MEDICALISATION IN PSYCHIATRY AND SOCIETY

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Abstract

This dissertation critically reviews literature concerning the medicalisation of human behaviour into mental illness, and that of psychiatry itself. By accumulating ideas and arguments in journal articles, books, newspaper reports and documentaries, a variety of perspectives are analysed to understand the effects of medicalisation within society, and the medicalisation of psychiatry. The central focus is the initial problem of psychiatry, the fact that mental illness is unidentifiable on a scientific level. Philosophical and historical perspectives have been provided to allow better understanding of how this issue has led to problems including misdiagnosis, over-diagnosis, and the prevailing ambiguity which blurs boundaries surrounding mental illness, allowing the pharmaceutical industry to medicalise human behaviour and market both illness and drug. Social factors surrounding psychiatry will be reviewed, also to gain understanding of medicalisation and psychiatry as it occurs today. The validity of psychiatry and existence of mental illness, including analysis of anti-psychiatry and arguments that it is pseudoscientific will be seen. Following this will be a case study analysis of bipolar disorder, providing both a historical and modern analysis of the illness, and a review of the development of rating scales such as the DSM and it's involvement in regulatory agencies, pharmaceutical marketing, and the growth of the industries in terms of finance, global awareness and literal expansion of mental illnesses. Definitions, understanding, use of information and various alternate perspectives will be provided to review the medicalisation of both society and psychiatry.

Introduction

This thesis aims to look at the medicalisation of both psychiatry and society, by analysing it from various perspectives including the historical, the philosophical and the social. In order to do so, scientific literature as well as documentaries and television programs concerning the related topics have been analysed, providing a variety perspectives and arguments.

One of, if not the primary issue concerning the medicalisation of psychiatry within society today is that the existence of mental disorders is very difficult to prove scientifically, and thus faces struggles when attempting to be seen as equal to other fields of medicine. This paper reviews arguments related to this issue, such as the relationships formed between psychiatry and other global institutions, and the advantages and shortcomings of such an occurrence throughout society. The problems caused by the lack of identification of mental illness are at the core of this thesis, and the issues caused by this problem will be assessed. It will be suggested that this problem leads to the need within psychiatry for self-medicalisation, as well as the global phenomenon that mental illness has become, through the medicalisation of society.

An historical review of psychiatry provides insight into the dissolution of boundaries and the expansion of psychiatry and social understanding of mental illness; additionally, a recent documentary concerning bipolar disorder will be analysed to assess an alternative perspective on the illness, to that seen within the majority of scientific literature. Additionally, a step backwards will be taken and a review of the validity of psychiatry and existence of mental illness will be taken into account, an important factor to be established before continuing such a discussion.

An analysis of specific case studies including bipolar disorder, premenstrual dysphoric disorder and social anxiety disorder, together with historical, philosophical and social comparisons will be

interspersed; through these examples and concurrent discussions of medicalisation, psychiatry and surrounding social factors to provide insight into how psychiatry is understood, used and managed in todays world, and to argue that psychiatry itself is being self-medicalised. Methods of measurement and regulation such as the DSM, FDA and clinical trials will be evaluated, alongside the ways these are used to further medicalise and assist the relationship that psychiatrists have with the pharmaceutical industry for various purposes.

Overall, this thesis will attempt to show the ways in which medicalisation occurs throughout society, and how and why psychiatry itself is self-medicalising, in attempt to legitimise itself as a field of medicine. On a philosophical plane, justification can be seen by removing the need for tangible evidence; it is difficult to translate such theories into modern society however, particularly when Big Pharma has such a financial stronghold and influence over society as a whole, and over-medicalisation appears common. The medicalisation of psychiatry and society, as well as the literature concerning these ideas will be reviewed from various perspectives, with specific examples provided to allow greater understanding of the methods and relationships between psychiatry, the pharmaceutical industry and society as a whole.

THESIS NOTES

Why focus on American psychiatry?

As will be seen throughout this thesis, the majority of literature, statistics, facts and evidence either discuss, or are, American. There are various reasons as to why the focus is on US psychiatric practise, namely the fact that the majority of literature concerning the topics discussed circulate around events in American psychiatry, such as FDA regulation, the use of the DSM and marketing and advertisements for pharmaceuticals and their companies. Additionally, statistics show that more Americans are diagnosed with mental illnesses than any other nation, and that mental illness is "now the leading cause of disability in children" in the US (Lane 2011). In a NIMH-funded survey run between 2001 and 2003, "an astonishing 46% met criteria established by the APA for having had at least one mental illness within four broad categories at some point in their lives" (Angell 2011).

NIMH statistics report that approximately 18.8 million American adults suffer from a depressive disorder, another 2.2 million with schizophrenia, 19.1 million with various anxiety disorder sand of the 30 535 people who committed suicide in 1997, over 90% had been diagnosed with a mental illness. (NIMH 2004, Blalik 2011) These statistics are significantly higher than those of UK and many European countries. Additionally, the APA, FDA regulatory processes and the international usage of the DSM IV have placed American psychiatry at the forefront of international analysis, creating it's image as a global point of comparison and prime area of research. Finally, there is simply too much information to include, were one to address psychiatry throughout the world. Mental illness often appears as far more accepted and advocated in the US, whereas other countries do not recognise it in the same way, and therefore, statistically, will not have the same results. Americans may seem to have more mental illnesses; though, this may only be due to the definitions and criteria set out.

Media & Multimedia

This thesis is an accumulation of not only literature found within books, articles and journals but television programs and documentaries. The majority of sociological and scientific literature on the subject tend to exclude these multimedia sources, yet they provide useful analysis and allow for alternate perspectives to be explored. Documentaries such as Selling Sickness and Big Bucks, Big Pharma, whilst somewhat sensationalist in terms of sound, special effects and so forth not only provide interview footage of psychiatrists and critics; ex-pharmaceutical salespeople, employees at advertising companies and such are also included, providing the viewer with varied opinions and views. It seems useful to analyse documentaries and programs aimed at public viewing for this very reason; it is important to assess information not only intended for scientists and those within the medical profession, but those aimed towards the general public, who are so deeply affected. It is far more likely for a member of the public otherwise unaffiliated with psychiatry and medical literature to view a documentary or program reviewing the topic; therefore, it only seems appropriate, indeed necessary, to include these in a review and critical analysis.

As well as education-based media, popular culture has played an important role in the way that psychiatry and the pharmaceutical industry are understood today. This paper does not explore effects that film and (fictional) television have had on the social understanding of mental disorders, but it is important, again, to be aware that popular culture has had great effect on public understanding, encouraging awareness of mental illness. There are often advertising components to these campaigns and programs, urging people to seek medical attention if they believe they are suffering from a disorder. Celebrities including Stephen Fry, Richard Dreyfuss, Catherine Zeta-Jones, Robbie Williams, Carrie Fisher and so forth have spoken publicly about their experiences battling mental disorders (English 2011).

The analysis of one documentary in particular is included, that produced by Stephen Fry, concerning his relationship with bipolar disorder. This has been included to provide an analysis of bipolar from a completely different alternate perspective to that in most scientific literature, and to demonstrate the importance of using information intended for general public consumption, alongside the strictly scientific. In fact, it could be said that programs of this nature are even more important than the scientific, as it is more easily accessible by the public; it is, after all, the public who are at stake when concerning medicalisation of society and psychiatry.

Commonalities & Criticisms

Through exploring the vast literature concerning medicalisation and psychiatry, one often finds that many concepts and theories are repeated by critics and advocates. Emphasis is placed on certain arguments; for example, critics focus on how mental illness is too difficult to define and therefore no attempts at medicalising psychiatry should be made, whereas others see the same point as creating space for improvement, a continuous search for answers. This dissertation attempts to provide additional perspectives by adding a philosophical level to the debate; analysing how logical positivism and realism could be used to determine psychiatric evaluation and practise, reconciling the belief that mental disorders exist, despite the lack of tangible evidence, nor available test to provide proof.

Many critics of medicalisation, psychiatry and the pharmaceutical industry also appear to use scaremongering tactics to incite fear, paranoia and suspicion amongst the public concerning pharmaceutical companies and their interests. Whilst information is not necessarily exaggerated or fabricated, many texts, particularly the radical anti-psychiatry literature such as Thomas Szasz portrays these institutions as evil in an overly dramatic way, seemingly to not only educate, but incite fear and suspicion in the reader. These tactics aren't exclusive to radical literature, however,

and are seen in commonly cited books such as those by David Healy, and films and documentaries which focus on the evils of the pharmaceutical industry and their lack of concern for human health and wellbeing. The ability to use sound effects, visuals and dramatic, deep voice-overs, clearly used for the purpose of instilling fear within the mind of the watcher are inherent in documentaries, and exaggerated further in film and other popular culture.

It is somewhat ironic, that the 'catchy' terms and phrases used by pharmaceutical marketing to attract public attention are commonly used by the critics themselves. In a similar fashion to the ways in which Big Pharma advertise their products as though any other commodity on the global market, article headings, documentary and book titles etc. use catchy phrases, bright images and exaggerated examples. Upon conducting research for this literature review, amusing titles were to be found everywhere. Books entitled 'Comfortably Numb' (inevitably referring to the 1979 Pink Floyd song), 'Anatomy of an Epidemic' 'The Emperors new drugs' 'Let them eat Prozac', documentaries such as “Big Bucks, Big Pharma” and “the Selling of Sickness.”

MEDICALISATION

What is Medicalisation?

Medicalisation could be seen as both gift and curse. By turning aspects of human behaviour and emotion into illnesses to medicalise society and psychiatry, forms a type of social revolution, the accumulative result of parts of past societies and cultures; “the diminution of religion; an abiding faith in science, rational, and progress; the increased prestige and power of the medical progression; the American penchant for individual and technological solutions to problems; and a general humanitarian trend in Western societies. These factors, rather than being explanatory, set the context in which medicalisation occurs.” (Conrad 2007) Science and medicine are highly important and influential parts of modern society and medicalisation has occurred with unquestionable strength throughout the world.

Foucault

The main definition of medicalisation refers specifically to the translation and classification of a human condition or behaviour into one which can be identified as a psychological or biological problem. This allows diagnosis and, when possible, treatment. The 'medicalisation technique,' stemming from Foucauldian analysis and Marxist perspectives (Bunton 1997) explores the emergence of societal norms being characterised and classified into medical conditions. Foucault's ideas focus upon the intertwining of health and medicine with other aspects of life, becoming “the wholesale incorporation of the body and disease... in the discursive matter via the productive effect of power/knowledge, viewed as socially constructed entities.” (Williams 2001) Whilst not using the term 'medicalisation' itself, it presents itself to allows 'a consonant vision of a world in which individuals' lives are profoundly experienced and understood through the discourses and practises of medicine and its allied professions” (Bunton 1997) Foucault addresses medicalisation in Birth of the Clinic; “The two dreams (nationalised medical profession and the disappearance of disease) are

isomorphic; the first expressing in a very positive way the strict, militant, dogmatic medicalisation off society... the second expressing the same, but in a triumphant, negative way, that is to say, the volatilisation of disease in a corrected, organised and ceaselessly supervised environment, in which medicine itself would finally disappear, together with its object and raison d'etre" (Foucault 1966)

The postmodern critique of categorisation and its limits are clear, however, it can be seen that medicalisation is indeed created by medical categorisation and processes. Whilst not all aspects of the Foucauldian perspective is thus agreed upon, there are "complementary lines of analysis... [medicalisation focuses] especially on the creation, promotion and application of medical categories to human problems and events" (Conrad 2007), with an interest in social control and the transformation of "the normal into the pathological... to put it crudely, medicalisation of all sorts of life problems is now a common part of our professional, consumer, and market culture" (Conrad)

Medicalisation in Psychiatry

Psychiatry was the focus of many early critiques of medicalisation before it expanded to the whole of medicine and other social forces. Extending the idea of medicalisation to the field of psychiatry as a whole provides an interesting perspective throughout the history and sociology of the field, particular with the introduction of pharmaceuticals. It could be claimed that psychiatry as a field, has been making attempts at self-medicalisation. Conrad writes that essentially, medicalisation is "defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it." Psychiatry has long come under fire due to its ambiguous nature and problems in proving the existence of mental illness beyond observation. Psychiatry as a field is searching for ways to be able to define itself on a medical basis, by providing medical intervention as treatment.

Far before the introduction and influence of the pharmaceutical industry however, psychiatry was attempting to medicalise the study and treatment of mental disorders, and to see it become a recognised, legitimate field of medicine alongside anatomy, pathology, genetics etc, which use biological, empirical, tangible research and evidence to study, treat and prevent illness in the human body and throughout society. "The new biomedical psychiatry is the most recent in a long series of efforts to fully integrate psychiatry into medicine" (Lakoff 2005) and with advancements in pharmaceutical research, questions begin to arise as to whether psychiatry is growing into a field in which illness is treated, or for the "pathologisation of the abnormal."

Has Medicalisation Gone Too Far?

Many claim that the rates of those diagnosed with mental problems is largely due to the concurrent rise in availability and marketing of pharmaceuticals. There are other factors which be taken into consideration however. Problems including alcohol and drug abuse, child abuse, hyperactivity and sexual issues were prevalent throughout history, but had not been medicalised, and therefore not recognised as treatable illnesses. (Conrad & Schneider 1980) Common illnesses today such as PTSD, ADHD, anorexia nervosa, PMS and such were "either esoteric diagnoses or not yet described in medical literature" (Conrad 2005). The medicalisation of such traits and symptoms indicates that whilst not all illnesses have been essentially fabricated or designed by pharmaceutical companies specifically for the purpose of selling a drug, it is still seen as an issue of much concern; where, or when will medicalisation stop?

Some critics are somewhat cynical regarding the ever-increasing list of symptoms and medical diagnoses; "If you don't see yourself on that list [of DSM illnesses] don't fret, more are in the works for the next edition." (Kirk 2005) Kirk's remark, whilst spiteful, mirrors the belief of others; the notion that medicalisation will never cease and that some aim to see entire populations being

diagnosed and treated; “Every marketers dream is to find an unidentified or unknown market and develop it. That’s what we were able to do with social anxiety disorder.” (Vedantam 2001) and marketing tools used, particularly in direct-to-consumer television advertising universalise the experience of mental disorders, affirming the public that mental illness could affect anybody. (Koerner 2002) New illnesses are created, and already existing disorders are updated with added criteria.

Jack Gorman, a psychiatrist working for various drug companies explains that extensive testing is done for many different, often constructed, illnesses. Generalised anxiety, pre-menstrual dysphoric disorder, post-traumatic stress disorder, female sexual dysfunction, adult ADHD, paediatric bipolar and various others are listed as illnesses created by companies to split various drugs apart, allowing each specific illness a specific treatment. At this point, it is claimed, almost anybody could find themselves diagnosed with a disorder, and it is thus portrayed as nearly a moral duty to use drugs to fix this, to “take vitamin serotonin” (Healy 2004) Pfizer for instance, supposedly required the concept of post-traumatic stress disorder to market Zoloft.“If you sell the illness, you sell the drug.”

Another example is PTSD, originated during the Vietnam War, with symptoms including ‘flashbacks,’ insomnia, anxiety attacks and so forth, attached to a specific cause and context. Subsequently, the criteria has expanded and symptoms now include both victims and witnesses of sexual abuse, rape, violence, or natural disasters. (Scott, 1990; Young 1995). Whilst it is indisputable that events such as these can lead to deep depressive and anxious states, it does not necessitate the diagnosis of a disorder requiring pharmaceutical attention. The following section will further assess psychiatry and mental illness; it's definition, existence and problems. The medicalisation of behaviour into psychiatric conditions requires definition and assessment of human emotion and behaviour. It is difficult however, to define the unidentifiable, and universally understand notoriously ambiguous mental illnesses.

QUESTIONING PSYCHIATRY

The Fatal Flaw

The definition of psychiatry, and its aims is a topic of ongoing debate, due to the ambiguity of it's subject matter. Psychiatrists are oft faced with inevitable, unavoidable problems because there is great difficulty in defining a physically unidentifiable illness and thus, greatly lacking in objectivity or common understanding. Depression cannot be identified in the same way as a brain tumour, lung cancer or any other biologically-identifiable disease. Instead, the understanding and diagnosis of the illness is left to the psychiatrist, aided by the DSM and other rating scales to determine illness and severity. This lack of firm ground to base research and definitions on, leads to psychiatry being considered by many as non-medical, further pushing self-medicalisation attempts.

In defence of psychiatry, Nancy Andreasen expresses frustrations; “A neurologist..defined psychiatry as the discipline that deals with the syndromes of unknown cause, while neurology... turns them into 'real diseases' and then assumes responsibility for studying and treating them.” The amorphous, ambiguous qualities remain intact and problematic, however; “Psychiatry... studies and treats a variety of disorders that affect the mind – mental illnesses.... defined by its province, the mind” and another definition attempt focuses instead upon what the task of psychiatrists is, saying that they “modulate the psyche” through medication and/or psychotherapy. (Andreason 1997) Despite the constant attempts at understanding and definition, it can be seen that the question, 'what is psychiatry?' remains unanswered.

It appears that the very problem which hinders the legitimisation of psychiatry, has also inadvertently led mental illness becoming a universally acknowledged concept; the very fact that psychiatry is so ambiguous and that the boundaries separating mental illness and health are so vague and difficult to define, allows widespread speculation and diagnosis. Endless gateways are

opened for researchers, physicians and pharmaceutical companies to medicalise human behaviour, and market both illness and drug.

Science or Pseudoscience?

Whilst psychiatry has seen the medicalisation of many common human emotions and behavioural traits, it's subjectivity makes it difficult, in some cases, to separate from other pseudoscientific fields, in the Popperian sense that they are unfalsifiable. Whilst Popper does note, "..science often errs, and pseudo-science may happen to stumble on the truth" (Popper 1963), and Lakatos believes "a statement may be pseudoscientific even if it is eminently 'plausible' and everybody believes in it, and it may be scientifically valuable even if it is unbelievable and nobody believes in it.." (Lakatos 1973), he criticises theories which have '"explanatory power" such as Marxism and Freud, in that they "appeared to be able to explain practically everything that happened within the fields to which they referred.." The same could, to an extent, be said of psychiatry, in that behaviour can be explained in any which way, depending on the observer. These theories are non-testable and irrefutable, thus, highly difficult to contradict. (Popper)

Anti-Psychiatry

It is difficult to prove the scientific status of psychiatry as a whole due to it's inevitable subjectivity and lack of evidence. Many believe that whilst mental illness exists, it doesn't to the extent to which people are led to believe through over-diagnosing, advertising and globalisation of theories. The anti-psychiatry movements take an extreme view, arguing that psychiatry is entirely pseudoscientific and non-medical. Thomas Szasz provides his irreverent definition of psychiatry: "The subject matter of psychiatry is neither minds nor mental diseases, but lies... [which] begin with.. the designation of one party as 'patient' even though he is not ill, and of the other party as 'therapist' even though he is not treating any illness. The lies continue with the deceptions that

comprise the subject matter... - the psychiatric 'diagnoses,' 'prognoses,' treatments,' and 'follow-ups'.. Accordingly, if we wished to give psychiatry an honest name, we ought to call it 'pseudology,' or the art and science of lies and lying," (Szasz 2008) and so on.

Considering that as yet mental illness cannot be physically identified and is therefore unfalsifiable, one cannot entirely rebut the argument that psychiatry could be considered pseudoscience. The following section assesses philosophical concepts which can justify the existence of mental illness despite a lack of evidence; stepping away from a tangible, sociological perspective into the philosophical here seems to provide a possible answer to the fatal flaw of psychiatry.

Psychiatric Realism

Unlike behaviour, cognition cannot be observed, and therefore the cause of mental illness, insinuating a cognitive abnormality, is difficult to prove. Whilst it is possible to validate and verify certain behaviours as being a result of thoughts and cognitive processes, there is no way of observing or ensuring how and if such a connection exists. Behaviour is the process and result of cognition having external effects through bodily movement, not a direct presentation.

The logical positivist argument that meaningful science can only come from verified, empirical evidence has been criticised, however. (Curd & Cover 1998)These ideas severely restrict notions of truth to only matters verifiable by empirical observation or experiment, a problem for psychiatry and its subsequent medicalisation. Realism can instead be employed; the idea that the world and entities within it exist independently of any representation of it. (Cromby & Nightingale 1999). Realism allows commitment to the ontology of a hypothetical construct, even if it is undetectable, until inductive reasoning proves otherwise. Realism attempts to provide an ideal theory about an existing property or set of properties and accepts process and progress of science, searching for

truthful connections between objects and structures that are largely metaphysical; meaningful despite being non-empirical. (Putnam 1991; Smart 2004) In terms of psychiatry, this could imply that a lack of evidence does not infer pseudoscientific status; analysis would revolve around patient observation and the behaviour in relation to external stimuli, and non-empirical factors would be both included and valid. With this explanation in mind, it could be concluded that psychiatry, whilst empirically difficult to prove, is scientific and worthy of research and medical status.

The notion of realism in psychiatry is furthered by Charles Rosenberg's model of 'disease specificity' which applies this notion to the organisation of illness, here understood as a stable entity, existing separate to, and outside any particularly individual. The disease is explainable through specific causal biological mechanisms, identified inside the body of the patient. This model is a tool of administrative management, allowing large-scale research to be gathered, the mandating of clinical practise by introducing protocols for treatment and more generally, to rationalise health practise. (Rosenberg 2006)

Whilst this perspective allows the justification of psychiatry and it's medicalisation, the non-empirical nature of its research is still difficult to avoid. The blurred boundaries and definitions provide wiggle-room for psychiatrists, drug companies, regulatory agencies and consumers to come to various conclusions, diagnoses and so forth. However, it remains a plausible and conceptually acceptable addition to the ongoing debate about the existence of mental illness, and the status of psychiatry.

The Structure of Psychiatric Revolutions

The introduction of pharmaceuticals as 'miracle cures' or 'magic bullets', and their subsequent

demise can be likened to concepts in Thomas Kuhn's 'Structure of Scientific Revolution'. Rather than seeing science as a continuous accumulation of knowledge, Kuhn explains that the knowledge and understanding of science occurs in revolutions and paradigms. He describes how theories and laws of science occur in various phases. Scientific knowledge at a certain time may be challenged by any number of anomalous events, neither explainable nor avoidable due to their repetitiveness or emergent prevalence. From this comes a 'crisis' stage, in which the idea or theory previously considered fact is falsified and proven wrong, following which comes a phase oft described as chaotic, an intellectual 'battle' in which scientists clamber to research new ideas and race to find a new theory and a new paradigm in which this theory serves to explain the problematic events. Eventually a 'new world view' is discovered, new theories emerge and a new paradigm is created, within which science now continues and is understood in this way. (Kuhn 1996)

This theory of revolutions and paradigms can be seen within psychiatry, when looking at it's history and the ways in which it has changed over time, specifically when speaking of the various ways in which physicians and psychiatrists have tried to treat patients over the years. A scientific 'breakthrough' occurs, be it ECT, the short-lived lobotomisation procedures and in particular, the many types of medication which has been seen throughout the past 50 or so years of psychiatry – imipramine, chlorpromazine, lithium, benzodiazepines, SSRIs and so on. (Mental: History of the Madhouse)

In the same way that Kuhn describes the structure of scientific paradigms to undergo a crisis stage, so too can each progression of psychiatry be seen as having faced this crisis. Most commonly it occurs when observing the longer term effects of medication and other treatments, discovering the highly addictive or dependancy-creating properties of a drug, or the dangerous side effects such as the notorious, notable increase in suicidal behaviour when taking Prozac (Healy 2003). Researchers

then clamber to find new medication or treatment methods, as has been seen throughout the history of psychiatry. One of the problems is that due to this fast-paced environment, research is conducted as fast as possible and clinical trials do not last as long as they could be, which leads to a lack in evidence of any long term side-effects, as well as dishonesty in reporting the trials.

Eventually a new drug is found and marketed to the public, to treat either a new illness, or an old illness in a better way. Thus, the crisis stage is over and psychiatry operates within a new paradigm, having now included it's new medication and/or illness, and disregarding the old as harmful, ineffective or simply incorrect.

The following case study will assess bipolar disorder, taking these ideas into account; the development of new ideas in psychiatry creates a new paradigm in which an illness is understood, treated and marketed.

CASE STUDY – BIPOLAR DISORDER

History

The ways in which symptoms of human nature and industry have been medicalised into definable, diagnosable and treatable illnesses is not new; it has developed and vastly expanded throughout the past two centuries and most strongly over the past 50 or so years, with the rise of pharmaceutical use in psychiatry. From a sociological perspective, many external factors surrounding science and medicine at the time of the first 'antidepressants' and the subsequent influx of countless drugs, new symptoms and related illnesses led to it's formation. “The 1950s gave rise to the Korean War, the Cuban revolution, the Hungarian revolution, the hydrogen bomb, beatniks – and antidepressants.” (Kirsch 2009) Terms such as 'melancholia', 'mania' and 'endogenous depression' (Greenberg 2010) were used before bipolar, manic depression, anxiety disorders and such were later officially recognised through the introduction of the Diagnostic and Statistical Manual of Mental Disorders, particularly from the DSM III (1952) onwards. The medicalisation of such illnesses came along at the same time that certain sedative side effects in drugs were slowly being discovered and tested by psychiatrists; the earliest antidepressants.

Throughout the 18th and 19th centuries, bipolar had a 'relatively privileged' place within the field, despite ongoing debate regarding it's boundaries, origins and specific symptoms. (Lakoff 2005) What came together were the common notions of 'mania', a term used to classify general madness, and melancholia, a subtype of mania and predecessor of depression. By the 19th century, the term 'monomania' or partial insanity had been introduced, wherein not all faculties of a patient are seen as malfunctioning in entirety, due to mental illness. (Goldstein, 1988; Berrios 1987) This opened the boundaries separating mental illness from health, leading onto modern psychiatry as it is today, having allowed far more room to move about, alongside the idea that not all mental patients require

constant supervision and institutionalisation. Mental illness was no longer 'all or nothing'.

In 1854 the idea of 'circular madness' was introduced by French analysts, bringing together the aforementioned mania and melancholia in a way which explained the two as opposite ends of the spectrum of the same illness and by the late 1880s it became 'manic-depressive insanity' (Lakoff 2005). The term 'manic depression' coined by Emil Kraepelin, referred to the most commonly diagnosed categories of what had developed into 'functional psychosis'. The introduction of 'functional psychosis' was a momentous occasion in the history of the field as it was a forerunner of widespread treatment and study of psychiatry, outside the institution. Functional insanity meant that the person can live and function with a mental illness but 'needn't be full time in an institution. This opened the gateway to thousands of generalised treatments, the availability of occasional therapy, psychotherapy, home treatment and self-medication.

Manic-depressive insanity was the most commonly diagnosed illness amongst Kraepelin's patients, and a smaller percentage were described as having 'dementia praecox', a predecessor to schizophrenia. Manic-depressive insanity allowed for ones intelligence to remain intact despite emotional instability, permitting the patient to live outside an institution. Manic depression was 'a disorder of the will'; "...an impediment of volition, in the sense that the transformation of the impulses of the will into action meets with obstacles which cannot be overcome without difficulty and often not at all by the patients own strength. This constraint is by far the most obvious clinical feature of the disease, and compared with this, the sad, oppressed mood has but little prominence." (Kraepelin 1904) It can be seen that this explanation describes the emotive problems and constraints that a patient with manic-depression has, but does not include any reference to dementia, nor lowered intelligence.

Additionally, it was noted that the same disease could have widely varied effects; "[Kraepelin] saw manic-depressive illness [as ambiguous, in that].. it might involve swings from mania to depression and back, but it could also manifest itself as recurrent mania without depressions or, more commonly, recurrent melancholias without mania.... similar to the differences between tuberculosis of the head and of the gut or lunch. They might look clinically different, but all were basically the same disease." (Healy 2003) From this realist perspective, (in that the illness exists according to it's own definition and regardless of how or what it does to any individual body which encapsulates the illness), the problematic ambiguity is again seen, and attempts at medicalisation remain present; it was the illness itself which changed in definition, to include far more symptoms and possible indications to accommodate many more situations. Bipolar as it was understood at this stage was essentially a medicalisation of countless aspects of human emotion and behaviour, to allow further analysis and treatment.

When the earliest ideas about depression as a mental illness were being formed, differing types were said to have had varied causes and treatment options. If a 'melancholic' experienced depression at an older age, or with no apparent cause, was called involutional, and later, endogenous depression, in that it was believed that this form was genetic and treatable by ECT. Reactive or neurotic depression was recognised as a form which can have been triggered, hence the reactive, or caused by an event, rather than a genetic or biological defect. This type of depression was regarded as treatable by psychotherapy alone. (Conrad 2007)

'Bipolar' disorder is an “especially intriguing category of illness because it seems to exist on both sides of certain key boundaries of mental disorder; In DSM, the boundary between affective and thought disorder, and in psychoanalytic epistemology, between neurosis and psychosis” (Lakoff 2005) Due to this ambiguous definition and understanding of bipolar, boundaries surrounding

concepts of mental illness have been blurred further.

This notion, both in terms of definition and prevalence continued steadfastly throughout the 20th century. Now that mental illness was open-ended, with new illnesses, symptoms and treatment methods being discovered, psychiatry expanded vastly. This initial breaking down of barriers and definitions did, as aforementioned, led towards modern psychiatry; ambiguous, subjective and open-ended, factors which scientific boundaries are specifically utilised to rid themselves of. The following section looks at a modern documentary about bipolar disorder within popular and celebrity culture. It furthers the idea that bipolar disorder has not only allowed psychiatry itself to expand and blur its boundaries, but those around the illness itself allow it to become a social phenomenon, as well as an 'epidemic' (Whitaker 2010)

A Fashionable Disease?

In 2006 Stephen Fry's BBC2 documentary, “The Secret Life of the Manic Depressive.” was an 'expose' about his experience with depression and bipolar disorder. Both the documentary itself, and the media hype around it seemed to raise awareness about mental disorders, and furthered the medicalisation of much human behaviour, and the modern day requirements for diagnosis and treatment. Questionable reviews were found amongst everyday newspapers; “Fry had to wait until he was 37 before he was finally diagnosed with bipolar disorder... nobody saw it coming... The illness, affects hundreds of thousands.. Although it can be managed successfully with drug therapies, 15% of sufferers kill themselves.” (The independent 2006) The Guardian made a similar evaluation and added two points about mental disorders in popular culture and it's relation to public understanding. Firstly, it recalls that interviewees throughout the documentary were asked that, if a button existed to make their 'bipolarity' disappear, would they press it; the only person who says yes is non-celebrity Connie, the only person in the documentary who “doesn't have the glitzy media life,

or her beautiful bipolar friends in Hollywood; it hasn't made her creative or witty..” The documentary does indeed 'glamourise' bipolar, and Fry asks the audience, “Would I have been so successful if I weren't manic-depressive?” Secondly, it affirms that the awareness raised by such celebrity endorsements are important, despite exaggeration and possible scaremongering; “...when [members of the public are] first told about the illness: they are embarrassed, they avoid eye contact... (It's different in America, where bipolarity seems to be bordering on the fashionable...) This bold, touching, unsentimental film should help rid mental illness of some of its stigma.” (Guardian 2006)

Fry's documentary is somewhat different to others surrounding the same topic, in various ways. Firstly, he himself has been diagnosed with bipolar disorder and aims to discover whether or not he has been rightly diagnosed, and if he is getting better or worse. There are not many documentaries in which the narrator uses himself as a point of comparison, understanding and self-experimentation. Secondly, Fry's search for proof is rather different, in that he continues his search, and belief in, finding tangible proof of bipolar disorder. Visiting neuro-psychiatric researchers at the Institute of Psychiatry, and geneticists at Cardiff University, each answer his question of, 'can you detect bipolar disorder' with a resounding no. Whereas Big Bucks, Big Pharma, Selling Sickness and others criticise over-diagnosis and and argue that many diagnoses are simply bad behaviour or growing children, Fry does the opposite; he sees his past self as having been told he was behaving badly, but “really, it was undiagnosed manic depression.”

Fry travels to the US and interviews not only celebrities, but a family with two children, both of whom are diagnosed with bipolar, and have been since under ten years old. He notes that British psychiatrists are very wary of the 'American way' of diagnosis and medicating at such a young age. In contrast to his British interviewees, he visits a psychiatrist in the US known for diagnosing children as young as four years old with bipolar disorder, and prescribing drugs accordingly;

Finally, one large difference between Fry's documentaries and almost all others about psychiatry is that many of his interviewees are celebrities and known faces in society, as opposed to the majority of documentaries which follow the stories of everyday patients and more critics, researchers, sociologists etc.

MEASURING MADNESS

Rating Scales

Before, and alongside the use of pharmaceuticals in psychiatry came other ways of grouping together patients and symptoms in ways which attempted to rid the field of at least part of it's irreconcilable subjectivity. Alongside the development of illnesses, treatments, and the industry itself, scales and measurements were needed to rate illness severity. What with the sudden influx of so many similar disorders, 'checklists' were needed in order to 'accurately assign', diagnose and subsequently treat a patient in a correct - or, at least, objective – way. “Checklisting spread into all areas of life, from the school playground to the pages of magazines, covering anything from personality features to sexual behaviour and activity levels. Finding that we, or out children, fall outside some norms impels us to take action to minimise the risks we now 'know' we run.” (Healy 2003) Scales such as the Hamilton Depression Rating Scale (HAM-D) are used, alongside the DSM-IV, the WHO's ICD and other manuals. Whilst these methods promote objectivity on one level, it can be seen to cause problems on many others. Nevertheless, the illnesses and their severity levels are listed in the various manuals and scales and specific drugs exists to treat each, allowing for at least some objective analysis and understanding.

Scales provide the physician with some basic information to lend insight to the causes, severity and possible treatment methods of a problem within the individual. One example of this is the HAM-D, a questionnaire used to this day, to determine the severity of depression within a patient. Published

in 1960, it includes questions relating to possible side effects of depression including weight gain or loss, sleep, anxiety and so forth. The patient is awarded a number of points according to which of the three to five answers for each question is chosen and in turn, the accumulation of these points results in the patient being diagnosed with very mild, mild, moderate, severe etc depression.

The HAM-D has between 17 and 21 questions depending on the age and detail, and include further questions regarding paranoia. The small number of questions means that even a small change to the patient can lead to a change in score and thus, diagnosis. Whilst it is closer to face-to-face therapy in that the scale can be completed by the doctor according to their own observation and assessment of the patient, this does leave obvious room for error. An example is seen when many studies compare the use of a drug and that of a placebo against each other and rate their effectiveness according to observation and scaling. “The average difference [between drug and placebo groups] was only 1.8 points on the Hamilton scale. The Hamilton is a 51 point scale, so a difference of less than two points is very small indeed... one can get a six point reduction in Hamilton scores merely by sleeping better.” (Kirsch 2009) This kind of scale can thus be seen to have numerous problems due to it's small groups and ability for massive change through one question, entirely based on objective observation.

The use of scales can be beneficial by creating boundaries, allowing greater ease in the process of diagnosis and treatment. A similar example is the Research Diagnostic Criteria, an accumulation of diagnostic information used to further objectivity and consistency. “A major purpose of the RDC is to enable investigators to select relatively homogenous groups of subjects who meet specific diagnostic criteria” (Spitzer et al, 1978) It can be understood that in order for the use and regulation of pharmaceuticals to occur in a correct and ethical fashion, these scales are, regardless of their shortcomings and obvious problems, seen as largely necessary and useful. Whilst this is only true to

a certain extent, and they often cause more problems than they solve, they can help the psychiatrist, pointing them into the right direction perhaps for further analysis, diagnosis or methods of treatment.

DSM

The post WWII era was perfect in timing for psychiatry, and what was the quickly forming pharmaceutical industry. Diagnosis rates of schizophrenia, depression, PTSD etc were increasing extremely fast and the need for standardisation was needed now more than ever. The DSM was at this point released , allowing mental illness to enter industrial, governmental and biomedical domains, making it the global phenomenon it is today. The introduction of the Diagnostic and Statistical Manual of Mental Disorders allowed for boundaries to be drawn after they had been burst open in the 19th century. Analysis and research could seemingly now be conducted with set aims, methods, specific items to search for in order to both diagnose and treat illnesses.

Whilst the first two editions of the DSM were largely focused upon diagnoses and treatment methods common amongst Freudian psychoanalysis and other forms of psychotherapy, these criteria were still considered “unreliable.” Robert Spitzer made such criticisms and aimed to amend these, as he headed the task-force designing the DSM III. From this point on, 'remedicalisation' was the intention, hoping that the removal of Freudian 'couch therapy' would allow for psychiatry to be considered legitimate medicine. In addition to the hope of respect amongst peers, the DSM III would allow psychiatry to be more acceptable throughout the public domain; “The medical model is most strongly linked in the popular mind to scientific truth.” (Whitaker 2010; Adler 1981) It was a great surge forward for psychiatry and Jack Weinberg, then president of the APA stated that it would “clarify to anyone who may be in doubt that we regard psychiatry as a specialty of medicine.” (Kirk 1992) The DSM III listed 265 disorders, each with symptoms and a required

number in order for one to be diagnosed. For instance, “major depressive episode” listed nine symptoms, and a diagnosis could be made if five were present. (Whitaker 2010) It was criteria, lists, treatment methods and so forth which thus allowed psychiatry to seemingly recreate boundaries and establish itself as medical.

Today, the DSM is often taken as 'gospel' despite the many controversies surrounding it. Many claimed that its release was an historic occasion for psychiatry; Melvin Sabshin, former medical director at the APA exclaimed that it was an “amazing document... a brilliant tour de force” (Sabshin 1990) and many others agreed, believing it to be a milestone event. There are as many criticisms as there are praises however, many stemming from the initial problems in psychiatry itself; the difficulties in setting criteria and listing symptoms that aren't physically, objectively identifiable. Debates arise thus as to who decides upon the illnesses and their symptoms; in what ways is the information procured, and so forth.

Debate also continues concerning changes which could be made in between updates, including adding or removing certain symptoms, length of episodes and possible treatment methods, and the introduction of new illnesses, in addition to ulterior motives. The financial benefits that the pharmaceutical industry reap through DSM listings imply that further editions (The DSM V is due for release in May 2013) will not only revise it's predecessors to refine criteria and eradicate ambiguity; rather, new illnesses, or redefined disorders with additional criteria and treatment methods are more likely to occur. “..the DSM has become such a moneymaker for the APA that we shouldn't expect anything terrible revolutionary in the next version” (Barber 2008) Additionally, a great deal of networking revolves around the DSM and it's diagnoses. With each diagnosis comes specialists, research, conferences, legalities etc. (Marketing of Madness 2010)

The DSM diagnoses also tend to change according to context and social influences, which are clear both throughout it's history and the present day versions, such as the removal of homosexuality from the DSM III and the possible inclusion of new disorders in the DSM V such as Internet Addiction, Road Rage, Shopping Addiction and so forth. (Marketing of Madness)

Many surveys and other methods of measurement use DSM criteria as their basis for collecting data, alongside day-to-day psychiatric analysis; pharmaceutical companies not only use the DSM to promote uses for their medications, but to add new diagnoses, also to promote their drugs.
The National Comorbidity Survey, conducted between 2001-2003 was used to display rates of mental health in the USA. Whilst "mental illness in the community is notoriously difficult to measure", the findings are nevertheless relevant, important, and "stunning." Based on DSM criteria, 28.8% of people suffer from anxiety disorders, 24.8% from impulse control issues such as ADHD and 20.8% suffer from mood disorders. (Kessler et al 2005)

There are various ways in which this information can be interpreted regarding medicalisation, and Conrad lists three pivotal aspects. He first points out that in order for such a huge percentage of the population to be seen as having mental illnesses, "a hugely wide range of behaviours must be included in this paradigm". The abundance of criteria for many disorders is a common criticism, with largely ambiguous descriptions creating problems for limiting diagnoses. Following this is the notion that the boundaries between "mild disorder" and "normal life difficulties" are quite vague. Again, this can lead to problems in data collection and diagnosis, depending on the extent to which a psychiatrist or patient has been subjected to medicalised behaviour traits and so forth. Thirdly, he points out that despite the huge increase in treatment of mental disorders, "most individuals who have a putative mental disorder do not receive treatment" and that there are not only people being treated for "mild problems" which needn't necessarily be medicated, there are also people with

“serious disorders” who receive no treatment whatsoever. It is thus difficult to find confidence amongst any data collected regarding mental illness, again due to the lack of objectivity, ambiguity of criteria and the extent to which symptoms have been medicalised. (Conrad 2005)

The DSM not only allowed psychiatry to further its attempts at medicalisation and allowing objective bases for analysis, it allowed psychiatry to merge and correspond with many surrounding aspects of society. It “came to underpin diverse phenomena in US psychiatry” (Lakoff 2005) including regulation and development of drugs, external financial investment and identity of patients; now that illnesses were universally understood and commonalities were recognised, those diagnosed could 'label' themselves within society. These factors were utilised to great effect by the field, now that there was much greater ease of administration and practise; “health management, transnational epidemiology, patient self-identification and the re-biologisation of psychiatry as a clinical research enterprise... [the DSM] thus made mental illness transferable between the domains of industry, government and biomedicine” (Lakoff 2005)

Another primary issue concerning the DSM is it's inclusion of recommended treatment options, inevitably drawing in Big Pharma and the promotion of specific brands and drugs. This also ties in with political motivations, specifically American political associations with certain companies. The medicalisation process is seen here at a different level, in which behaviour is indeed medicalised and turned into illnesses, now that they have been published alongside a set of criteria, symptoms and according treatments. The FDA is a perfect example of how industrial heavyweights are strongly intertwined, as the legislature and regulations presented by the FDA seem to correlate with the desires and progression of the pharmaceutical industry. Initially this didn't seem to be the case, but the problems of writing regulations and laws regarding the treatments relevant to an as yet undefinable field are clear. In 1962 the FDA legislation was amended, enforcing randomised

placebo-controlled trials to be used to test the safety and efficacy of all new medications (Marks 1997). The initial hurdle is clear; in order for a drug to be seen as effective from a biomedical perspective, the disease must be definable and identifiable. This leads onto the second primary problem of the use of the DSM as explained by Thomas Hughes; 'for a radical invention to escalate within a technical system, it must 'embody' the economic, political and social characteristics that will enable its survival in use.' The relationship between illness and intervention had to be clear before this could take place, however. In order for all of this to occur, the illness itself must be understood, and recognised.

Clinical Trials

Whilst it may appear that legal requirements for randomised trials, publication and transparency of information may seem a failsafe way to ensure dangerous drugs are kept out, and only safe and effective drugs are released, this is not always the case. Secrets are kept and there are many reports of dishonesty, leading to potential harm of many people.. The necessary yet treacherous relationship that healthcare must maintain with political and economic sources must be assessed. In recent years for instance, the FDA was placed under great pressure by various companies, during which the regulation for minimum testing time was lowered from two years to one (Greenberg 2010). The relationship between the FDA and Big Pharma is notorious and it has been reported that in 2007, for instance, Big Pharma paid the FDA $305 million to review their drugs on an expedited basis, thus also shortening trials, and this figure is said to have risen to approximately $393 million. “These figures account for almost 20% of the FDA's entire budget and about half of the budget for reviewing drugs” (Barber 2008) Additionally, the FDA is known to have be considerably lacking in resources, including employees, funding, capacity to fine or otherwise condemn companies for acting wrongfully, as well as the time it takes for any regulatory movement to be either passed or rejected, including drug and advertisement approval. Most television ads do not require approval

before being aired “A company could blanket the airwaves with ads for 45 days before the FDA finishes its review. Even if the ads are pulled, a lot of folks will now be asking their doctor for that drug, which could have risks that weren't fully explained” writes policy analyst Bill Vaughan. (Barber).

Whilst scientists and companies are legally required to be as detailed, careful and transparent as possible in both testing and publishing of information, there are hindrances, pressures and points at which this is certainly not encouraged. “RCTs make it possible to show in a practical way that agents with very weak effects nevertheless are linked to certain outcomes” (Healy 2003) Firstly, the need to budget and correlate spending money with earning in order to turn profits must come into play. Secondly, pressure from the public, the government and media, as well as competition to patent, release and advertise a drug for doctors to prescribe to patients are all involved factors. Finally is the controversial 'dirty little secret' (Kirsch 2009) of the pharmaceutical industry, that companies are aware of adverse side effects and negative long term effects of certain drugs, or a lack of effects altogether. To avoid these becoming known, the shortening of testing, excluding or destroying of some results etc is somewhat common.

Kirsch lists various methods used by some companies to maintain such a secret. “In some cases, the authors were different, and references to previous publications were often missing. Sometimes there were minor differences [between publications of the same data]… another trick was to publish only some of the data, [known as] 'cherry picking'..” (Kirsch 2009) It can be thus seen that much information provided, particularly when coming from a trial funded by a particular company – which most are – may not necessarily be complete, honest, nor reliable. This inevitably leads to great problems in transparency, distrust and an overall paranoia and even fear of pharmaceutical companies (an ironic side effect to the public availability of antidepressants). Information goes by

unseen, concealed and unpublicised, and information regarding the efficacy, safety, uses, consistency and side effects are not always honestly portrayed when results are reported. RCTs using both active and inactive placebos are the most effective ways to test out the efficacy and safety of new medicines. However there are many initial problems and it seems as though any publicised results must be analysed with a rather large grain of salt.

David Healy's lecture The Future of Medical Care displayed a number of early transcripts of reports and articles to be submitted to journals, with 'Author to be determined' written on them, for instance. A major issue is that RCTs are often funded, sponsored and run by drug companies and specifically appointed scientists. Additionally, it is often the same people who have the final look at which results are published and submitted for approval, meaning that transparency is rarely guaranteed.

Whilst the trial results are published to show that drugs are safe, unharmful and effective, it is alarming and indeed unsettling to discover that the published results are often somewhat far from the truth. Kirsch and his associates used the Freedom of Information act to obtain information sent by drug companies to the FDA, allowing for unpublished studies to be analysed alongside those published, a highly useful and important aspect of his meta-analysis; looking at only published articles can lead to the very problems which they revealed, as it is often the most successful which are published, and even these can be altered. For instance, a report by Swedish organisation the Medical Products Agency, suggested that up to 40% of clinical trials relating to antidepressants are unpublished (Kirsch 2009) His review revealed that not only do many of the marketed antidepressants show no significant differences between them and placebo drugs, but that there are often very dangerous or harmful results to the person, leaving the patient worse off than if they had taken no drug at all. (Kirsch) The very fact that the results are altered at all is worrying in itself,

before considering specifics. It is indicative of dishonesty and a lack of transparency amongst the FDA and Big Pharma, a display of the various problems when medicalisation extends too far, and loses track of priorities.

BIG PHARMA

Marketing & Advertising

Marketing of pharmaceuticals is one of, if not the most important and controversial areas of debate within analysis of psychiatry and its relationship with the pharmaceutical industry today. There are countless facts and figures regarding the huge sums of money spent on advertising to psychiatrists and direct-to-consumer public advertising. Television advertising is one of the most important, expensive and successful aspects; a total of $2.5 billion was spent in 2000 (six times higher than that spent in 1996) and in 2004, $4 billion was spent on DTC television advertising alone. (Lenzer 2005)

One need only look at statistics regarding the percentages of people diagnosed with mental disorders to understand that the market for psychiatric drugs is enormous, particularly when companies have the ability to design new illnesses as well as drugs. (Healy 2002) "..Without being too cynical studies [such as the National Comorbidity Survey] are a boon for the drug companies; consider the yet untapped market for their products." (Conrad 2007)

It can be understood that pharmaceutical and marketing companies are not entirely to blame for the increased numbers of diagnoses. Social factors play highly pivotal roles, particularly in times of recession, low employment, war and social unrest. Marketing drugs gives the public a greater awareness and understanding of mental health concerns in ways which are not always negative; to

recognise and appreciate mental health within society is an important part of social progression and acceptance of mental disorders is a positive, and necessary aspect. “The fact that drug research is both structured by, and structures marketing practices does not in itself de-legitimate knowledge produced...” (Lakoff, 2005; Sabel 1997)

Anxiety in Argentina

This double-edged sword, in which media campaigns about mental illness are important for raising awareness, but can often do more harm than good is common amongst media-centred and Big Pharma-funded campaigns. A media campaign run in 2001 in Beunos Aires, Argentina “Anxiety Disorders Week” saw the promotion of anxiety and the need to raise awareness through television programs, celebrity-endorsed adverts and billboards, articles in magazines, newspapers and television as well as scientific journals and so forth, to promote the campaign and the need to raise awareness; “One of every four Argentines suffers from them.. panic attacks, phobias. Specialists say that they are increasing...” (Cecchi 2001) It appeared to be perfect timing for the general population; uncertainty and feelings of insecurity were common due to recession, high rates of unemployment and so forth. As a result, the campaign was extremely successful and patients showed up at hospitals throughout the city, complaining to suffer from symptoms of anxiety.

The campaign was sponsored by pharmaceutical company Bago, a factor not publicised by articles and advertisements. “It was still prohibited [in Argentina] to market a drug directly to the public, an alternative was to 'grow the market' by making general practitioners and patients more aware of the illness” (Lakoff 2005) Figures showed the huge success of the campaign; despite the recession having shrunk the pharmaceutical market in Argentina between 1998 and 2001, antidepressant sales raised 16.5% between June 2000 and June 2001 alone. (IMS Health) The relationship that Big

Pharma has established with physicians, hospitals, advertising firms and so forth are evident through this and many other similar examples. The declining political and economic security felt by many seems to not only create greater anxiety throughout the general population, it also allows the pharmaceutical companies to scaremonger and play upon these fears, creating a snowball effect in which even more people are led to believe they suffer from mental disorders which require pharmaceutical treatment. (Lakoff 2005)

PMDD – Honing in on hormones

Medicalising 'normal' aspects of human behaviour has been used, primarily throughout the past 50 years of medical history, to categorise and simplify what would otherwise be an impossibly complex web of subjectivity in psychiatric assessment. It has also been used by pharmaceutical developers to market and patent drugs which have reached their expiry. “Eli Lilly.. wanted to squeeze a few more dollars out of Prozac, or Serafem, as the company had relabelled it..” (Greenberg 2010) Niche marketing is utilised as well, an example being 'premenstrual dysphoric disorder', to be treated by Serafem, released by Eli Lilly in the late 1990s. Whilst not recognised in most countries, it is recognised in the DSM IV, and is defined essentially as a particularly severe case of PMS. In fact it appears as though a medical condition is being re-medicalised, under different circumstances, to allow for the marketing of PMDD and Serafem. (Lane 2007)

The addition of the word 'disorder' is a technique used to market an illness, and subsequently release related medication. Serafem, the drug marketed to treat PMDD is in fact fluoxetine, commonly known as Prozac. Typical advertising methods have been used with the marketing of this drug, including the changing of the pill colour to a feminine purple, and the name 'Serafem' is 'calming and relaxing'. From a marketing perspective, it is understandable that such a drug should be advertised differently. Women who have been led to believe that they are sufferers of PMDD are

likely to feel uncomfortable with being prescribed Prozac, used for depression and other serious mental disorders. (Selling Sickness 2004) These language and marketing techniques perhaps indicate that the quest for profit is more important than that for the health and wellbeing of the people, particularly as PMDD has been so widely criticised for coming into existence in the first place; PMS is extremely common for women due to the hormone changes undergone throughout the menstrual cycle, and PMDD generally does seem to simply fall under the same, albeit stronger symptoms and categories as PMS.

To further the argument that profit overrides health as a priority, it certainly appears to be more than just coincidence that PMDD and Serafem were released in July 2000, just before the two patents which Eli Lilly held over Prozac were to end in 2001 and 2003. “It continues to represent the drug as a key treatment for 'the symptomatic relief of generalised social phobia, as well as depression, panic disorder and premenstrual dysphoric disorder' “ (Lane 2007) Statistically, from a financial perspective, the reasons for wanting to re-patent a drug so popular and widely recognised as Prozac are obvious. In 1998, Prozac alone provided Eli Lilly with over $2.8 billion profit, prescribed to over 30 million people for countless reasons ranging from obsessive compulsive disorder to bulimia nervosa.

GSK and the Paxil Scandal

The 2004 trials of GlaxoSmithKline (GSK) and the paroxetine scandal is a great example of many of the issues and problems in and around pharmaceutical companies; it showed the ethical, legal and social problems caused by withholding information in terms of patient wellbeing, legal and public status; so too did it exemplify the ways psychiatry has become so deeply ingrained in a financial business model, in which the benefit of patients is a noticeably low priority. (McGoey & Jackson 2009) It was revealed that the company had concealed information for five years concerning trial

results showing Paroxetine, marketed as Paxil or Seroxat was not only ineffective as an antidepressant to teenage patients, but that it increased the risk of suicidal behaviour. The information was only uncovered when accidentally sent to the Canadian Medical Association Journal, leading to a four year investigation following an initial case for fraud, during which a $2.5 million settlement was reached after accusations of being "engaged in repeated and persistent fraud by concealing and failing to disclose to physicians information about Paxil" (Kirsch 2009) After a lengthy investigation, it was announced in 2008 that despite the potentially countless physical and mental injuries caused by concealing this knowledge, that GSK would not be prosecuted. This decision was made due to the fact that there appeared to be insufficient evidence that the company had acted illegally. Loopholes had been pointed out by lawyers, such as the fact that prescribing Paxil for under-18 year old patients was an off label use, and therefore information regarding it is not required to be publicised. (McGoey & Jackson)

Various reasons for GSK to have not publicised this information have been suggested. Paxil had become one of the top three most recognised drugs, alongside Claritin and Viagra (Marino 2002) If a warning is given to doctors about effects of the drug in one age group, it might cause the doctor to consider prescribing a similar but different medicine, one with less negative effects to their next patient, regardless of age. Whilst obviously beneficial for the patient, it is not so for the company, and thus not encouraged. It also costs a huge amount to withdraw a medication from the market, and of course the reputation of not only GSK but Big Pharma would have, and did, suffer a somewhat large blow.

During the GSK trials, members of the public were given three minute spaces in which to share personal experiences and reactions to the information. Many came forward, in a similar style to the thousands of testimonials about Prozac. "Like you, we trusted both the FDA and pharmaceutical

companies to produce treatments that would help my daughter. What has happened however, is that companies like GSK have become increasingly big and their priority is profit not health and very few doctors understand the marketing targets they have become. They allowed our daughter to become the victim of a highly commercial enterprise." (ABC Primetime, 2004) It also highlighted the ways in which many who should never have been diagnosed nor given drug treatments in the first place, were greatly effected.

It seems unreasonable and extremely immoral to not prosecute the company after this case, on the grounds of loopholes found. The unethical behaviour of GSK is to be greatly condemned; it is clear that there were no beneficial reasons for withholding data from Studies 329 and 377 that were not focused on financial and commercial values. This is one of many examples in which highly important information and data has been concealed, alongside additional cases in which people involved in trials, results and other data were simply made up (Healy 2008), and furthers the case that medicalisation of society and its behavioural 'abnormalities' such as the symptoms which 'cause' SAD aren't always positive.

This is a good example of the effect medicalisation can have on society, not only when examining the relationship between psychiatry and Big Pharma, but also through examining the pressure that doctors, law-makers and other professionals are under as a result of involvement with such companies. Despite the estimated statistics concerning the amount of potential deaths caused by the concealing of this information, GSK were not prosecuted due to 'loopholes' in regulations and again, the filtering and 'censorship' of information. It has been claimed by various medical professionals and other employees of pharmaceutical companies that one can lose their job, get sued or even arrested if challenges to the chemicals and marketing of certain drugs occur. (Healy 2008)

Costs of medicine are another obvious example of how the wellbeing of the patient is not the first priority of the industry, yet another negative result of medicalisation. Patients throughout the US have, upon being low on money, reportedly driven to Mexico to purchase cheaper drugs where a prescription is not needed. This combined with the unreported heavy dependancy and withdrawal properties of paroxetine (according to the WHO, paroxetine has the highest amount of reports relating to problems and withdrawal symptoms of any drugs, legal or otherwise) add insult to the already vast injury that is part of the 'dirty little secret' of the pharmaceutical industry (Kirsch 2009). In February 2011, Ian Read, the new CEO of Pfizer announced that around $3 billion of funding into research would be cut to combat declining sales. Major research facilities in Sandwich, England are to be shut down, alongside the "demand for more accountability of its business managers and scientists for the commercial success of experimental drugs, which can cost $1 billion each to develop." (Randall 2011) It can be seen here that the initial concerns of these companies are indeed commercial stability, rather than the health of patients. To cut money on funding as opposed to advertising or other PR campaigns is quite evidently not in the interest of the patient, but the shareholders and management within Pfizer.

Pharmaceuticalisation

One of the key moments, and perhaps the most poignant of those in the ever-growing quest to medicalise, prove and legitimate psychiatry and its treatments methods was the introduction of drugs as a form of therapy. Initially found only as side effects of other drugs, such as the realisation that imipramine had sedative effects, led it to then being used for psychiatric purposes. Translational research and developments have since allowed for much faster and more specific routes towards psychiatric medication. Pharmaceuticalisation "denotes the translation or transformation of human conditions, capabilities and capacities into opportunities for pharmaceutical intervention" (Williams et. al 2011) Whilst this does overlap with medicalisation

concepts, it differs in that it needn't necessarily have a medical purpose, for pharmaceuticalisation to occur. Thus, the relationship between the two is complex and multifaceted.

One of the primary differences between the two terms is that pharmaceuticalisation needn't necessarily be medical; whilst medicalisation involves designing specifically and exclusively medical concepts around otherwise normal human behaviour, this criteria isn't necessary in pharmaceuticalisation, allowing it to have a somewhat broader conceptual scope.

The two concepts, whilst different and disconnected in many ways are seen to intertwine in various ways. An example of this can be seen in the study of Paxil and Social Anxiety Disorder (SAD), which will be analysed in further detail in the following chapter. The loose boundaries and definitions of which, combined with the highly 'aggressive' marketing surrounding it, indicates that marketing and advertising for SAD goes well beyond that of simply an SSRI antidepressant; "The impression often conveyed by commercials for the drugs is clear: almost anyone could benefit from them" (Goode, 2002) For medical purposes or otherwise, aspects of everyday life are given medicated 'cures.' The website for Paxil not only describes it's uses as an antidepressant but for generally improved performance such as sleep, concentration and decision making. Rather than fixing mental illnesses, the use of drugs in a pharmaceuticalised context could be considered "cosmetic psychopharmacology," (Vedantam, 2001) going beyond medical legitimation, concerning itself with general quality of life. The financial and marketing aspects involved in psychiatric medication has led to the industry being one of the most highly profitable in the world. Medicalisation, but to a greater extent, pharmaceuticalisation here has almost singlehandedly redefined the ways in which many consider both the world and the way that the human mind and behaviour works. Drug treatments seem to stem from the fairly new idea that it is far easier and simpler to modify oneself, rather than ones surroundings. (Steinman, 2008) The next section of this dissertation continues to consider the relationship that psychiatry has with the public, the

pharmaceutical industry and society as a whole, by outlining areas of future research and development concerning ways in which psychiatry is understood and practised, including regulation of medicalisation, greater accuracy for a better understanding and separation from economic ties, to re-prioritise health, stability and correct awareness amongst patients and the general public.

CONCLUSION AND DISCUSSION

Conclusion

This dissertation has analysed literature ranging from scientific papers and reviews of psychiatric practise, medicalisation and related aspects of the pharmaceutical industry. By looking at the history and development of psychiatry, including the definitions, understanding and expansion of mental illness, the ways in which medicalisation has occurred through the growth of psychopharmacology and the pharmaceutical industry, contextual influences and the globalised translation of human behaviour into symptoms of mental illnesses. An analysis of literature aimed towards psychiatrists and other medical professionals has been interspersed with a review of documentaries and other media articles directed towards the general public, in order to provide a well-rounded understanding of the topics and a variety of related perspectives. Looking at the medicalisation of human behaviour as a way of expanding psychiatry, and that of psychiatry itself, allows a greater understanding of how psychiatry has come to have such strong and often, problem-causing ties to the pharmaceutical industry; additionally, the effects of medicalisation and the marketing of mental illness to the public are seen from various perspectives, including those highly critical of psychiatric practise and the problems in defining and identifying mental illness, the consequences seen amongst patients and the public, such as the over-publicising and over-diagnosing of harmful pharmaceuticals. The inclusion of a philosophical justification of the existence of mental illness, despite it's biologically unidentifiable nature too allows a greater understanding, and alternate

perspective of one of the greatest problems faced by psychiatrists. Due to this hindrance, medicalisation of behaviour into illness is reflected in that of psychiatry itself; attempts made to legitimise the field as one equal to other medical practises, often through the use of pharmaceutical research and treatments can be seen, alongside both the beneficial and harmful effects felt by society.

By analysing the marketing of antidepressants and the use of the DSM and other rating scales on an international level allows awareness of the influence and globalisation of American psychiatric practise. Some international comparisons regarding the definitions and diagnostic rates of various illnesses are also seen to be useful in understanding how psychiatry has been medicalised globally, often with the help of the pharmaceutical industry and developments in psychopharmacological research.

Through a critical review of scientific and popular literature, documentaries and so forth, it can be understood that medicalisation occurs on multiple levels, through various channels, and to differring levels of success; whilst the medicalisation of social and human behaviour into mental illnesses has had a strong effect on the social understanding of humanity and mental health, the medicalisation of psychiatry has as yet proved not so successful. Despite the many attempts to define and create boundaries around mental illnesses by DSM regulations, rating scales, advances in drug treatments and so forth, the ambiguous, objective nature of psychiatric analysis prevails as an issue which continues to allow controversy and scepticism, particularly when reviewing such issues as the relationship with Big Pharma and the analysis and use of clinical trials, advertising and harmful effects felt by the public. Medicalisation has allowed worldwide recognition of mental illness, and psychiatry is developing as a legitimate, scientific field of medicine; however, it can be argued that medicalisation has 'gone too far', in that mental illnesses are 'designed' for financial and other benefits not directly related to the health and wellbeing of the patient. Medicalisation of psychiatry, it could be said, has led to that of all of society; as yet, there appear to be greater numbers of

negative consequences than the positive, and this dissertation has attempted to review the ltierature and criticisms of these topics from historical, philosophical and social perspectives.

Strengths

There are various strengths found throughout this dissertation which set it aside from the many others related to similar topics, such as medicalisation, psychiatry and the pharmaceutical industry. One criticism common to much of the related literature is that it focuses almost exclusively upon books, articles and so forth written by other researchers, psychiatrists and critics. There are two primary problems with this. Firstly, it has been seen that if a text uses only that written by, and for their medical and scientific peers, there is not a large variety of perspectives and arguments. This is particularly important when the main topic of discussion is one which isn't entirely scientific, such as the tumultuous relationship between psychiatry and the pharmaceutical industry. Examples of common features when discussing this includes the financial aspect of the relationship, and the marketing of pharmaceuticals on television, both of which would necessarily include perspectives of those in the marketing and advertising industry and sales within Big Pharma, in order to provide a sound, multidimensional analysis. There are only a small number of examples to be found amongst the literature, however, and the majority focus almost exclusively upon the arguments and opinions of their peers. This thesis has attempted to provide alternate views on some of the subjects discussed, such as an in-depth analysis of Stephen Fry's documentary, which is non-scientific nor composed by a researcher or psychiatrist. Instead, it is produced by a celebrity and well-known figure in society, with the majority of interviewees throughout not involved in the medical communities.

The wider analysis of documentaries, as well as newspaper articles (as opposed to those primarily found in scientific journals) furthers the strength of this case, as it can be seen that documentaries

designed for public viewing are highly important to analyse, as it is often these sources which members of the public gain their information from. Much debate found within the literature focuses upon the ways in which the public is affected by the relationship between Big Pharma and psychiatry, and there are two areas which are most commonly discussed; the mistreatment of research and clinical trial information, leading to the possible, and in some cases, eventual harm of patients, as seen in the aforementioned cases of suicidal behaviour found amongst those taking Prozac, and similar effects of children under 18 and paroxetine. Additionally, direct-to-consumer television advertising is often assessed, the main focus aimed at criticising the marketing of pharmaceuticals and the 'evils' of Big Pharma. Newspaper articles and television programs which are funded and produced by neither Big Pharma or their critics, such as those written by journalists, celebrities and so forth tend to go without analysis, despite their important role in relaying additional information to the public.

Alongside adding the public-aimed perspectives concerning the topic, this thesis finds strength in including historical and philosophical additions to the literature reviews. By exploring the history of specific illnesses and treatments, it enables one to gain a better understanding of the development of psychiatry and the pharmaceutical industry, particularly when the focus is upon the gradual medicalisation of behaviour into symptoms, illnesses etc. The use of a philosophical analysis places the argument regarding the existence of mental illness on a completely different level of debate; by going beyond the strictly scientific, one is also able to understand a way in which psychiatry can be seen as legitimate, scientific and worthy of further research endeavours, despite the difficulties faced by many psychiatrists and researchers, as the quest to provide tangible evidence of mental illness continues. Additionally, by comparing the development of psychiatry to the Kuhnian Scientific Revolutions, it too allows this thesis to involve perspectives not often found amongst the general literature concerning medicalisation and psychiatry, furthering an understanding of these

within both modern society and throughout it's history. The diversity of perspectives, alternate examples, varying forms of media and comparison to non-scientific aspects of society are aspects which strengthen the arguments made in this thesis, and serve to provide a multidimensional analysis of medicalisation and psychiatry.

Essentially, the greater strengths within this paper stem from the criticisms of those reviewed; the repeated use of example, the exclusion of alternate perspectives and that of articles and programs directed to the public, rather than to the scientific communities. It is important to analyse not only the ways in which the pharmaceutical industry markets medication to the public, but discussion, criticisms and ideas concerning psychiatry and mental illness which are created directly for public consumption. By including some of these documentaries and news articles in the analysis, a deeper understanding of the portrayal of psychiatry mental illness can be seen, as can the effects of medicalisation within general society.

Weaknesses

The various weaknesses found throughout this thesis and hindrances in research were often those which led directly to the strengths, as it compelled the necessity to expand the subject matter being analysed, and to search for case studies and examples which had not already been used many times over. One of the primary criticisms of the literature that much of this dissertation uses is that many examples and case studies are repeatedly used to exemplify the problems of medicalisation, and its effect on psychiatry and mental illness in society. Whilst this dissertation attempted to veer away from these by including a variety of examples and uses of media and other publications designed for public consumption as well as strictly medical and scientific, it remained difficult to avoid common ground in certain areas.

As explained earlier, the majority of examples and literature analysed concern American psychiatry. Whilst this is important, as American psychiatry is highly controversial and it's use of medicalisation is the cause of so much debate, it was also due to difficulties in finding many examples, case studies and analyses of psychiatry in other regions of the world; in particular, throughout it is difficult to obtain research and analysis of psychiatric practise in some African, Asian and other non-Western countries. This is often due to the fact that psychiatry is practised in different ways, and not recognised using the same diagnostic, analytical and measurement methods as Western psychiatry, making it near impossible to compare and analyse statistics involving diagnostic rates within a population, methods of diagnosis and treatment, definitions and cross-cultural influences amongst others. Such a comparison, if possible, would have been highly informative and instrumental, particularly as it could potentially lead to further developments and hypothesising within neuropsychiatric or genetic research.

In a similar vein, the following weakness, or difficulty found throughout the research process of this dissertation did inadvertently lead to certain strengths. As mentioned at the start of the thesis, most scientific literature, including books, articles and research papers tend to follow a similar argument, share a common perspective about the troublesome relationship and dependancy that psychiatry often seems to have with Big Pharma, and uses common examples. It is difficult to find any book, and even many articles which do not mention the GSK Paxil scandal, nor the 'Prozac Era' and it's associated problems. Likewise, the majority of literature is somewhat single-sided in terms of argument; regardless of whether an argument or perspective is considered more accurate, ethical or otherwise valid than another, it is nevertheless important in many cases to provide varying perspectives and opposing sides to the same argument or issue. For instance, it is difficult, for various reasons, to find accounts within the scientific literature about medicalisation and psychiatry of not only advertisers and lawyers representing pharmaceutical companies (such as in Let Them

Eat Prozac, in which Healy recounts his experiences as an expert witness for cases concerning Prozac-related deaths) but advocators of newly-designed illnesses such as PMDD as legitimate illnesses worthy of both DSM recognition, and drug treatment. Whilst some interviews of this nature can be found in various documentaries, it's assumedly negative nature leads such information to be excluded from most research papers and related texts.

A final weakness found in this dissertation is inevitable when discussing such a broad topic; there is far more information, research, ideas and evidence which must be excluded due to word limit constraints. Whilst it would have been possible to provide small sections concerning a far broader analysis, this would not allow in-depth analyses and reviewing of the topics covered, nor would it have provided room to include the historical and philosophical discussions included. Ultimately, despite the exclusion of much information, the examples and discussions included have been carefully analysed in detail, and have been specifically chosen for their relevance to exemplifying the use of medicalisation in psychiatry, the ability to use these to justify philosophical and other non-scientific arguments, as well as continuing the attempts made to avoid analysis of only those which have been used time and time again in other literature.

Future Research

It can be seen that the search for proper treatment of mental illness is ongoing and as yet remains both unanswered and undetectable. Future neuropsychiatric research is a possible area in which biological symptoms and causes of mental illness may be identified and could lead to more accurate identification and treatment methods. Similarly, future genetic research could lead to answers regarding ways in which mental illness can be identified, and perhaps even manipulated, although this is debated. With the completion of the Human Genome Project, some promoted the benefits to mental health that were now possibilities. “Pharmacogenomics underpinned a projected future of

personalised medicine, in which gene chips would guide physicians to the most appropriate pharmaceutical intervention, bypassing wasteful medication trials and avoiding harmful side-effects" (Lakoff 2005) Lakoff describes a particularly promising landscape for genomic research, hoping that it may lead to a better understanding of mental illness, and methods of both diagnosis and treatment. As yet, genetic promises remain unfulfilled and researchers greet such information warily. Nevertheless, it remains a possible future path which can lead to answers about the causes of mental illness.

Another area worthy of future research is the idea that perhaps, a regression is necessary in order to progress. What has been found is that some suggest a regression, de-medicalisation or "re-biologisation" of psychiatry, could lead to a better understanding. In terms of future research regarding the benefits and problems of medicalisation in psychiatry, Healy suggests that there is now a need to move beyond the drugs and clinical trials for results; that one must go back to the science, to understand the mechanisms, so as to avoid being so caught up amongst the financial, legal, marketing and other social factors involved in healthcare. Further research and greater attention can be provided in medical training, providing psychiatrists and physicians with greater tools for individual analysis and diagnosis, and an understanding of how to identify and correctly treat patients. Doctors could be retrained with further knowledge of statistical significance in trials, and ways to recognise a drug which works, as opposed to a drug which is widely advertised and promoted. What must be ensured is that "the law is put into practise in the spirit in which it was designed. That is, there must be a clear benefit to the community as opposed to the pharmaceutical companies." (Healy 2008) If these advanced could occur, either a reliance upon the DSM and other rating scales wouldn't be as necessary, or perhaps such manuals would gain better accuracy and separate themselves from financial bias.

As well as de-medicalisation, alternatives to drug treatment could be further researched, and

currently existing psychaotherapies such as CBT could be used to a greater extent, and a better comparison could be made between these and pharmaceutical therapies. Additionally, further psychopharmaceutical research can be conducted to refine and design new, safer and more efficient drugs. In order to do so however, the aforementioned regression would be necessary, as stronger definitions, boundaries and methods of identification would be needed.

On a scientific level, further research is needed when testing new drugs, alongside greater transparency relating to clinical trials and financial relationships between Big Pharma and psychiatrists. The 2011 UK Budget plan lists a plan for complete transparency in clinical trials "The Government is committed to opening up information about clinical trials so that patients can find out about trials that may be relevant to their condition. The NIHR is developing a web-based UK Clinical Trials Gateway. It will present, in accessible form, information about trials conducted in the UK. By 2012, the Gateway will make it easy for patients, their doctors and carers, friends and families to see what a trial is about, where it is taking place, and who is running it. It will help patients to join in clinical trials if they are suitable and choose to do so with full information and advice" It can only be hoped that such an action will improve future analysis and honesty within trials, so as to reduce the risk of misinformed data leading to wrongful approval and prescription of pharmaceuticals. (HM Treasury 2011)

Clinical trials must be registered before they begin, including all locations, the number of patients, methods used in the trials and other administrative notes must be made and available for public consumption. Both summary and raw data should be made available for all completed trials, as well as throughout, prior to conclusions being drawn. "references to prior publications and reports of data,so that they cannot be inadvertently counted twice by reviewers" is another suggestion (Kirsch 2009). Access to any and all data relating to a drug, be it research, clinical trials, sales and levels of

safety and efficacy should be freely accessible. Similarly, transparency concerning researchers and articles funded by Big Pharma, would be useful tools in creating an honest, correctly prioritised relationship between psychiatry and the pharmaceutical industry.

Overall, there are two particularly important, and necessary areas for future research; firstly, further attempts to strengthen definition, identification, understanding and treatment of mental illnesses beyond checklists must be continued. Whilst the possibilities for recognising and understanding mental illnesses are increasing, the need for stronger, less objective diagnostic skills throughout all psychiatric practise is necessary, including the modification of the DSM to rid any ambiguity and room for error. Following this is the second most pressing area of research and development, which is the need for psychiatry to separate itself from financial and political motivations, such as the need for stronger regulation of advertising and marketing to physicians and consumers.

Medicalisation must only occur to an extent at which these aspects are not prioritised over the health and wellbeing of patients; over-diagnosis, misdiagnosis and the promotion of mental illness to a healthy audience is highly problematic, causing a lack of integrity, honesty and a disregard for ethical responsibilities. With a greater understanding of mental illness, together with a reorganisation of priorities, future psychiatric research can strengthen the case for psychiatry as a field of medicine, regulate and understand itself and utilise the medicalisation of itself and society as a whole in an ethical and responsible manner. This can potentially lead to a decrease in diagnostic rates, pharmaceutical prescriptions, public misinformation and scaremongering, whilst allowing for a better understanding and confidence in diagnosing and treating mental illness.

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