psychological perspective. It is argued that cultural psychology has the potential to develop a comprehensive understanding of mental disorder that combines awareness of the brain and body with sociocultural norms and practices without reducing mental disorder to either of these. In that sense, it may steer a course between essentialist models of psychopathology on the one hand, and radical social constructionist ones on the other, in particular by putting the *person* (and not the brain or mind) at the centre of the theory. ADHD in adults is again referred to as an illustrative example, but the theory presented here has more general ambitions.

The final chapter sums up and looks to the future: Are we approaching the end of pathologization, becoming unable to locate further areas of pathology in diagnostic cultures, or will the future (with increasing uses of brain scans and genetic tests) only expand the diagnostic cultures further – even diagnosing before the symptoms appear, on the basis of risk calculations and genetic vulnerabilities?

## Introducing the Concept of Diagnostic Cultures

This chapter has two main purposes: first, I shall introduce the very idea of diagnostic cultures, which will be analyzed throughout the book, and second, I shall articulate the theoretical approach that will be used to analyze the phenomenon of diagnostic cultures. This approach is cultural psychology.

### Living in Diagnostic Cultures

In one way, it should be quite easy to pinpoint the phenomenon of diagnostic cultures, because we (and when talking about “we”, I include everyone in the imagined hemisphere we call the West, but also elsewhere on the planet) live in and with these cultures in almost every arena of social life, whenever people experience problems or act in ways that are considered deviant. Formal psychiatric diagnoses are not as old as one might think. The first edition of the diagnostic manual published by the American Psychiatric Association, called the DSM,<sup>1</sup> appeared as late as 1952, and although diagnostic terms were of course used before this time, it was only from the second half of the 20th century that psychiatric diagnoses really spread from practices in clinics and hospitals to schools, welfare organizations, and families. Today, most of us can use diagnostic terms such as depression, anxiety, bipolar, ADHD, PTSD and OCD, and also semi-diagnoses such as stress, when we talk about the problems that we or our children face in everyday life. We read self-help books about how to manage various psychological afflictions that can perhaps be diagnosed, and consume novels and television series (e.g. *The Sopranos*) in which the heroes or villains suffer from diagnosable mental disorders. When we open our newspapers, we are routinely confronted with frightening statistics that tell us, for example, that the WHO expects that depression will become the second leading cause of global disability by 2020; we learn that up to one quarter of the population is mentally ill within any one year; and we witness how pharmaceuticals against symptoms of depression, anxiety and ADHD are prescribed to more and more people – children and adults alike. Even in Denmark – allegedly the happiest nation in the world – more than eight per cent of the population consumes antidepressants, and for some age cohorts (especially older people), the number is dramatically higher.

<sup>1</sup> The Diagnostic and Statistical Manual of Mental Disorders.

In what I call diagnostic cultures, psychiatric diagnoses are used by health professionals and lay people for many different purposes. Psychiatric terminology has been democratized and has travelled from the clinics and medical textbooks into popular culture (witness the example in Box 1.1).

### Box 1.1 Mad or Normal? Psychiatric diagnoses as entertainment

In 2012 the national Danish Broadcasting Company aired the documentary “Mad or Normal?”<sup>2</sup> The idea was to challenge people’s biases about the mentally ill by showing that they are in most respects “just like you and me”. The show was run in an entertaining way, somewhat like a quiz, and hosted by a famous Danish “TV doctor”: three experts (one psychiatrist, one psychologist and one psychiatric nurse) were confronted with a group of ten people they had not met before, and five of these people had different psychiatric diagnoses (schizophrenia, eating disorder, OCD, social phobia and bipolar depression). Through the episodes, the experts were supposed to match the diagnoses with five of the participants. The viewers could also participate by voting on the internet, trying to guess which of the participants were mentally ill. In order to help the experts and also the viewers in this guessing game, the participants had to go through a number of trials that were supposed to provide clues as to who were ill and who were well. For example, they had to perform stand-up comedy in front of a live audience (the idea being that this would be difficult for someone with social phobia), and do a farm animal clean up task (possibly revealing the OCD sufferer). But in fact – and seemingly in line with the programme’s intentions – the experts could *not* guess who were ill, or which diagnoses belonged with whom. And the viewers were also quite poor at the guessing game.

What does a show like this tell us about diagnostic cultures and our complex attitudes to mental illness today? Initially, it can be observed that a show like this would have been quite unthinkable (at least in Denmark) just a few years ago. Psychiatric diagnoses were not publicly visible and would not be the centre of attention in a popular entertainment show on television. Superficially at least, this indicates that psychiatric problems are no longer taboo to the same extent and that stigmatization due to diagnoses has decreased. Furthermore, and in rather more subtle ways, the show points to a number of paradoxes inherent in the logics of the diagnostic cultures of the 21st century. For example, one powerful discourse, which is also mobilized in the television show, claims that

2 The show was a Danish adaptation of the BBC programme *How mad are you?* (See Progler, 2009, for a brief description and analysis from a medical science perspective.) Information on the Danish version can be found at: <http://www.dr.dk/sundhed/Sygdom/Psykiatri/Psykiatri.htm>.

psychiatric problems are illnesses: “just like somatic illnesses”, as it is often said. In principle, there are no differences between somatic and psychiatric problems, and the two ought to be equal in the health care systems of the welfare state.<sup>3</sup> At the same time, the underlying logic of the show seems to go against this discourse of “illness equality”. This can be seen if one imagines a similar show with people suffering from somatic illnesses. Would such a show be aired, with the participants having to go through trials that would bring forth their symptoms? This is very unlikely. Think of people with osteoporosis being forced to play hockey, for example, or diabetes patients eating loads of sweets. For some reason, it did not lead to public outcry (in fact quite the opposite) that people with mental disorders engaged in activities that were meant to disclose their illnesses. This reveals the contradictory understandings of psychiatric problems that we have in our diagnostic cultures: on the one hand, they are “just like somatic illnesses”, but, on the other, they are clearly implicitly thought of as something else.

Related to this point, it was noteworthy that the people with diagnoses in the programme were said to be “not ill” at the time when the show was made. For ethical reasons it seems reasonable, of course, to only enrol people who are not overly vulnerable, and as a form of protection against the tests in the show, but, given this, it is hardly surprising that the experts and viewers were unable to guess who were suffering from the various mental disorders. Also in the book, which accompanied the television show, we hear that Kirstine (diagnosed with OCD) “is now cured”, and she refers to her remaining problems as “bad habits, which everybody has” (Kyhn, 2012, p. 46). Again, to compare with somatic illness: if someone had once suffered a fracture, or had once had a tumour, but had since been cured, then no one would ever expect that people (not even experts) could come up with accurate guesses regarding these matters. So, although the programme meant to transmit the message that “they” are “just like us”, it paradoxically came to implicitly conclude that “once a psychiatric patient, always a psychiatric patient” – even if the symptoms have disappeared. The premise of the show was that it should be possible to guess the disorders even though the (former) patients were now symptom free, so, contrary to its surely good intentions, the show came to reinforce a discourse of chronicity concerning psychiatric problems. Again, we see the contradictory logics operating in diagnostic cultures: on the one hand, we define and identify mental disorders on the basis of symptoms (which is something I shall return to a number of times in this book), but, on the

3 Recently, in Denmark, a “diagnosis guarantee” has been established, which means that patients have the right to obtain a diagnosis within one month of contacting the medical system. At first this guarantee did not pertain to psychiatric diagnoses, but this has now been changed, so that all kinds of health problems are put on an equal footing.

other, we hold the belief that such disorders may somehow persist even in the absence of manifest symptoms.

A couple of years later, in 2014, the show was followed up with two new episodes called “Mad or Normal? At the Job Interview” and, instead of mental health experts, three business managers were confronted with disguised psychiatric patients in a group of job applicants, and asked whom among the participants they would be interested in offering a job. Interestingly, the managers were very positive toward many of the people with diagnoses, and the “winner” was in fact a psychiatric patient. This second series, now thematizing psychiatric diagnoses and work life, demonstrates yet another paradoxical aspect of our diagnostic cultures: On the one hand, it is surely very positive that people who are diagnosed are considered “one of us” (which was the name of the accompanying national campaign to raise awareness about psychiatric disorders) to the extent that experts and business leaders cannot recognize them in a group of people. This can be seen as a demonstration that “they” *are* indeed “like us”. However, they are still “they”, and paradoxically identified as excluded through the diagnostic label. On the other hand, the argument or demonstration of just-like-us-ness can quickly be turned on its head to become a demonstration that if they are “just like us”, then why do they need special welfare benefits, pensions and other societally sanctioned advantages? The accompanying book asks the question directly: “If the three experts in the program are incapable of guessing who among the ten participants suffer from which disorders, then how on earth should the rest of us be capable of guessing it?” (Kyhn, 2012, p. 9). It might be a good thing in an ethical sense that viewers discover that psychiatric patients are nice people without dramatic problems, but the downside is that it might at the same time become difficult for patients to explain their sufferings and legitimize their need for help. This illustrates a broader dilemma concerning psychiatric diagnoses that will surface in various ways in this book: diagnoses may on the one hand be stigmatizing and pathologizing (and thus something one might wish to avoid), but, on the other hand, the labelling they provide can bring certain advantages in the diagnostic cultures of welfare states, which explains why some people actively seek to be diagnosed.

Box 1.1 is about psychiatric diagnoses as entertainment, or perhaps more accurately, “edutainment” aired on a respected public service television channel in Denmark, and it is meant to illustrate some of the ways in which diagnoses are conceived in contemporary society. From this little example, we have seen that a number of paradoxes are likely to emerge when dealing with psychiatric diagnoses today: (1) Through diagnoses, psychiatric problems are addressed as medical problems – and yet they are not just that; (2) Through diagnoses, psychiatric problems are equated with manifest and sometimes transient symptoms – and yet diagnoses have a tendency to reinforce chronicity; (3) Through diagnoses, psychiatric problems

appear as “nothing special”, because many of us could be diagnosed at any given point in time – and yet normalizing the disorders may cause problems for people if this means that their problems cannot be recognized as sufficiently serious. There are indeed many paradoxes inherent in the logics of diagnostic cultures, which in itself might add to the suffering felt by those who live in these cultures and are diagnosed. Unsurprising, it is easier to explain one’s problem to oneself and others if it can be physically observed like a fracture or a tumour.

### Expanding Diagnostics

The term “diagnostic cultures” is meant to point to the spread of diagnostic vocabulary and associated social practices to new areas of sociocultural life. But it is also meant to designate more concretely the increasing number of people, who are “living under the description” of a diagnosis (Martin, 2007). Today, we witness a diagnostic expansion in (at least) two ways: In many countries, more and more people receive a psychiatric diagnosis, and new diagnoses are continuously fabricated and suggested, some of which end up entering the official manuals (ICD and DSM), while others stay on the fringes of medical practice. In 1952, when DSM-I appeared, there were 106 diagnostic categories in a manual of 130 pages. In 1994, with DSM-IV, the number of diagnoses had increased to 297 in a manual of 886 pages (Williams, 2009). And now that DSM-5<sup>4</sup> has been published, we see 15 new diagnoses (including hoarding and cannabis withdrawal), and elimination of a few others (most remarkably Asperger’s Syndrome). The number of official diagnoses thus increased dramatically in the latter half of the 20th century, but seems now to be slowing down.

In spite of the different changes, Rachel Cooper concludes in her recent book on DSM-5: “The most striking thing about the DSM-5 is how very similar it is to the DSM-IV” (Cooper, 2014, p. 60). This is particularly striking in light of the huge efforts that were put in to discussing and reconstructing the diagnostic system. Originally, the ambition while developing DSM-5 had been to instigate a paradigm shift equivalent to that which occurred in the transition from DSM-II to DSM-III in 1980. The transition in 1980 had implied a change from an etiological approach to diagnosis, with the doctor employing a holistic approach that took the patient’s entire biography into account, based in large parts on psychoanalytic theory, to a purely symptom-based approach to diagnosis in DSM-III. Horwitz has simply referred to this transition as one in which etiological psychiatry was replaced by “diagnostic psychiatry” (Horwitz, 2002). After DSM-III a diagnosis was (and is still) made by counting symptoms within a given period of time (e.g. two weeks). The change to DSM-5 was thought to imply a similar shift, only this time away from a categorical approach, where

4 Note the change to Arabic numerals, which is thought to facilitate the creation of more editions of the manuals in the future, e.g. DSM-5.1, DSM-5.2 etc.



one either has or does not have a mental disorder based on the number and severity of symptoms, to a dimensional approach, where everyone can be placed somewhere on the continua. But the efforts to construct a dimensional system failed, and instead the chapters of the manual were reorganized. The similarity of the two editions of DSM – number IV and number 5 – means that many of the criticisms that were raised in response to DSM-IV (e.g. by Kutchins & Kirk, 1997) still pertain to DSM-5, and ironically are now voiced by people such as Allen Frances who were centrally placed when DSM-IV was created (Frances, 2013). (Frances was the chair of the DSM-IV task force.)

In addition to the rise in the number of people diagnosed, and also in the number of diagnoses that it is possible to give, there is according to some studies a third kind of rise, *viz.* in the number of people who *ought* to be given a psychiatric diagnosis, but who are currently not diagnosed. This is the problem of under-diagnosis, which co-exists with claims about over-diagnosis. Strictly speaking, these two tendencies can logically occur simultaneously if it is the case that ill people are *not* diagnosed and well people *are* diagnosed. The difference between the number of people who are diagnosed, and the number of people who *ought* to be diagnosed, is called the treatment gap, because a psychiatric diagnosis is in many societal contexts the obligatory passage point to treatment. According to authoritative estimates, the treatment gap for most mental disorders is more than 50 per cent (and for some, such as substance abuse, considerably higher), which means that more than half of those suffering from a mental disorder are not treated (Kohn, Saxena, Levav & Saraceno, 2004). References to the treatment gap can be used by patient organizations, researchers, professionals, and the medical industry to support the view that “more needs to be done” in finding and treating the mentally ill among us. The diagnoses are here central, because they define what mental illness is and how it should be found.

A good example of the discourse of expanding diagnostics can be found on the webpage of the World Health Organization,<sup>5</sup> which states the following:

Lifetime prevalence rates for any kind of psychological disorder are higher than previously thought, are increasing in recent cohorts and affect nearly half the population.

Despite being common, mental illness is underdiagnosed by doctors. Less than half of those who meet diagnostic criteria for psychological disorders are identified by doctors.

Patients, too, appear reluctant to seek professional help. Only 2 in every 5 people experiencing a mood, anxiety or substance use disorder seeking (*sic*) assistance in the year of the onset of the disorder.

This is indeed a very dramatic message: the prevalence rates for *any* psychological disorder are higher than we thought and are rising – now affecting nearly half of us

5 [http://www.who.int/mental\\_health/prevention/genderwomen/en/](http://www.who.int/mental_health/prevention/genderwomen/en/)

around the world! The disorders are underdiagnosed (cf. the treatment gap), in part because people do not seek help when they suffer. Seemingly, the prevalence rates are taken at face value, and the WHO does not even consider that one reason why people do not seek help can be because they do not feel they have a psychiatric problem – even when their problem meets the diagnostic criteria for a mental disorder. Needless to say, it can also be the case that people do not receive help, because no help is available (or is too expensive where they live), but the point is that there are likely to be many reasons for not being treated for what is allegedly a mental disorder.

The expanding diagnostics are seen around the world, but this book is almost exclusively about the so-called West, where half of the population is said to be mentally disordered in their lifetime and approximately a quarter of the population within any one year (Wittchen & Jacobi, 2005). In the West there are certain, quite fixed, ideas about what counts as mental disorder, as specified in the diagnostic manuals, and although the DSM (in particular) affects the local understandings of mental problems all over the world (Watters, 2010), there are still curious differences and exceptions. One such exception was reported in June 2014 in Nigeria, when Mubarak Bala was sent for psychiatric treatment because of a case of *atheism*. His disbelief in God was here interpreted as a mental disorder, likely an effect of schizophrenia, and he was detained against his will in a psychiatric ward. Fortunately, he has since been released, but is allegedly living in danger because of his (dis-)beliefs that were pathologized by the local doctors.<sup>6</sup> This extreme example illustrates the variability in what counts as mental disorder and how psychiatry and larger cultural and political issues are intertwined. This is easy to see for Westerners when finding an extreme case in Nigeria, but it is much harder to notice in our own diagnostic cultures, given the way that the current conceptualizations of mental disorder are being naturalized through the diagnostic categories. That is to say, it has become hard for us Westerners to think of mental disorder outside what is made possible by the psychiatric categories. This means that the psychiatric-diagnostic discourse is close to becoming hegemonic, and even those who are aware of the negative effects of diagnosis – who argue, to quote Rachel Cooper, that diagnosis “suggests that the source of a problem should be located within an individual, and [...] tends to remove an issue from the political or ethical domain” (Cooper, 2014, p. 4) – often remain caught in a diagnostic language when addressing the problems raised by diagnostics: does the pathologization of sadness make us depressed, for example?

At this point I hope I have provided enough examples to indicate what I mean in this book when addressing the *diagnostic cultures* of contemporary society. It is important to use the term *cultures* in the plural, because there is not a monolithic, agreed-upon understanding of mental disorder delivered by the diagnoses, and there is no unitary way that the diagnostic language is used. Diagnostic categories are used in numerous ways, by sufferers, parents, teachers, managers,

6 See <http://iheu.org/mubarak-bala-is-free/>.

clinicians, medical doctors, psychiatrists, psychologists, researchers, policy makers, social workers etc., and, within these different groups, there is also much heterogeneity concerning diagnostics: there are patient groups that fight *for* the right to be diagnosed (recognized) and others that fight *against* being diagnosed (pathologized). How can one determine what in one case is a proper recognition of suffering through a diagnosis and what in another case represents illegitimate pathologization of deviant or eccentric behaviours? This is not an easy task, and not something this book can settle once and for all. Instead, the task will be to unfold the societal situation through the concept of diagnostic cultures, charting some of the ways in which diagnoses operate in people's personal lives and on a larger social scale.

Nikolas Rose has recently summed up the societal functions of diagnoses in (what I call) our diagnostic cultures (adapted from Rose, 2013), illustrating the huge variability in how diagnoses work:

1. A diagnosis is a condition of suitability of an individual for treatment – without a diagnosis of pathology, there is generally no case for treating the person.
2. In insurance based regimes, it is a condition of financial coverage of the cost of treatment.
3. For those who are employed, it can be a condition of legitimate absence from work.
4. For those who are unemployed, it may be a condition for access to welfare benefits.
5. For hospitals and medical establishments it is a central feature of patient records, which often shape the allocation of funding from those who commission services for various conditions.
6. For lawyers, it can be a condition for involuntary detention and treatment.
7. In the school system, a diagnosis may be the basis of allocation to special educational provision.
8. For epidemiologists, diagnostic categories are the very basis of their estimates and predictions that are based on assessments of incidence and prevalence.
9. For planners of services, those estimates and predictions are the essential raw materials for their work.
10. For funders of research, especially charities focused on a particular disorder, diagnoses may delineate a problem that is really worthy of investigation.

The list could have been considerably longer, so although psychiatric diagnoses were created as the work tools of psychiatrists, we see that they today operate in and between a large number of social practices, in addition to providing the individual with an experience of getting an explanation for his or her problems. Diagnoses affect how people feel and interpret themselves, they enter different social arenas (in schools, at work and at home) and are used to regulate a huge

number of practices, and they have complex histories leading up to how they are used today. So where can one find an analytic framework that enables one to study the phenomenological, discursive, and historical aspects of a phenomenon such as diagnoses? My answer in this book points to cultural psychology to which I will now turn. Readers who are familiar with this theoretical paradigm may jump directly to the next chapter, and others, who find the theoretical framework overly abstract, may also read the more content rich chapters first before returning to the theory unfolded in the rest of this first chapter.

## Cultural Psychology

Cultural psychology has a long history, going back quite directly to the work of Lev Vygotsky in Russia in the early 20th century (Vygotsky, 1978), and more indirectly to different philosophical bases. Vygotsky drew inspiration from many sources, but was placed in the tradition of Marxism, trying to address the relationships between mind and world, individual and society, dialectically rather than as separate entities that somehow interact. One can trace this line of thought back in time to philosophers such as Hegel and Spinoza, and it stands in contrast to Cartesian dualist philosophies, depicting subject and object as discrete entities. This is not the place to unfold a full history of cultural psychology; others have done this much more thoroughly, for example Jaan Valsiner and Rene van der Veer (2000). In their book, they trace the notion of the *social* mind, which was found not just in the work of Vygotsky, but also in that of American pragmatists such as John Dewey and George Herbert Mead. The dialectical approach offers the idea that the mind is social, and that the social is also “minded”. In other words, as Valsiner puts it: “Human beings are *individually social* and *socially individual*.” (Valsiner, 2014, p. 53). It is simply not possible to delineate two different ontological realms, one of minds of individuals, and another of culture or “the social”. Instead, persons – human beings considered as creatures with minds and not simply as physiological organisms – belong to culture, and culture belongs to persons (Valsiner, 2007, p. 21). This means that psychology, sociology and anthropology are all needed to create the discipline of cultural psychology, and other disciplines could and should be added, in particular history, because cultural psychology sees every mental/cultural process as existing and developing in historical time. There is a focus on culture as a historical *process* rather than an entity or substance. Culture is not a thing, and, for cultural psychologists, it has no agentive or causal powers (Valsiner, 2014). Thus, culture does not *do* anything; culture does not act and culture does not cause *us* to act either. Culture is not a variable that can be isolated and measured. “How much of our active life is determined by culture?” is a meaningless question from this perspective, because culture does not determine anything, and it would not be possible to calculate its relative importance (alongside biology, nature or genes, for example) anyway. It would

be more correct to say that everything in the human world is cultural – just as everything in the human world is natural (mainly because it is natural for humans to live as cultural beings).

From the point of view of cultural psychology, only *persons* (not culture) act (Brinkmann, 2011b). Unlike other psychological approaches that approach mental phenomena as aspects of a *mind*, or neuroscientific approaches that view them as aspects of a brain, cultural psychologists argue that psychological predicates pertain to persons only. They are neither “mindists” or “brainists” but “personists” (Sprague, 1999). This also separates cultural psychologists from many sociologists who operate with social structures or entities as having some sort of agentive power. Only persons have this kind of power, but no human action would be possible without culture. So, even though culture is not a variable, a force or an agent, it is *everywhere* in human life and minds. Culture is a name for all those *mediators* that *persons* use when performing actions, thinking thoughts or feeling emotions. Language, for example, is a cultural tool that mediates the human capacity for conceptual thought and enables complex forms of communication and self-consciousness. Language is particularly important for cultural psychologists because it is what enables human beings to create a distance to the here-and-now contexts that they are in. The process of creating distance – and reflecting upon the context, one’s preferences and desires to act – is called *semiotic mediation* by cultural psychologists (Valsiner, 2007, p. 33). Sign *mediators* such as language are not exactly the same as *means*. For means quite directly enable one to realize one’s pre-formed intentions (means-ends reasoning), whereas mediators at once constitute and transform the intentions that they carry. When we think abstract thoughts, for example, it is not the case that we have pre-linguistic ideas that we somehow translate into language that we can communicate to others. Rather, it is the case that we use language to think the very thoughts that we have. Language is, as Wittgenstein said, “the vehicle of thought” (Wittgenstein, 1953, § 329). In this sense, language mediates the activity of thinking, and the categories we use in thinking mediate the actions we may undertake. I cannot celebrate Christmas, for example, without the category “Christmas”, but this does not mean that Christmas is a purely linguistic or discursive event. Obviously, Christmas is a set of *practices*, which involve semiotic *and* material tools, ranging from trees and presents to carols and holidays and many other things that have evolved historically. To return to the notion of agency: cultural psychologists will argue (the quite obvious point) that *persons* celebrate Christmas. It is not the tree or the presents that celebrate this event; rather, persons are the irreducible agents in cultural life (Harré, 1983). However, it is equally obvious that persons could not celebrate Christmas, or even have the intentions to do so, without a whole range of mediators, some of which are semiotic while others are material, both of which are equally important in constituting the *practices* of Christmas.

Now, the ambition in this book is not to study Christmas cultures. Other cultural psychologists could do this, and it would be a fascinating topic. The ambition is to study diagnostic cultures, and the complexities already introduced –

of persons and practices, semiosis<sup>7</sup> and materialities, all in dialectical relationships – necessitate a comprehensive and yet precise framework of cultural psychology. The various schools and traditions within cultural psychology put emphasis on slightly different aspects of minded-persons-in-practices, and I find that they are all legitimate and fruitful for the project of this book. This is why I will turn to briefly unfold three aspects of sociocultural life studied by cultural psychologists, but first I shall say a little bit more about the concept of *mind*, which is just as important as *culture* for cultural psychologists.

### What is the Mind?

In the version of cultural psychology articulated here, the mind is conceived as normative (Brinkmann, 2006; see also Brinkmann, 2011b, on which the following is based). This has significant consequences for the analyses of what we think of as mental *disorders*, as we shall see particularly in Chapter 7. That the mind is normative means that the mind cannot be equated with purely receptive or experiential consciousness, or what is sometimes referred to as qualia in contemporary philosophy of mind; nor can it be equated with any substance or entity, not even the material entity of the brain. Why is that? Because if the mind were identical with some causally operating process or entity in the world or brain, we could have no way of distinguishing psychological phenomena from physiological ones, and since we are in fact able to make this distinction, it means that the mind cannot be purely causal. An example from Harré (1983) may illustrate what this means: although dread, anger, indigestion and exhaustion all have behavioural manifestations as well as fairly distinctive experiential qualities (qualia), we have no trouble concluding that only the two former phenomena should be included among psychological (or mental) phenomena, whereas the latter two are physiological. Why so? Because, argues Harré, dread and anger are psychological phenomena to the extent that they fall within a normative moral order, where they can be evaluated according to local norms of correctness and appropriateness. Dread and anger do not merely happen, like physiological phenomena, but are *done* (by skilful human persons), and are therefore subject to normative and indeed moral appraisal. One can feel and express legitimate as well as illegitimate anger, whereas indigestion may be painful and annoying, but it is meaningless to say that it can be legitimate or the opposite. Mental phenomena – our ways of perceiving, acting, remembering and feeling – do not simply happen, but can be done more or less well relative to cultural customs, norms and conventions. In short, they are normative.

To study the mind is thus to study a set of skills and dispositions to act, feel and think in particular ways, and we cannot determine whether someone has a skill by examining the person’s brain, but only by studying the acting person in her practical life activities. To have a mind is not to have some “thing” attached to the

7 Processes involving the use of signs.



brain or the body (for skills are not “things”); rather, for a creature to have a mind “is for it to have a distinctive range of capacities of intellect and will, in particular the conceptual capacities of a language-user which make self-awareness and self-reflection possible” (Bennett & Hacker, 2003, p. 105). In other words, using the concept of mind is to use “a generic term for our various abilities, dispositions and their relationships” (Coulter, 1979, p. 13). It is not to talk about a place (e.g. the “inner world”) or an object (e.g. the brain). Hilary Putnam has made a similar point from the standpoint of pragmatism: “the mind is not a thing; talk of our minds is to talk of world-involving capabilities that we have and capacities that we engage in” (Putnam, 1999, pp. 169–170). As we shall see in this book, this has consequences for how we should address mental disorders as one species of mental phenomena of persons.

Cultural psychologists reject the widespread tendency in psychology and our culture as a whole to reify the mind by treating it as an independent entity, which “does” certain things (attends, remembers etc.). The mind does not do these things, just as culture does not do anything. Only *persons* do such things, and it is exactly their capacities, abilities, capabilities and dispositions to do these things that we refer to with the term “mind”. Valsiner (2007, p. 125) refers to a related fallacy as “entification”, which is the fallacy of treating psychological constructs (e.g. personality, intelligence *or* mental disorders) as causal entities “in the mind” that cause persons to do certain things. Again, it is better to follow the pragmatist John Dewey and insist that psychological phenomena are adverbial (see Brinkmann, 2013a); they concern things done, which means that there are no psychological *entities* as such (e.g. intelligence, anger, depression), but only persons and what they do (and they may indeed act intelligently, angrily, depressed etc.). (See also Billig, 1999, for a convincing defence of an adverbial approach to the emotions.)

Thus, cultural psychologists insist that it is fruitful to think of the mind as a verb rather than a noun, as an activity or process rather than a static entity, and, when we do so, we address the mind as a normative phenomenon: as a set of skills and dispositions to act, think and feel. With this framework some old problems dissolve and new ones arise. The Cartesian problem of how to find a place for the mind in a physical universe is no longer pertinent, for this problem presupposed that the mind was an (immaterial) substance that somehow had to be hooked up with the material world. If the mind is not a substance, though, it is neither material nor immaterial. Skills and dispositions are hardly approachable in these terms. (A question such as: “Are the golfing skills of Tiger Woods material or immaterial?” sounds mysterious to say the least, for skills cut across such strange divides.) Instead, the question to ask is what enables the skills and dispositions to unfold and come under control of persons. The answer given by cultural psychology – at least in the version advocated here – is that *mediators* constitute and enable the skills and dispositions of people. So, there is an inner conceptual connection between *persons, minds, culture* and *mediators*.

Elsewhere I have suggested that four sets of mediators are particularly important in this regard (Brinkmann, 2011b): brain, body, practices and

technologies. These are generic sets of mediators, and it may sound strange to talk about the brain, for example, as a mediator of mental life, but what it means is quite simple: the brain can be thought of as a tool that mediates human life activities. Humans use their brains when performing the cultural tasks that make up a life (Harré & Moghaddam, 2012), and when the brain does not function adequately, say, if someone begins to suffer from dementia, then it is sometimes possible to use auxiliary devices such as Post-it notes with names written on them, if the person cannot recall the names of things simply by using the brain. This illustrates how technology (in a broad sense, including Post-it notes) can serve a psychological function. In the same way, our bodies and the social practices in which we participate mediate the ways we perform the tasks of psychological life. I will return to this later in the book (Chapter 7), when I seek to develop a cultural psychological understanding of mental disorder, which builds on the idea that “disorder” can have many different sources in brains, bodies, practices and material culture, and which identifies the important roles played by our conceptual designations (e.g. through diagnoses).

### Three Aspects of Sociocultural Life

This whole complex of acting, embodied persons in a sociomaterial world (who may experience problems that can be diagnosed) has been studied from different perspectives by different cultural psychologists. It is unsurprising that scholars have needed to purify certain perspectives and downplay others, given the complexity at hand. At least three distinct approaches can be singled out, which are all important to the analyses of the present book. They are depicted below in Figure 1.1.

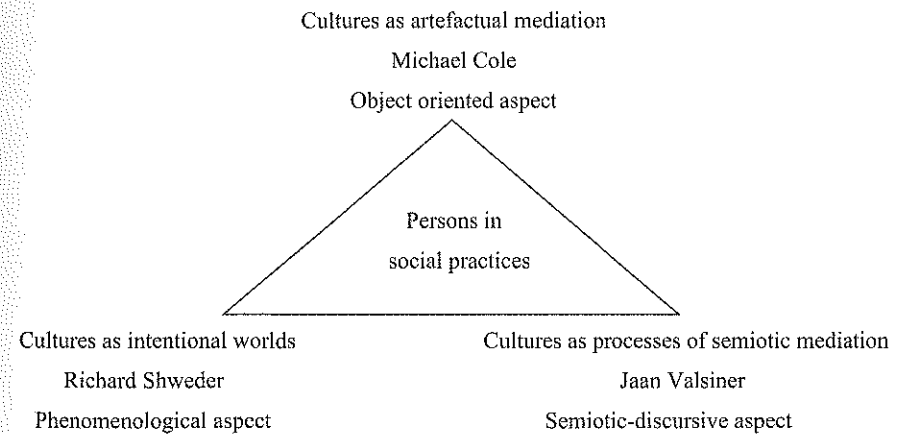


Figure 1.1 Three aspects of sociocultural life

In the middle we have what most cultural psychologists agree on studying: acting persons involved in social practice. We study not brains or information processing apparatuses, but living, suffering, acting, feeling, thinking persons. They – or we – can, however, only act in social practices. Celebrating Christmas is only celebrating Christmas because of the social practices of this event and their histories. Absent the historically developed practices of Christmas, and dancing around the tree would be nothing but meaningless twists and jerks. Social practices, however, are not static, but are constantly and creatively renewed and restructured. Around the centre, we have three schools, or traditions, of cultural psychology, which share many premises, but which have slightly different emphases and approach acting persons from different perspectives.

We have the school represented by Richard Shweder (1990), who argues that cultural psychology studies what he calls “intentional worlds”, which are sociocultural environments that are constituted by the representations and interpretations that human beings direct at it. Intentional worlds can usefully be studied using phenomenological approaches; that is, approaches that take an interest in the life world of human beings, how they experience and act in the world prior to formulating explicit theories (e.g. scientific theories) about it. In relation to diagnostic cultures, the phenomenological aspects concern how people experience the process of being diagnosed and how diagnoses appear in their lived experience.

Next, we have the school represented by Michael Cole (2003), whose cultural psychology is a kind of activity theory or cultural historical theory. Coming from a Marxist perspective, the key idea here is that human activity is mediated by different material artefacts. Our relationship to the social and material world is mediated by everything from shovels to computers. In relation to diagnostic cultures, it is the case that diagnoses themselves can be conceived of as epistemic objects (see the following chapter) that gain a kind of objective status when they come to function in the world, and the object oriented aspects obviously also come in when we look at how these diagnostic cultures are co-constituted by numerous things and technologies, ranging from standardized tests and databases, to pills and clinics. There is an entire material world that mediates the emergence of diagnostic cultures – or, one could say that such cultures are partly “assembled” by a range of material mediators (Latour, 2005).

Finally, we have the school represented by Jaan Valsiner (2014), which does not deny the importance of intentional worlds or artefact-mediation, but whose version of cultural psychology focuses our analytic attention on *semiotic* mediation specifically. Valsiner’s cultural psychology is a version of semiotic psychology, which means that it studies how human beings use signs, symbols, language etc. as mediators in and of their lives together. The concept of culture here refers to the semiotic mediation that is part of the system of organized psychological functions. From this perspective, persons necessarily belong to culture – yet, culture necessarily belongs to persons. In relation to diagnostic cultures, it is quite evident that psychiatric diagnoses have a significant role to play as semiotic mediators

that are put to use by individuals and collectives to regulate a large number of processes in modern society.

The three aspects focus on different approaches to cultural psychology, but the view in this book is that they do not exclude each other; rather they provide a more complete picture if put together. Contemporary diagnostic cultures have an *experienced* aspect, since they are populated by living, sensing human beings who often understand their problems in light of the diagnostic categories they are offered by medical and psychological authorities. They also have an *object* aspect with the many material mediators that play a role, and they certainly have a *semiotic* aspect, which, in other traditions, is studied as *discourses* (Gee, 2005) or *social representations* (Schmitz, Filippone & Edelman, 2003). Each is an aspect of a cultural whole, and each aspect is influenced by the others in ways that cannot be predicted until one looks closely at the empirical world. Diagnoses have a cultural history (as objects) and affect the ways in which people experience their lives (phenomenology) and the ways they talk reflectively about their problems (semiosis). As we shall see in Chapter 3, these are all aspects of social practices, which represent the core of cultural life: acting persons in social practices.

All aspects, as I see them, are infused with *normativity*, as I argued above, and what is interesting in relation to psychiatric diagnoses and mental disorders is that normativity becomes particularly problematic. Do persons really *do* OCD, depression, ADHD etc. relative to cultural norms, or do these afflictions *happen* to them? One significant conclusion of the present book (shared, for example, with Martin, 2007) is that people in fact *do* their disorders through diagnoses, although rarely in a fully explicit and willed manner. People *do* ADHD, but they also *have* it, and might even come to think of themselves as *being* ADHD. These three dimensions (which will be unpacked more thoroughly in the following chapter) correspond in some ways to the aspects studied by cultural psychologists: the phenomenological aspect is primarily about how people experience their lives *as* suffering from a disorder. Thus, a phenomenological approach is useful when one is interested in the self-identity of the diagnosed. The object aspect is about what people say (using a diagnostic category) they have, when they *have* a mental disorder. The diagnosis itself can here be studied as an object in the world with a biography (Daston & Galison, 2007). Finally, people also *perform* or do their disorders through the diagnoses, which points to a discursive or semiotic aspect that stresses the performative nature of mental life. All aspects of sociocultural life are affected by today’s diagnostic cultures – or so I hope to demonstrate and discuss in the following pages.

### Critiques of Psychiatry

Before moving on to the next chapter, I shall here return to the discussion of psychiatry and diagnoses, by summarizing four of the most important critiques

that have been directed at psychiatric ideas, several of which will play important roles in the remainder of this book (and are helpfully articulated by Busfield, 2011). By referring to these critiques, I hope to show that the discussion of diagnoses plays a role in all of them, albeit in different ways.

(1) The first states that psychiatry is inhumane and ineffective, which is a classic critique that was articulated, for example, by Erving Goffman (1961) in a famous study of life in a psychiatric hospital. After the emergence of anti-psychiatric movements in the 1960s and 1970s (represented by Ronald Laing, Thomas Szasz and Goffman himself), much has changed in psychiatry, but the classic critique has nonetheless been rearticulated in recent years with a focus on the dangers of psychopharmacology and the use of force in psychiatric hospitals. Well-known international critical voices are represented by Robert Whitaker (2010) and David Healy (2012), who have argued that the so-called iatrogenic effects (the disease producing effects) of long-term use of psychiatric drugs are so massive that they often outweigh the possible benefits of using the drugs. This conclusion is currently hotly debated, which testifies to the enduring relevance of this kind of critique. I return to this point below, most thoroughly in Chapter 6, where I present some interpretations of the current epidemics of mental disorders, some of which might be related to the harmful effects of drugs. Since diagnoses represent the gateway to treatment, they are at least indirectly struck by this first line of criticism.

(2) The second major critique states that psychiatry's categorical model of psychopathology is faulty. Unlike Freud's dimensional approach to mental disorder, according to which everyone is to be found somewhere on the psychopathological dimensions and axes (which means that we all, in a way, have a grain of each of the mental disorders), current diagnostic practices are built upon the idea of disease specificity, which implies that the mental disorders can in principle be clearly delineated from each other, so that one either has them or does not have them. As recounted above, when DSM-5 was developed, some commentators hoped that it would change into a dimensional model, but it ended up building on the same categorical approach as previous editions of the manual (Cooper, 2014). After Freud, it was especially Hans Eysenck who became famous for a dimensional personality theory (according to which an individual personality can be understood through the dimensions neuroticism, psychoticism and introversion/extroversion), and who criticized psychiatry's conception of disorder for its lack of dimensionality. In the next chapter, I return to the notion of disease specificity and its relationship to diagnoses.

(3) A third group of researchers, most of them belonging to the anti-psychiatric movement, have radicalized the critique of the categorical model of psychopathology and argued that it is misguided in the first place to even have a concept of mental illness. Thomas Szasz is the best known of these critics, who from the 1960s attacked what he called "the myth of mental illness" (Szasz, 1961). His critique is grounded in an argument that the concept of illness rightly belongs to somatic medicine, since it logically refers to lesions and dysfunctions

in organs and other forms of bodily tissue. Szasz argued that instead of talking of mental illness, we should approach mental disorders as "problems in living". If not, we simply stigmatize human suffering and deviation as pathological, and thus medicalize and pathologize life, something that was particularly evident in the Soviet Union, for example, when political dissidents were treated as mentally ill. Pathologization will be a key theme throughout the book.

Partly as a reaction to the anti-psychiatric critique, it has become common to talk about mental *disorder* rather than illness, but, in principle, the challenge for psychiatrists remains the same regardless of the terminology: that of identifying *what it is* that is disordered or ill, if it is not just (as Szasz would argue) the individual's way of life as such. For if it is uniquely a person's actions that are perceived as problematic (either by the person or by people around him or her), then it seems reasonable to address these as problems in living that we rightly judge in moral or legal terms. Discourses of illness or disorder seem to presuppose a more clearly defined physical object that can be damaged and which calls for medical judgment and intervention.

In recent decades, many researchers in the biomedical sciences have pinned their hopes on the possibility that neuroscience can identify mental disorders with a damaged object, *viz.* the brain (or parts of it), but so far no valid biomarkers have been found in psychiatry that would make possible a diagnostic process using a brain scan (Singh & Rose, 2009). Singh and Rose demonstrate that the widespread idea that it is possible to diagnose psychiatric disorders through genetic screening or brain scanning is wrong, and the hunt for biomarkers, which goes on in many corners of the biomedical sciences, represents a remarkable shift in psychiatry away from concentrating on identifying the causes of suffering (in ontogenesis or social life) and to charting the physical correlates of experienced suffering. (See also Rose & Abi-Rached, 2013, who provide a thorough discussion of the role of the neurosciences in this regard.) There is much that indicates that the hunt for simple, determining biomarkers is futile, since both the neurological and genetic backgrounds to mental disorders are at once much more complex, heterogeneous and particularistic than previously assumed. Singh and Rose conclude that information from biomarkers alone is insufficient to explain most of the variance in observed behaviors (Singh & Rose, 2009, p. 205).

The most thoroughly worked-out attempt in recent years to conceptualize the "psychiatric object", which may be ill or disordered, is that of Jerome Wakefield (1992). His theory of mental illness is called the "harmful dysfunction" theory, since it has these two components. In order for us to talk about mental illness, Wakefield states, there should first be something that is *harmful*. A person can only be said to be mentally ill, if that person experiences suffering or distress to some extent. Wakefield explains how this first component is a value component, since he believes that social norms and values determine the extent to which something counts as suffering or distress. How much one should suffer in order for the suffering to be pathological varies across epochs and cultures. Besides this value component, there is also a purely factual component stemming from a *dysfunction*,

he claims. One is not mentally ill, just because one suffers, since suffering can be caused by all kinds of problems and life situations. Only if the suffering is related to a dysfunction in the person's mental processes can the person rightly be said to be mentally ill (or disordered).

Wakefield here mobilizes arguments from evolutionary psychology, where researchers invoke the existence of genetically based "mental modules" to account for mental functioning. Mental modules are said to be innate psychobiological mechanisms analogous to physiological mechanisms in bodily organs. Just as a heart can be dysfunctional, when something is wrong with it that makes it unable to operate adequately as a blood pump, so a mental module can be dysfunctional if it, say, causes a person to feel constant fear without any frightening object being present. It is not pathological to feel fear if one is a soldier who is about to attack the enemy, but if a similar kind of fear is felt in everyday situations that are objectively safe *and* if the discomfort is caused by defective mental modules, then we are entitled (says Wakefield) to talk about mental illness. The object that may "break" and become dysfunctional (and thus produce mental illness) is thus a mental module. In short, for Wakefield, a mental dysfunction is a failure of the capacity of a mental mechanism to perform a function for which it was biologically designed. I return to this theory in Chapter 7.

(4) This takes us directly to the fourth influential critique of psychiatry, which is also in focus in the present book: that diagnoses pathologize. A consequence of Wakefield's two-component theory is that quite a few of psychiatry's existing diagnoses must be said to be pathologizing by implicitly breaking down the distinction between life problems and psychopathology. Together with Allan Horwitz, a medical sociologist, Wakefield has thus argued that the diagnostic criteria for depression (Horwitz & Wakefield, 2007) and anxiety (Horwitz & Wakefield, 2012) are overinclusive and do not make possible a necessary distinction between common sadness and clinical depression, or between normal fear and pathological anxiety. The main reason is that the component of dysfunction has not been developed in psychiatric diagnostics. A diagnosis is formulated by psychiatrists by examining the symptoms, and counting them using checklists, and it is therefore much more difficult to assess whether the symptoms are caused by an underlying mental dysfunction or rather by a given life situation. Significant sadness, Wakefield and Horwitz maintain, should only be diagnosed as depression if there is a dysfunction involved (and not just if the person has been divorced or has suffered a loss, for example), but the existing diagnostic category does not capture this difference adequately.

Wakefield's theory of mental disorder as harmful dysfunction thus holds significant critical potential, yet without being anti-psychiatric or rejecting the concept of mental illness as such. It can serve to warn researchers and practitioners in the psychiatric fields of illegitimate pathologizations of ordinary (harmful) experiences and conditions, which are not dysfunctional (and therefore not expressions of mental disorders). The main problem related to pathologization is that unpleasant experiences and conditions may be related to various social

problems such as marginalization, poverty and social injustice, which run the risk of being interpreted as individual psychopathology when looked upon through the diagnostic lens – and when the authoritative understanding of some experience or problem employs the psychiatric interpretation (and approaches something as, say, depression), it is of course natural to act as if it is a psychiatric problem (and treat it with anti-depressants, for instance). To repeat a basic point: the risk is that pathologizing something leads to an individualization of social problems and narrows down our ways of understanding and treating the problems that people have (Brinkmann, 2014a).

However, there are also certain problems inherent in Wakefield's theory, and it has often been criticized (e.g. Bolton, 2008). Perhaps its most significant problem is its lack of specification concerning what mental modules are. The theory rests on the premise that there are such mental modules, developed in the course of natural history to solve specific problems in humanity's evolutionary childhood, and that these modules are innate and relatively independent of sociocultural contexts, but critics of Wakefield here (rightly, in my view) object that this represents an outdated view of the nature-nurture relationship (in this case, the relationship between mental modules and social practices), which presents them as different and perhaps contradictory forces. Many contemporary researchers in biology (e.g. Sterelny, 2012) and anthropology (e.g. Ingold, 2011) now reject the idea that we can separate what is psychobiologically innate from what is acquired socioculturally.

Human psychology, including the sufferings of human beings, is most likely always biological and sociocultural in a way that makes it impossible to draw a firm distinction between these as separate components. In the words of Lock and Nguyen: "culture, history, politics, and biology (environmental and individual) are inextricably entangled and subject to never-ending transformations [...] biological and social life is mutually constitutive" (Lock & Nguyen, 2010, p. 1). This leads these authors to an intriguing concept of "local biologies", that Lock has worked on for several years (Lock, 2001). Such recent ideas of entanglements of the biological and the cultural suggest that the very idea of innate mental modules may be a myth, or at least too speculative to serve as the basis for a theory of mental disorder. I shall not pursue this argument further here (I return to it later in the book), but just conclude that even if Wakefield's theory has considerable problems regarding its positive definition of mental disorder, it nonetheless offers a very significant critique of many existing psychiatric diagnoses, since it highlights the widespread confusion of ordinary, painful phenomena of life with mental disorders. I believe there is much to learn from Wakefield's critique of the pathologizing effects of some diagnoses without having to accept his theory of mental disorder as such – and there is likewise much to learn from scholars who break down the distinction between the biological and the sociocultural in relation to mental disorders.

The four lines of criticism mentioned here – (1) that psychiatry is inhumane, (2) that the categorical model is faulty, (3) that the very idea of mental illness

is misconstrued, and (4) that the diagnoses, or at least some of them, are pathologizing – are important as a background to discussions of the notion of mental disorder and of the relationship between diagnoses and disorders, which will be central themes throughout this book.

## Chapter 2

# Psychiatric Diagnoses as Epistemic Objects

Diagnoses are classifications of diseases, illnesses or disorders. The word comes from the Greek term for distinction or assessment. *Dia* literally means through or via, and *gnosis* is knowledge. So a diagnosis is something through which we may gain knowledge of diseases. A diagnosis should enable us to distinguish between various abnormal conditions. The English term first appeared in 1681, and the project of developing disease classifications took off in the 18th century, when different sciences in general became obsessed with categorizing and measuring many different properties of the world (Jutel, 2011, p. 6). According to the historian of medicine Charles Rosenberg, the more recent history of medical diagnoses is closely connected to what he calls disease specificity. This refers to the modern idea that diseases are specific entities that have a kind of independent existence beyond their unique manifestations in sick individuals (Rosenberg, 2007, p. 13). The idea of disease specificity is so ingrained in medical practices today, and has become quite obvious for patients and professionals alike, that it is difficult to imagine that it was once different. But, according to Rosenberg's studies, this was in fact once different. Disease specificity is a cultural idea from the end of the 19th century that has enabled people since to imagine diseases as discrete conditions in an organism, which can be defined and separated relatively clearly from other diseases, and which are therefore identical with similar conditions in other organisms. Needless to say, this applies to somatic medicine, where examples such as cancer or diabetes can serve as illustrations, but it has also become a commonplace in psychiatry, although the idea is here more debatable, as we shall see in this chapter.

The idea of disease specificity has been established in psychiatry through the dissemination of diagnostic categories in DSM (the classification system of the American Psychiatric Association) and ICD (the WHO's system), particularly since the middle of the 20th century. When a category exists (such as ADHD, OCD or PTSD), it is easily taken as a matter of course that it refers to real, existing objects in the world. The idea that the diagnoses point to objectively existing instances of universal forms of mental disorder has been generally accepted in our diagnostic cultures. However, as Frances has critically pointed out: "Billions of research dollars have failed to produce convincing evidence that any mental disorder is a discrete disease entity with a unitary cause." (Frances, 2013, p. 19), while Rosenberg demonstrates that the relationship between diagnoses (categories) and disorders (forms of suffering) is extremely complex: "Diagnosis labels, defines, and predicts, and, in doing so, helps constitute and legitimate the reality that it discerns" (Rosenberg, 2007, p. 16). The formulation of diagnoses in a society leads to a naturalization and legitimation of different problematic conditions and forms