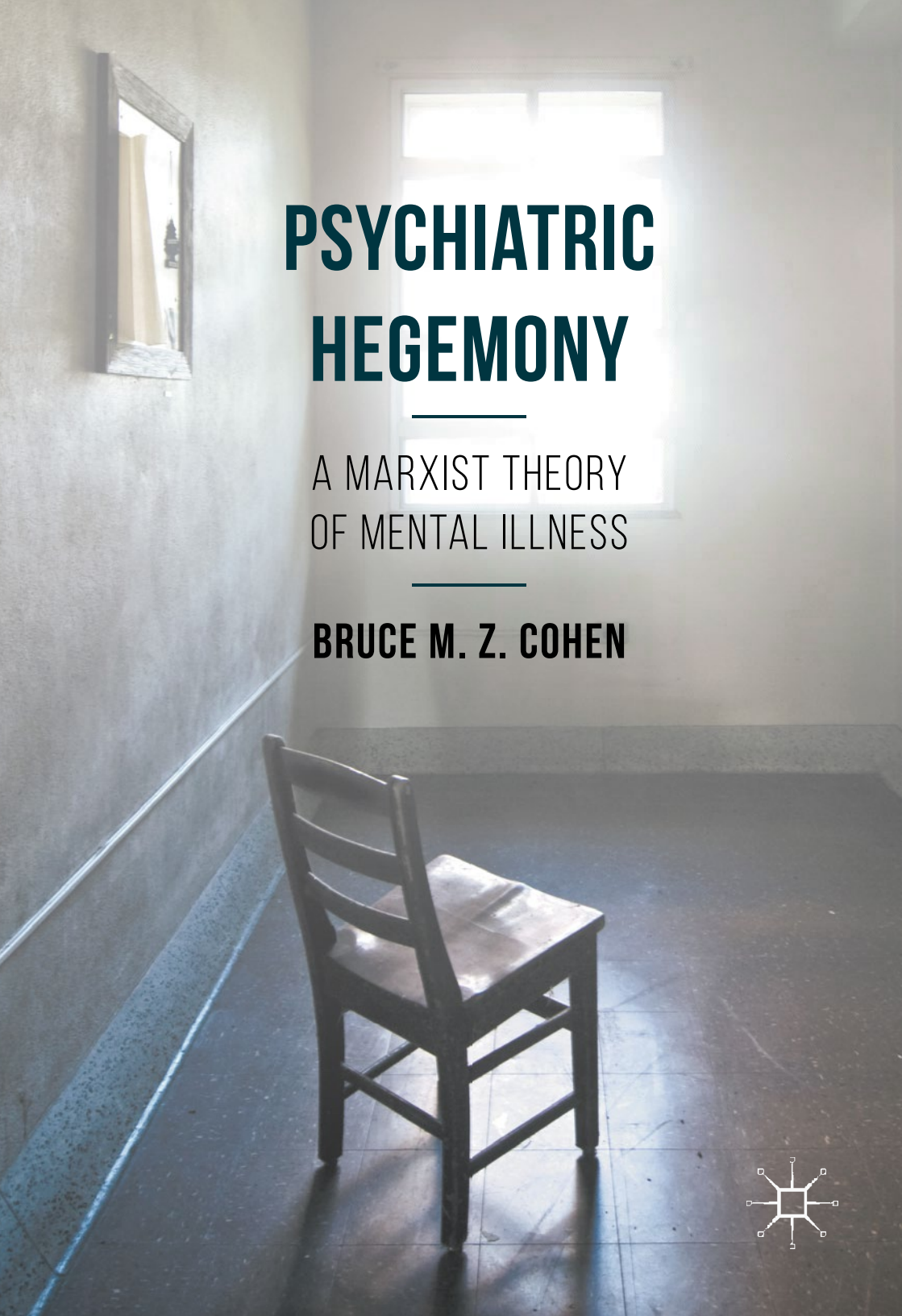

PSYCHIATRIC HEGEMONY

A MARXIST THEORY OF MENTAL ILLNESS

BRUCE M. Z. COHEN

Psychiatric Hegemony

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A Marxist Theory of Mental Illness

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This book is dedicated to three critical sociologists who continue to inspire:
Stanley Cohen (1942–2013)
Stuart Hall (1932–2014)
Jock Young (1942–2013)
&
An old friend and revolutionary footballer:
Hafty (d. 2014)
Es geht voran!

Preface

This book exists for two main reasons. First, to fill a gap in the current sociology of mental health scholarship. This omission was brought to my attention by my postgraduate students; though I was initially very sceptical of their research capabilities, it turned out that they were basically correct. Granted, there are bits and pieces of Marxist analysis out there, but compared with the other mainstream areas of sociological investigation such as education, youth, crime, and the family, the use of the big man's work to make sense of the continuing power of the mental health system is nearly non-existent. Second, this book offers a radical challenge to the conservative and theory-free scholarship which is currently infecting my area of sociology. I believe we need to bring critical scholarship back to the heart of the sociology of mental health; we desperately need to have the theoretical as well as the empirical debates.

The book title may suggest radical polemic, but at the same time, I think the argument is relatively simple and straightforward, and also, I think there is plenty of evidence to support it. Under capitalism, we live in a society of fundamental inequalities defined by our relation to the means of economic production. Public or private, every institution in capitalist society is framed by these same power disparities. The dominant understandings of who we are, what is expected of us, and the limits of our behaviour are constructed and defined by the capitalist class, then reproduced through the state and institutions of civil society (e.g., the

systems of education, criminal justice, and health). This is necessary for the progression and survival of capitalism. For example, we are socialised by the family, the school, and the mass media to accept social and economic disparities as natural and common sense; as the inevitable result of differential talent and competition within the marketplace, rather than class privilege and the exploitation of the majority of the population. In this respect, the mental health system is no exception. Led by the institution of psychiatry as the ultimate experts on the mind, mental health professionals are far from immune to the needs of capital. In fact, I will demonstrate in this book that the mental health system has been impressively compliant to the wishes of the ruling classes and, for that reason, has gained more power, authority, and professional jurisdiction as industrial society has developed.

While this book is centrally a theoretical interrogation of psychiatric discourse and professional power, I have also attempted to make it accessible to practitioners and non-theoreticians. I think theory is vitally important to achieving a broader understanding of human existence within this world, but I appreciate that many put more faith in the "practical solution," in being "pragmatic," and in changing the world through "doing." I think mental health practitioners—and I have met plenty over the years—are particularly prone to this view. For this reason, there are four substantive chapters in the book (on the issues of work, youth, women, and political protest) which are written with the pragmatists in mind. These apply Marxist ideas to specific issues within the field and highlight the many dangers of simply "doing" mental health work without any thought to the wider structures in which they carry out such activities. Often performed by professionals who similarly believed that they were "acting in the best interests of the patient," the history of psychiatry and its allies is littered with too many acts of violence, torture, and death to be able to write them off as aberrations or exceptions in a "progressive" and "scientific" system of health care. It can instead be seen as a regular service performed by the mental health system in support of the ruling elites.

What follows is my version of a Marxist theory of mental illness. It is only one contribution within the sociology of mental health, but nevertheless, I hope it inspires others to follow my analysis in equally challenging and critical directions. And if you want to continue the discussion, you can email me at b.cohen@auckland.ac.nz or @BmzCohen on twitter.

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This book could not have happened without the emphatic support of Palgrave Macmillan; I am eternally grateful for their faith and trust in this project. In particular I would like to thank my Editors, Nicola Jones and Sharla Plant, as well as the ever-helpful Assistant Editors, Eleanor Christie, Laura Aldridge and Cecilia Ghidotti. The idea for the book originated from my postgraduate "Sociology of Mental Health" class. I thank all of the students that I have had the pleasure to teach on that course over the years, in particular Dhakshi Gamage (a student who articulated the specific connection between neoliberal values and the construction of shyness as a mental disorder long before I did). In 2015 I had the chance to meet with a number of international colleagues working on critical issues in mental health and I would like to thank them all for their kind words of support and advice. They include Suman Fernando, China Mills, and Peter Morrall. My good friend Jeff Masson has become something of a mentor, what a guy! I would like to thank both him and his family for being such warm and generous people on the many occasions that we have visited them and outstayed our welcome. The Department of Sociology at the University of Auckland continues to be the home of a vibrant crowd of collegial people who understand how important it is to have the time and resources to complete a major research project like this one—many thanks to you all. Of particular note, hello to my friend and colleague Colin Cremin, with whom I have shared some really useful

conversations on the slippery subject of academic writing. And he lets me win when we play PES 2016, result! Thanks also to Helen Sword for the conversation on the ferry about scholarly writing and her very useful book *Stylish Academic Writing* (I tried, Helen!). This would be an appropriate point to add that all the ideas and attempts at style in this book are my fault alone. My thanks and appreciation to the Faculty of Arts, who approved my research and study leave in 2015; this allowed me to complete most of the writing for the book. The Faculty also funded a summer scholar, Rearna Hartmann, for three months (from November 2014 to February 2015) to undertake some additional analysis of each edition of the *Diagnostic and Statistical Manual of Mental Disorders*. This work appears in Chaps. 3–7 of the book. Rearna should get a special mention here as she proved to be such an incredibly talented and efficient scholar-in-training; it was a real pleasure to work with you on this project.

For inspiration, support, and temporary escape from the book writing, I would like to thank my football team, Tripzville/University-Mt Wellington (the 2015 Division Three (Seniors) Over-35s champions!), especially the boss, Mark Rossi, and my left-back partner in the crime, Tony Westmoreland. The music from the Killers kept me reasonably buoyant throughout the writing phase. Thanks also to friends and family in England, Germany, Australia, and New Zealand for all the good times, including the constant flow of alcohol, much needed. Maeby and Milo constantly interrupted my writing to show me wildlife they had "found" in the garden; on reflection, probably useful exercise for me. Finally, from the east to the west, the north to the south, she is the love of my life and the brains of the operation, Dr Jessica Terruhn—thanks for all the feedback on the drafts and, you know, everything else. I love you, honey!

Contents

List of Abbreviations

ADD	Attention Deficit Disorder
ADHD	Attention-Deficit/Hyperactivity Disorder
APA	American Psychiatric Association*
APD	Antisocial Personality Disorder
BPD	Borderline Personality Disorder
CTO	Community Treatment Order
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECT	Electroconvulsive Therapy
EL	Encephalitis Lethargica
FDA	Food and Drug Administration
GD	Gender Dysphoria
GID	Gender Identity Disorder
HPD	Histrionic Personality Disorder
ISA	Ideological State Apparatus
LLPDD	Late Luteal Phase Dysphoric Disorder
NIMH	National Institute of Mental Health
OSDD	Other Specified Dissociative Disorder
PENS	Psychological Ethics and National Security
PMDD	Premenstrual Dysphoric Disorder
PMS	Premenstrual Syndrome
PMT	Premenstrual Tension
PTSD	Posttraumatic Stress Disorder

SAD	Social Anxiety Disorder
SSRI	Selective Serotonin Reuptake Inhibitors
UK	United Kingdom
US	United States
WHO	World Health Organization

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

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Introduction: Thinking Critically About Mental Illness

This book is a critical reflection on the current global epidemic of mental disease, and with that, the global proliferation of mental health professionals and the expanding discourse on mental illness. Over the past 35 years, scientific ideas on mental pathology from the designated experts on the mind have seeped outwards from the psychiatric institution into many spheres of public and private life. It is part of my role as a sociologist to explain how this epidemic has come about and the extent to which it is a valid reflection of real medical progress in the area. I am not alone in undertaking such a project; other social scientists—as well as psychiatrists and psychologists themselves—have investigated the recent expansion in the varieties of mental disorder and their usage among western populations, and have voiced similar concerns to the ones that I will articulate in this book. However, as the title suggests, this work goes further than most other scholars and mental health experts appear able to. This is because I frame the business of mental health within its wider structural context, within a system of power relations of which economic exploitation is the determinant one. Ignoring the development and current dynamics of capitalist society has been a significant omission of most

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other scholarship in the area; this is my contribution to getting critical social theory back to the heart of research and scholarship in the sociology of mental health.

"We are," according to the psychotherapist James Davies (2013: 1), "a population on the brink." The figures for mental disease suggest that not only are we currently in the grip of an illness epidemic but we are nearing a tipping point towards catastrophe: out of a global population of seven billion inhabitants, 450 million people are estimated to be currently affected by a mental or behavioural disorder (World Health Organization 2003: 4), with 100 million of them taking psychotropic drugs (Chalasani 2016: 1184). The projected rates in developed countries such as the United States and the United Kingdom are even higher with one in four people suffering from a mental disorder each year (Davies 2013: 1). The World Health Organization (WHO) (2003: 5) estimates that the expenditure on mental health problems in western society amounts to between 3 and 4 per cent of gross national product; the cost in the United States alone is over $100 billion per year (Wilkinson and Pickett 2010: 65). By 2020, according to the WHO, depression—a disease which will affect one-fifth of all Americans at some point in their life (Horwitz and Wakefield 2007: 4)—will be "the second leading cause of worldwide disability, behind only heart disease" (Horwitz and Wakefield 2007: 5).

Consequently, the WHO (2003: 3) states of this mental illness epidemic that "[t]he magnitude, suffering and burden in terms of disability and costs for individuals, families and societies are staggering." From being a relatively rare affliction just 60 years ago, mental illness is now everybody's concern. Whitaker (2010a: 6–7) has noted of this change that the rates of debilitating mental illness among US adults has increased sixfold between 1955 and 2007. However, the "plague of disabling mental illness" as he calls it has fallen particularly hard on young people in the country, with an incredible *35-fold* increase between 1997 and 2007. This makes mental disease the "leading cause of disability in children" in the United States (Whitaker 2010a: 8). The varieties of known mental illnesses have also increased over time, with the American Psychiatric Association's (APA) *Diagnostic and Statistical*

Manual of Mental Disorders (DSM) identifying 106 mental disorders in 1952, yet 374 today (Davies 2013: 2).

In the current milieu it is no surprise that the power and influence of the mental health professionals are—like the above statistics—"growing at a remarkable rate" (Davies 2013: 2). However, as every critical scholar on the topic is aware, very serious problems remain with the current science and practice within the mental health system. These concerns inevitably lead us to questioning the reality of the claims to a mental illness "epidemic" made by health organisations such as the APA and the WHO, and to ask who really benefits from the global expansion of the psychiatric discourse. An essential issue here is the continuing contested nature of "mental illness," for there remains no proof that any "mental disorder" is a real, observable disease. Consequently, the "experts" still cannot distinguish the mentally ill from the mentally healthy. In fact, a recent attempt by the APA—the most powerful psychiatric body in the world—to define mental illness was bluntly described by one of their most senior figures as "bullshit" (see discussion below). Accordingly, it also follows that no "treatment" has been shown to work on any specific "mental illness" and that there is no known causation for any disorder. Of course, these issues are highly disputed by many mental health professionals, so the evidence and debates are outlined in detail in the chapters that follow.

I appreciate that questioning the validity of mental illness comes as little comfort to those people who are currently experiencing stress, trauma, or behaviour which causes what Thomas Szasz (1974) has previously referred to as "problems in living." Let me clarify briefly here that this book is not denying such experience; rather it is questioning the discourse of "mental illness" which is produced by groups of professionals who claim an expert knowledge over this experience. Therefore, the current discussion is a critique of professional power not of personal experience and behaviour which may have been labelled (or self-labelled) as a "mental illness." Though my previous work has investigated the multifaceted meanings of illness and recovery for those so labelled (see, e.g., Cohen 2015), this is not the focus of the current book. Instead, the issue at hand is how to explain the incredible expansion of what we might

call the "mental health industry"—that is, the entirety of the professionals, businesses, and discourse surrounding the area of mental health and illness—without a concurrent progression in the scientific evidence on mental pathology. The next section briefly explores some of the main explanations given for the dominance of the current mental health system and the gaps in this work.

Critical Scholarship on Mental Illness

Most commonly, critical scholars focus on one major reason for the current expansion in the numbers and categories of mental illness in western society—namely, the influence of pharmaceutical corporations (colloquially referred to as "big pharma") on the construction of new categories of disorder and the promotion of drug solutions for those disorders (see, e.g., Davies 2013; Healy 2004; Moncrieff 2009; Moynihan and Cassels 2005; Whitaker 2010a; Whitaker and Cosgrove 2015). The institution of psychiatry is the ultimate authority responsible for defining and treating mental pathologies, yet commentators argue that the profession has been steadily compromised by forming close relationships with big pharma, who are now effectively setting the mental health agenda. For example, critics point to the 69 per cent of psychiatrists responsible for the development of the latest edition of the DSM (DSM-5, see American Psychiatric Association 2013) who have financial ties to the pharmaceutical industry (Cosgrove and Wheeler 2013: 95). Research has also demonstrated the close involvement of big pharma in the development of current mental illness categories including social anxiety disorder (SAD) (Lane 2007) and premenstrual dysphoric disorder (PMDD) (Cosgrove and Wheeler 2013). The more behaviour and experience that can be successfully medicalised—that is, reconceptualised as in need of medical intervention—through this medico-industrial partnership, the more drugs can be potentially sold to the public. Thus it is argued that the expansion of the mental illness discourse is the result of a market takeover of health care; corporations rather than medical practitioners are now designating what mental pathology is and, as a result, dictating treatment. The obvious solution to this situation involves the

de-coupling of mental health services from the influence of big business. Tighter government regulation and oversight of pharmaceutical corporations is required, as is transparency within the relevant professional organisations.

While this critique of big pharma's intervention in the production and promotion of the contemporary psychiatric discourse is relevant, it is perhaps the least surprising aspect of the operation of the mental health system within capitalist society. Scholars of medical history such as Andrew Scull (1989, 1993, 2015), for example, have profiled a continuing "trade in lunacy" which can be traced back to the beginnings of industrial society and witnessed throughout the development of modern mental health work. That the market is part of the workings of psychiatry and related professions should be self-evident to any scholar aware of the history of the mental health system in western society. Such critics would also acknowledge that while psychiatry legitimates the products of big pharma, pushing psychopharmaceuticals in turn helps legitimate the psychiatric profession. The prescribing of drugs is a key symbol of modern doctoring which serves to align psychiatric practice with other branches of medicine through a shared biomedical understanding of health and illness.

The medico-industrial relationship described above has raised an associated criticism from critical scholars as to the efficacy of the biomedical approach in understanding mental health problems more generally. Biomedicine conceptualises disease as a physical pathology of the body. Thus, biomedical psychiatry theorises mental disorder as having a physical aetiology (causation) that can be observed, measured, and treated. Modern psychiatry focuses on the brain as the organ that causes such "disease," and most often regards mental illness as the result of faulty neurotransmitters or "chemical imbalances" in the brain. The biomedical approach to understanding mental illness have been a part of psychiatry since its emergence over 200 years ago, yet has become increasingly dominant within the mental health system since the 1980s (Chap. 2). According to critics, however, despite its current "hegemonic" moment (Cosgrove and Wheeler 2013: 100), bio-psychiatry lacks the legitimacy of scientific evidence. The scholars blame corrupt individuals and powerful interests both inside and outside of psychiatry for reiterating

biomedical myths regarding the "normal" and "abnormal" workings of the brain so as to be able to promote physical interventions such as drugs and electroconvulsive therapy (ECT) as potential "cures" for mental illness. Such writers note the continuing lack of proof of biological causation for any mental disorder, the potential for corruption at the hands of big pharma, the perversion of the psychiatric profession by particular self-interested, powerful parties and individuals, and the reductionist nature of the biomedical model which is seen to have damaged the founding aims of the profession to improve the care and treatment of people who suffer from mental disorders and to always perform their duties in the best interests of the patient (see, e.g., Bentall 2009; Breggin 1991; Davies 2013; Greenberg 2013; Whitaker and Cosgrove 2015).

Critics call for an understanding of mental disorder which goes beyond biological reductionism to consider psychological, social, and environmental factors which correlate with mental illness. Often conceptualised as the "psychosocial model" (or simply, the "social model") of mental illness, scholars and experts highlight a range of evidence from socio-economic data which demonstrates that such factors as family income, educational level, ethnic group, geographical location, and social class are all closely related to the chances of developing a mental health problem. While the social model suggests that we all have the potential to suffer mental disorders if exposed to traumatic situations, some groups are particularly vulnerable to mental illness due to experiencing comparatively more stressful life conditions and, at the same time, having less access to cultural and economic resources which can alleviate the threat of mental problems. As the WHO's (2013) recent *Mental Health Action Plan 2013–2020* has emphasised,

> Depending on the local context, certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may (but do not necessarily) include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies.

Interventions are then aimed at the personal and the social; therapy and counselling allows individuals to work through their disorder with trained professionals, while community health services target certain deprived communities for mental health promotions and the additional resourcing of mental illness prevention teams.

Explanations for the increase in rates of mental illness given by socially orientated models of mental health, therefore, draw attention to the widening social inequalities experienced in neoliberal society which impact levels of well-being in vulnerable populations. For example, Wilkinson and Pickett (2010: 67) draw on WHO data to claim that people suffer more mental illness in countries with wider inequalities (as measured by income distribution and the disparities between the richest and the poorest in that society). Their comparison of twelve advanced industrial nations shows the United States as having the highest rates of mental illness and, correspondingly, the highest rate of income inequalities. In comparison, Japan experiences the lowest rate of mental health problems and has a relatively equal distribution of income. It is a popular piece of sociologically orientated accounting in which society has the potential to make us sick; particularly those societies with higher levels of social and economic inequality appear to make us sicker. Thus, some Marxists have similarly argued that capitalism is ultimately responsible for causing mental illness (see, e.g., Robinson 1997; Rosenthal and Campbell 2016). However, as with most epidemiological work on mental illness, this analysis is weak and inconclusive. The research ultimately suffers from the same fundamental deficit as the biomedical model in that, while speculative correlations are made, there remains no proof of causation for any mental disorder.

As with psychiatrists, the many mental health workers in allied professions—such as the psychotherapists, psychologists, counsellors, and psychiatric social workers—who promote the more socially orientated approaches to mental illness, continue to stand by the validity of psychiatry's knowledge base and for good reason: it is a discourse which furthers their own professional interests and legitimates their own "mental health" practices in a currently expanding market. Many scholars make the same mistake in arguing for such socially oriented approaches—they reinforce the psychiatric discourse as having validity where none has been established. Thus, what

may first appear as serious critical scholarship on psychiatric knowledge production and the mental health system is often quite conservative and reformist in nature. These attempts at "critical" literature on the mental health system are most likely written by those inside the mental health profession, especially psychiatrists and psychologists (see, e.g., Bentall 2009; Davies 2013; Paris 2008). Unless they wish to give up their high-paid jobs—some escape into academia, others retire early—these writers continue to be complicit in supporting the mental health system that has produced them. For this reason their arguments go no further than pleas for reform (fewer drugs, more therapy, and so on) which allow their profession to continue to expand their operations relatively unhindered by serious critique.

To firmly ground the mental health system as a moral and political project, the following section discusses the continuing lack of validity of psychiatric knowledge. This deconstruction of the "science" of psychiatry is purposely undertaken here to highlight both the limits of previous critical scholarship—which has often failed to engage with the fundamental problems of mental health work—and the need to frame such institutions within structural systems of power and social control. Before this however, a brief note on a couple of key terms I will use in this discussion and subsequently throughout the book.

Psy-professions: my argument in this book implicates not only the psychiatric profession, but also allied groups such as psychologists, counsellors, psychiatric social workers, psychoanalysts, and the many other "talk therapy" professionals (for full critiques, see, e.g., Masson 1994; Morrall 2008). Collectively, I follow Rose (1999: viii) in understanding these groups as the "psy-professions": "experts" who have over time acquired an authority on the supposed "real nature of humans as psychological subjects." As medically trained practitioners, psychiatrists have the ultimate authority to define and police abnormal behaviour—which is why the book focuses primarily on this profession—yet they are ably assisted by other groups which have subsequently emerged and have vested interests in continuing to align themselves with the same knowledge base. The discussion in this book will demonstrate, for example, that psychologists, therapists, and counsellors can all be implicated in systematically serving the interests of the powerful.

Psychiatric discourse: I use this term to differentiate scientific evidence on "mental illness" (what some might call "psychiatric knowledge," although this is also a highly problematic phrase) from psy-professional

claims-making in the area. Psychiatric discourse is the totality of the propositions to expertise on "mental illness" and "mental health" (including the language, practices, and treatments) that psychiatric and allied professions have circulated to the public over the past 200 years. The term signifies the socially constructed nature of what is claimed to be expert knowledge in the area. For this reason, general terminology produced by the mental health system should be treated with caution. For example, in this book I refer to various labels of "mental illness," to mental health "experts," to "patients" and "users" of services, and so on; this does not, however, signal my acceptance of any such terminology as accurate or the truth of the matter.

Deconstructing the "Science" of Psychiatry

In his recent book *Shrinks: The Untold Story of Psychiatry*, former president of the APA, Jeffrey Lieberman (2015: 288–289), summarises the progress that psychiatry has made over the past 200 years in its knowledge and understanding of mental pathology. "We know that mental disorders exhibit consistent clusters of symptoms," he declares,

> We know that many disorders feature distinctive neural signatures in the brain. We know that many disorders express distinctive patterns of brain activity. We have gained some insight into the genetic underpinnings of mental disorders. We can treat persons with mental disorders using medications and somatic therapies that act uniquely on their symptoms but exert no effects in healthy people. We know that specific types of psychotherapy lead to clear improvements in patients suffering from specific types of disorders. And we know that, left untreated, these disorders cause anguish, misery, disability, violence, even death. Thus, mental disorders are abnormal, enduring, harmful, treatable, feature a biological component, and can be reliably diagnosed.

Underscoring psychiatry's worth as a medical enterprise, Lieberman (2015: 289) concludes by stating of the above summary that "I believe this should satisfy anyone's definition of medical illness." Likewise, Shorter (1997: 325) concurs with Lieberman on the ascendancy of the psychiatric discipline to a valid branch of medical science when he reflects that

> [i]n two hundred years … psychiatrists [have] progressed from being the healers of the therapeutic asylum to serving as gatekeepers for Prozac. Psychiatric illness has passed from a feared sign of bad blood—a genetic curse—to an easily treatable condition not essentially different from any other medical problem, and possessing roughly the same affective valence.

Such positive appraisal of the knowledge and treatment of mental disorders by the official historians of psychiatry necessarily rationalises the jurisdictional exclusivity of the profession as based on a progressive narrative of medical science and discovery. Nevertheless, it is a successfully cultivated rhetoric of truth claims which crucially lacks evidence to sustain the desired picture of medical advancement in the field. This section surveys the main issues with the current state of psychiatric knowledge—namely, the disagreements over aetiology and treatment of mental illness, the lack of agreement on what "mental illness" is, and consequently the lack of validity to any category of mental disorder. This deconstruction of psychiatric knowledge claims will lead us to question what the purpose of the psy-professions in capitalist society actually is.

A recent review of the science behind the psychiatric discourse concluded that "no biological sign has ever been found for any 'mental disorder.' Correspondingly, there is no known physiological etiology" (Burstow 2015: 75). This conclusion also became clear to the APA's own DSM-5 task force when they began work on the new manual in 2002. As Whitaker and Cosgrove (2015: 60) record, in reviewing the available research evidence it was plain to the committee members that "[t]he etiology of mental disorders remained unknown. The field [of mental health] still did not have a biological marker or genetic test that could be used for diagnostic purposes." Furthermore, the research also showed that psychiatrists could still not distinguish between mentally healthy and mentally sick people, and consequently had failed to define their area of supposed expertise. This issue was recently highlighted with reference to comments made by Allen Frances, the chair of the previous DSM-IV task force. When the DSM-IV (American Psychiatric Association 1994: xxi) was published in 1994, it stated that "mental disorder" was

> conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with

> present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom.

However, as the architect of the DSM-IV, Frances was later quoted by Greenberg (2013: 35–36) as stating of the above definition, "[h]ere's the problem … There is no definition of a mental disorder … it's bullshit … I mean you can't define it." The lack of knowledge on mental health and illness has haunted the entire history of psychiatry. Some have dismissed critics who highlight this fundamental hole in the science of psychiatry as "antipsychiatry" or "mental illness deniers." Such attacks on scholars who attempt to investigate the accuracy of the central pillars of psychiatric knowledge should further concern us, as it perhaps signals that plenty in the profession are already aware of the flimsy nature on which their "expertise" continues to rest. Together with an understanding of the history of the psychiatric profession—summed up by Scull (1989: 8) as "dismal and depressing"—I would argue that it should be the duty of *all* social scientists concerned with the mental health field that, in good conscience and putting the needs of the public first, they remain highly sceptical of a psychiatric discourse that poses as expert knowledge on the mind but produces little actual evidence to back up the assertions made.

Though at first glance historical mental disorders such as masturbatory insanity (Chap. 2), drapetomania (Chap. 7), hysteria (Chap. 5), and homosexuality may appear as evidence of the profession reflecting the dominant norms and values of wider society, they are argued by the official historians of psychiatry to be examples of the false starts, early experimentations, and theoretical innovations of an emerging scientific discipline. It is suggested that this history is evidence of medical and scientific progress within the area of mental health to the current point where we know more about mental distress than ever before. Yet problems in the legitimacy of psychiatry's vocation have remained, and reached crisis point at the cusp of deinstitutionalisation in the 1970s. At the time, a number of significant studies demonstrated the profession's inherent tendency to label people as "mentally ill," to stigmatise everyday aspects of a person's behaviour as signs of pathology, and to make judgements on a person's mental health status based on subjective judgements rather than objective criteria.