Constructing psychiatric certainty

BY EFRAT GOLD

Efrat Gold is a PhD candidate at the University of Toronto engaging in Mad and Disability Studies. Through her writing and activism, she challenges dominant views of mental health and illness, moving toward contextualized and relational understandings of well-being. Gold critiques psychiatry, focusing on those most vulnerable and marginalized by psychiatric power, discourse, and treatments. Her work is staunchly feminist, anti-racist, and anti-oppressive. Through explorations into meaning-making and constructions of legitimacy, Gold unsettles psychiatric hegemony by "returning to the sites where certainty has been produced."

My dissertation research returns to the era following the Second World War in Canada, when biological psychiatry began to carry the weight of medical certainty. In exploring this history and challenging psychiatric legitimacy, I take up the concept of what Canadian Disability Studies scholar Tanya Titchkosky (2011) calls "a restless reflexive return to what has come before," which "requires us to be restless with the concept of certainty by returning to its production and not permitting it to remain unquestionably certain" (p. 15). In revisiting the era when psychiatry became perceived as having scientific and medical legitimacy, I enact a restless return to the concept of psychiatric certainty. In doing so, I ask: *Where did this era of psychiatric legitimacy come from? And how does it fit into larger historical trajectories of ascribing meaning to human difference, struggle, and suffering?*

PSYCHIATRIC DISORDER AS SCIENTIFIC FACT

Psychiatric disorders are often understood to be scientific fact—as established as any physical disease. However, unlike in other branches of medicine, psychiatric diagnoses are made on the basis of a person's behaviour, or feelings of distress, and generally preclude medical and scientific testing. In other words, the precursor to receiving a psychiatric diagnosis is being *distressing*, either to oneself or to others. The diagnostic criteria that this distress is measured against consider such factors as a person's ability or willingness to work and socialize in ways considered "normal." In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), these criteria are expressed in language that defines supposed psychiatric symptoms as causally interfering in a person's "social or occupational functioning" (American Psychiatric Association, 2013). As a branch of medicine, psychiatry represents a medicalized approach to treating human distress, lack of productivity, or other types of suffering. The underlying premise—that those given psychiatric diagnoses have a *biological* or *genetic cause* behind their disorder—relies on unproven theories of genetic heredity and predisposition. And yet, without testing, psychiatric diagnoses largely hinge on a person's social or occupational functioning—factors that speak to a person's ability to cope only within current Western ideations of productivity and sociality (Taylor & Gold, 2019; Cohen, 2016).

The legitimacy bestowed upon psychiatry is not, nor has it ever been, based on whether or not psychiatric methods work. Contemporary psychiatry speaks to the context out of which it arises more than it does to any stand-alone objective scientific or medical *fact*. Unlike in other branches of medicine, definitions of psychiatric disorders rely heavily on relational norms—for example, whether a person can work and socialize appropriately, whether they can behave in line with societal standards, and whether a lack of behavioural adjustments to societal standards interferes with their daily functioning. These examples suggest that people who are not adjusted to cultural norms are classified as mentally ill, providing relational definitions for phenomena that are mostly assumed and presented as having a biological basis. Contemporary psychiatric diagnoses speak to capitalist ideals of productivity, according to which being unproductive is the defining factor of being mentally ill; these disorders are constructed into existence through the use of norms. To quote Canadian anti-psychiatry scholar Bonnie Burstow (2015):

> The fact that this is an institution that operates on conjecture and declaration rather than on proof, an institution that not just occasionally but routinely calls things diseases in the absence of observable physical markers, I would add, raises the question whether we are truly dealing with medicine here, at least in the modern sense of the term. Indeed, it raises the question of whether we are dealing with science at all. (pp. 13–14)

BIOLOGICAL PSYCHIATRY IN CANADA

In Canada, biological psychiatry, loosely defined as "the search for physiological, genetic and chemical bases" for psychiatric disorders (Kirk & Kutchins, 1992, p. 10), gained traction following the Second World War. As traumatized veterans and European refugees tried to recover their lives, and as militaries around the world took interest in the potential of the psy-disciplines (psychiatry, psychology, and psychiatric social work) to change and/or control human behaviour, these new frontiers created interest and investment to explore the potentials of psychiatry (Gold, 2016). However, the goals of changing and controlling human behaviour were not new and speak to the cultural origins of biological psychiatry,

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which lie in ideologies of eugenics and mental hygiene.

During the eugenics era (from the late 1800s to the mid-1900s), social constructions of deviance and undesirability became framed in terms of genetic heredity. This led to social and economic policies that characterized marginalized groups as needing to be removed from society in order to preserve its integrity. Theories of genetic superiority and inferiority were utilized to justify conceptualizations of Indigenous people, Jews, queers, the mad and disabled, those in poverty, the so-called feeble-minded, and other undesirables as "parasites," "useless eaters," "life not worthy of living," and those needing to be "weeded out" to protect the morality of society (Kevles, 1985; Russell, 1998). The eugenics era culminated in the Holocaust, which encompassed the killing of millions.

Following the end of the Second World War, eugenics was no longer widely seen as progressive; instead, it was robustly condemned as a dangerous, racist, and outdated ideology that had led to a terrifying episode of human depravity. However, the theories underlying eugenics did not simply disappear, but came to be reconstituted in new ways. Biological psychiatry continues to aggressively pursue theories that promote hereditary and neurological etiology underlying so-called mental illnesses (Burstow, 2015). One limitation of theories that assume genetic, chemical, or hereditary causes for behaviours and feelings is that they miss the role of context, oppression, agency, and, importantly, the connectedness between people and the social reality in which they are embedded.

IGNORING THE RELATIONSHIP BETWEEN BIOLOGY AND SOCIAL EMBEDDEDNESS

A medicalized approach to human suffering ignores the complex and multifaceted relationship between biology and social embeddedness. In the case of the chemical imbalance hypothesis, it is theorized that mental illness is *caused* by an imbalance of neurotransmitters such as dopamine and serotonin, the levels of which are not generally tested prior to a psychiatric diagnosis. In theory, treatment with psychiatric drugs should restore the balance of these neurotransmitters, and in doing so should *fix* or *eliminate* the psychiatric disorder. While it seems to be true that there is a relationship between neurotransmitters and affect, correlation does not equal causation. Within psychiatric frameworks, efforts are not made to integrate complex knowledge of the relationship between neurotransmitters and the material conditions of a person's world beyond basic cause-and-effect. Communities of people who have lived through psychiatric diagnoses and treatments, often referred to as psychiatric survivors, are among the first to call attention to the harms caused by psychiatric involvement. By returning to the sites where psychiatric certainty was constructed, I challenge this certainty and offer non-pathologized, relational approaches to suffering and distress.

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