The Failings of "Mental Health"

How a Seemingly Benign Concept Might be Dangerous

Ayurdhi Dhar

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MIA's Ayurdhi Dhar interviews Bruce Cohen about dismissive psychiatrists, pervasive psychiatry, and the field's ties to neoliberal capitalism.

Dr. Bruce Cohen is an Associate Professor of Sociology at the University of Auckland. His career spans over thirty years where he has time and again used empirical research to tackle the numerous shortcomings of the psy-disciplines. With his upcoming book series, *The Politics of Mental Health and Illness,* he continues to expose how the psychiatric discourse "doesn't work for us" but instead greases the wheels of a neoliberal capitalist society.

In this interview he talks about how the psychiatric discourse has left the clinic and entered workplace, how the DSM has been feminized to the detriment of women, how and why the ADHD diagnosis has shifted shape, and lastly, how the global move towards "mental health" and away from "mental illness" might not be positive or benign.

The transcript below has been edited for length and clarity. Listen to the audio of the interview here.

Ayurdhi Dhar: You have explored numerous criticisms of psychiatry. What brought you to them—when and how did you end up seeing these glaring problems?

Dr. Bruce Cohen: [Laughing] I am a sociologist, so disillusionment is what pays the bills. Back in the early 1990s, I was an undergraduate at the University of Teesside. As my first research gig at the time of community care in the UK, the psychiatric institutions were closing down and I did interviews with users, and survivors of the psychiatric hospital system.

I remember distinctly seeing a psychiatrist there as part of this team, the first experience I had of meeting a psychiatrist in my life—we mentioned how we were going to look at the needs of the users in the community, beyond the asylum system. The psychiatrist said to us, point blank, "There is no point in asking them what they want, you know. They are all mad. How are you going to get anything articulate out of this population?"

This was my first but not my last experience of the arrogance and the ignorance of the psychiatric profession. When we did these interviews with users and survivors, one of the first things they told us was, "We were never listened to by the psychiatrist, by the mental health nurses in the system. They ignored our voices. They avoided us on the wards." We learned about things that were typical of the inpatient experience that we know from Goffman and Rosenhan's work. Such is the hubris of the professional staff there—the use of medications, ECT, solitary confinement as forms of sedation and of punishment.

The paths that led users into institution were personal problems, family issues; this included the sectioning of people against their will into these places. There was also the rarity of being able to get out of these places, and many got out only because the place was closing. That was a really interesting and formative experience for me. A few years later I ended up doing an evaluation project on a home treatment service.

This service was an alternative to inpatient care for acute or severe mentally ill people like those diagnosed with psychosis or bipolar disorder or schizophrenia.

Bradford Home Treatment Team would take people who would have a crisis and usually go into the hospital, and actually keep them at home. The workers would come around and see them. This was a team set up by Pat Bracken and Phil Thomas. This team questioned the ways that psychiatry worked with these users. They were fundamentally challenging their own psychiatric knowledge base. For instance, team meetings would discuss "Should we still use psychiatric labels? Should we maintain their medications or encourage them to reduce them because of the problems many antipsychotics and antidepressants can cause? The use of ECT—should we encourage it or discourage it?"

It was interesting to see a team of psychiatrically trained nurses and doctors, psychiatrists, psychologists, be emancipated to do something different. This was fascinating for me as a sociologist, and I saw there was a potential for the mental health system to be something different.

This led to my book on mental health user narratives, which is influenced by Arthur Kleinman's work on Illness Narratives. I did open interviews with both those who were using the home treatment service as an alternative to inpatient treatment, as well as those who only had had inpatient treatment. I found with both sets of users a psychiatric discourse that was very powerful in their identities, and in explaining their situation and their future in terms of mental illness and recovery.

Hospital-only users would really follow a biomedical discourse—I have got schizophrenia. It's a lifelong disease of the brain. It's in the genes. Medications can only control the worst excesses of the diseases. Relapse is bound to occur. I feel I will require several inpatient treatments in the future for the rest of my life." With the home treatment users with social critical engagement from Pat's team, there was a downgrading of diagnosis. You have to remember all these people were considered acute and severe. But they downgraded their own diagnosis and they were saying, "I think I had more of a depression really. Or, it was a neurosis, or it was a crisis that happened due to social and environmental reasons. It's a one-off. I don't think it's going to happen again." That's generalizing, but that was often the narrative that we got from those users.

The team working with these users had an emancipated idea of the possibility of their living without further contact from mental health services. The psychiatric discourse, the psychiatric language, the practices, the treatments—these can all have a significant impact on our identities and our understanding of ourselves.

Dhar: You write that psychiatric discourse has become hegemonic. Could you tell us what that means, and what are some of the consequences of this happening?

Cohen: Hegemonic means that the psychiatric discourse is now everywhere. This idea comes from cultural Marxist Antonio Gramsci and it means to be ruled by consent. This is a more subtle form of power than direct control. Imagine direct control as

physical force from the army or police. Hegemonic control is more subtle—the dominant norms and values of the economic elites in capitalist society are proliferated through nonpolitical institutions—public institutions such as the education system, the criminal justice system, medicine, and the mental health system.

These ideas are communicated to us as being commonsense and become taken for granted ideas of how society should function. For instance, gender roles and the policing of the binary within the genders. So psychiatric discourse has proliferated. It has left the confines of the psychiatric hospital and the therapist office, and is present in our everyday lives, in schools, workplaces, unemployment centers, homes. It's constantly in the media and social media. It's a regular feature of our day-to-day conversations.

Previously, discussion of mental illness amongst the general public was rare. Now it's commonplace. We can all name a few mental disorders. Most of us can name symptoms and even suggest causation, for example, it's a brain disease, or chemical imbalances, or it's due to trauma. Some of us can probably also name typical medications and other treatments. My research has really been primarily concerned with answering this question as to why psychiatric discourse has become hegemonic across Western society.

One of the obvious reasons is maybe more of us are mentally ill than ever before. But that's incorrect. Robert Whitaker has noted that, using the marker of people in the US who are disabled by mental illness. The number of mental illnesses present in the DSM have gone up. We had 106 in 1952, we now have 374 today. For many of these classifications, the symptoms required to reach a disorder have been reduced. For instance, the DSM removing the exclusion criteria for major depression for bereavement following the death of a loved one. So that's kind of problematic in measuring has mental illness really gone up?

An interesting bit of research is Amy Johnson's article from last year. It's an analysis of US National Health Interview Survey data between 1997 to 2017. She uses psychological distress and asked people how much are you worried, etc., about these issues. She concluded that there is little evidence that psychological distress has actually worsened over time.

Lots of people, including Whitaker and Cosgrove and myself, have talked about the ongoing validity problems with the psychiatric science in accurately defining, measuring, and explaining mental illness. Just one example recently is that Allsopp and colleagues looked at the major diagnostic categories which included depression and anxiety disorders in the current DSM, and they concluded that all the categories were scientifically worthless as tools to identify discrete mental disorders.

There is Irving Kirsch's work among others, that point to the problematic conclusions of most antidepressants and antipsychotics being no more effective than placebo. The wonderful historian sociologist Andrew Scull concludes that the causation of most mental illness remains obscure, and its treatments are largely symptomatic and generally of dubious efficacy.

My answer for why the psychiatric discourse has become hegemonic is because Psychiatry has learned to speak the public language since the 1980s. Back in 1965, Mike Gorman addressed the American Psychiatric Association, and said, "Psychiatry must develop as public language. It must be decontaminated of jargon, and it must be suited to discussion of universal problems of our society. This is the difficult task that we face in psychiatry, but it must be done if psychiatry is to be heard in the civic halls of our nation."

Our emotions, feelings, and behaviors, in the recent DSMs, are now considered common mental disorders, and they reflect our concerns, our anxieties living in late capitalist society. Throughout these diagnostic classifications are things that speak to our anxieties about not multitasking effectively enough. We are not working or studying hard enough. We are not happy with our work-life balance. We feel we are ineffective parents or carers. Our sex lives are a mess. We are gaming or drinking or smoking too much, etc. These are all within common mental illness categories. My argument is—psychiatric hegemony has actually successfully medicalized more and more aspects of our everyday lives, and the discourse has become totalizing.

Some people might say this is a great thing, that this can really help us because "I just thought I was feeling lazy or I was self-obsessed and then I got diagnosed as ADHD or whatever." Many are relieved. But these are not mental disorders. My argument obviously follows Gramsci in that psychiatric discourse is, and always has been, a form of social control, which actually works to the better of capitalism; it doesn't work for us. So, with the advent of a neoliberal ideology in the 1980s—a discourse that focuses more on the individual for reform or change of character, for improvement of ourselves—this discourse has become increasingly important. It's not neutral or value-free, it actually reflects a dominant ideological rhetoric that speaks to a specific epoch, and has done ever since psychiatry has been around in industrial society.

Dhar: According to you, which diagnosis more than any other, betrays psychology's ties to neoliberal capitalism?

Cohen: The most obvious one for me is ADHD. It was previously Attention Deficit Disorder. Before that, it was hyperkinesis, and before that it was various terms like minimal brain dysfunction. We see the expansion of categories in the DSM. In the 1970s, significant shifts take place in Western society. There is deindustrialization, the rise of service industries, a collapse of welfarism. There is a rise of neoliberal politics and desire to deregulate the market, take it out of state hands, sell off public industries, make cuts in welfare services and provision, and force the general population to rely more on themselves rather than the state to have to upscale, to have to work on themselves.

How does ADHD fit into this? The education system and the work environment had to change towards more seatwork, more intensive study, more analytical sets of skills, more flexible skills for the service economy, more IT skills and so on. And we can see this in the way ADHD actually changes. First, it focused on young people and later on adults as well. So, young people at school and then adults more in the workplace.

Whereas hyperkinesis in the 1950s to 1970s was really seen as a rare condition amongst primary school children, ADHD is based on the changing demands of schooling at that time.

DSM is a fascinating document; DSM-III had things like "inattention caused by failing to finish things he or she starts, often not listening, easily distracted, having difficulty concentrating on school work, has difficulty staying seated, difficulty sticking to a play activity." These are all things directly related to the classroom.

But then it moves into the adult world of work—the person will make careless mistakes at work or during other activities as well, they miss or they overlook details, their work is inaccurate. We have seen that one of the problems for capitalism has been the active worker disengagement—absenteeism or sickness. In the latest version of ADHD, and quite blatantly, they have just added lots of stuff to make it about your occupation as well. Now they have added poor time management, fails to meet deadlines at work. These are all symptoms of mental disorder. So, if you are not paying your bills on time, you are not keeping appointments, you could have ADHD.

Peter Conrad has talked about the modern form of ADHD as the medicalization of underproductivity. For example, at the university, one regularly gets requests for student extensions and the related mental health issue is often ADHD. In academia we have a mountain of work and I had a colleague who has a reflective critical attitude towards mental health system, but was actually relieved to get the diagnosis of ADHD. They could now access Adderall or Ritalin and perform more, which is of course the major component of Adderall or Ritalin. These are not mental illnesses per se, but they are actually issues of performance in neoliberal environment.

Dhar: This reminds me that for Emil Kraepelin, one of the primary indicators of dementia praecox was the fact that this person does not want to work. We can't have that.

Cohen: Yeah, absolutely. This is the conservative nature of psychiatry going back to its birth.

Dhar: You write that psy-disciplines have provided a lot of pseudoscientific evidence to support neoliberal capitalism, thus turning social problems into individual problems, and social issues into individual deficits. I wanted to know more about this pseudoscientific evidence.

Cohen: The really conservative nature of psychiatry throughout its history reflects wider society. That's a struggle between the workers and the owners and the means of production. It reflects the dominant norms or values of that society, particularly being a profession that is dominated by white middle class men. They are a profession that are the lackeys of capitalism.

Looking at gender inequalities, patriarchal power, and the roles of women and men—these are sociopolitical issues of sexism, discrimination, partner violence, poverty, compulsory heteronormativity. Why would psychiatric discourse promote these ideas? As lots of critical feminist scholars have signposted, and I with Rearna Hartmann have argued, this is to enforce patriarchal capitalism, that is, to keep women as second-class

citizens to service the economy as unpaid or low-paid labor, to take the majority of the housework, as well as reproduce the future labor force here.

We have referred to this increased focus over time on women's roles by psychiatry as *feminization of the DSM*. There has been an increase in the number of mental illnesses that are really gender biased against women, like the whole history of personality disorder. We see borderline personality disorder, body dysmorphic disorder, female sexual arousal disorder, gender identity disorder, female orgasmic disorder, binge eating etc.

Dhar: PMDD?

Cohen: Yes, exactly! Feminist scholars have said these are feminist categories that are connected to prevailing moralities and norms regarding gender, sexual expression, the gender order, and heteronormativity. For example, premenstrual dysphoric disorder symptoms include a lack of energy, specific food cravings, physical symptoms such as breast tenderness, joint or muscle pain, bloating, weight gain and so on. This is the medicalization of menses.

DSM states there is a decreased productivity and efficiency at work, school, and the home. PMDD is a pathologization of women as being victims of their own biology. And hey, this is not the first time it's happened; it's 200 years of history and a lot of that by psychiatry—"the women are subject to raging hormones." It functions to legitimatize traditional constructions of femininity, and to restrict women's access to equal opportunities. That includes taking up senior professional and public positions.

We argue that PMDD cautions women not to place their work responsibilities above the family responsibilities. That's captured in contemporary advertisements for Sarafem, the preferred recommendation for PMDD. You see these adverts in which women are of course homemakers, they are carers, they are represented as mothers and wives.

Dhar: About your upcoming book, *Selling Mental Health*, you have written that the "mental health" discourse appears more benign than the "mental illness" discourse but it's just as dangerous. Could you tell us more?

Cohen: As with the work of missionaries and anthropologists towards the colonial project, the mental health project can be understood as the advance troops of psychiatric hegemony. This is a way of proliferating the hegemony to capture more and more people. It captures all of us. There is still a chance that hopefully some of us can escape the mental illness label, but the clever and simple phrase "mental health" actually captures us all in it. Mental illness is becoming a bit passé in public health discourse as opposed to the phrase mental health, which obviously has a more positive conversation.

Even though we actually have no idea what the hell it is we are talking about, we are just like, "Well it's got to be a good thing, it's about mental health." But when you break that down what the hell is that? One thing it is—it's really big business.

There are these taglines of "no health without mental health" and "mental health is everybody's business." These have become commonplace. It's not unusual to see

workplaces holding mental health awareness sessions or school instituting mindfulness classes. Every disaster crisis leads commentators and campaigners to say we need more targeted mental health services. And we have consumer products which are now sold to us on the basis that they are actually good for our mental health and wellbeing.

So, the *Selling Mental Health* book actually continues this analysis about psychiatric hegemony, but through this concerted focus on promotion and the selling of the psychiatric discourse. The profession is legitimating the services, products, and the treatments, and doing it under this beautiful umbrella of "mental health." And it's under the guise of "it's all for our public health, it's all for our benefit."

Dhar: These cracks that have been appearing for the last decades in the biomedical model—the dopamine hypothesis is under fire, prominent psychiatrists are saying, "Oh, we never said it was a chemical imbalance," and we are taking psychiatric drug withdrawal more seriously. I wonder if switching from "mental illness" to "mental health" effectively neuters any kind of progress that we could make—"Oh, we don't have to call it an illness, it's a more health thing."

Cohen: Absolutely. That normalization has happened very successfully. There is this saying "your wellbeing comes first." Many universities have taken up this mantle for staff, faculty, and students. During COVID, with the staff losses we had, it was still "your wellbeing comes first." We have a social wellness committee. It's established to help foster, it says "a positive workplace culture and environment that promotes staff wellness that's both physical and mental, and that is welcoming, inclusive and safe for all staff"—all very well.

We have had loads of activities—Auckland Bike Challenge, Auckland Walk Challenge, posters about of course mental health awareness week, etc. However, and this is where it gets political and serious for me: myself and my colleagues are basically expected to do more and more over time with less. This is especially true over the last couple of years, but I would say this goes back five to eight years. We lost administrative staff, two to three in sociology, there's been a virtual freeze on new academic employments. Even our tea room was taken away from us.

The morale is not good—how can chair massages take away the fundamental problems of institutional under-resourcing? These mental health initiatives in the workplaces have spread out in a relentless way on the back of slogans like "mental health is everybody's business" which is the idea that mental health is costing businesses a lot of money, so basically, the more you can aid the mental health of your workers, the more productivity will go up.

But, the finding of a number of surveys suggests this is more of a surveillance and social control process. This is despite evidence that if you made your workplace more favorable for the employees, that would have a positive effect on mental health. So, you had this focus on basically individuals rather than organizations. There is a report for the Australian government that suggests more explicitly involvement of employees themselves in surveillance measures.

Writings from North America suggests three things. First of all, all of this is about coercive practices which force workers to self-label as being mental disordered. There are expectations for the employees to be mentally well at all times.

Secondly, it's the reframing of workplace conflicts as personal issues. Structural issues within the organization such as downsizing our university, these are individualized through mental health initiatives—there is a concentration on the employee and their emotional reactions and need for personal adjustment. They have one of these sessions when they are about to sack employees.

The third issue is an increased use of diagnostic labels and discriminatory behavior against those who are labelled as mentally ill within the workplace. It actually avoids the focus on power imbalances and structural issues of the work environment. Instead, we can medicalize workers as at-risk of biological or psychological issues.

They have found in these cases that these are issues related to conflicts with manager or their supervisor. Despite arguments for mental health workplace programs having positives like leading to accommodation for workers, actually the employees are usually severanced out. Write a check, severance them out.

What this program seems to be about is it's really a case of surveying, pinpointing who's got mental health issues, getting rid of them, and making sure that their employees know that they have to be mentally well and productive at all times.

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MIA Research News Team: Ayurdhi Dhar is a spotlight interviewer for Mad in America. She does some professoring (at the University of West Georgia) and academic writing, but mostly likes to be known for her love for food, animals, friends, and family. She struggles daily with her desire to pet every dog she sees.

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