

Medical Characterisation of Mental Illness as a Risk Management Tool in a Postmodern Society

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This critical reflection endeavours to discuss why science's monopolisation of mental health understanding and categorisation is illogical within a postmodern society. I will consider how the Diagnostic and Statistical Manual of Mental Disorders (DSM) has become a risk management tool and how psychiatry itself is a failed attempt at paradigmatically fulfilling modernity's aspiration of objective scientific knowledge and truth (Lewis, 2000:72).

The shift from premodernity to modernity is notably characterised by the advancement and application of science and technology to navigate the fluctuating dimensions of social life that question previously 'certain' knowledge and produce 'risk'. Modernity lacked methodological scepticism within its uses of science, holding an unwavering faith in its ability to manage and rectify risk (Beck, 1992).

Scientific knowledge was, therefore, authoritatively circulated and perceived as an ultra-stable entity able to 'objectively' transform risks into developmental opportunities (1992:159). Within scientific methods, problems were defined, purposes for analysis clarified, and the information scrutinised, enabling a presentation of risk as

scientifically explainable (Cullen and Small, 2004). However, the superior status of science is indicative of modernity's social organisation of risk and not due to the scientific knowledge generated (Beck, 1992).

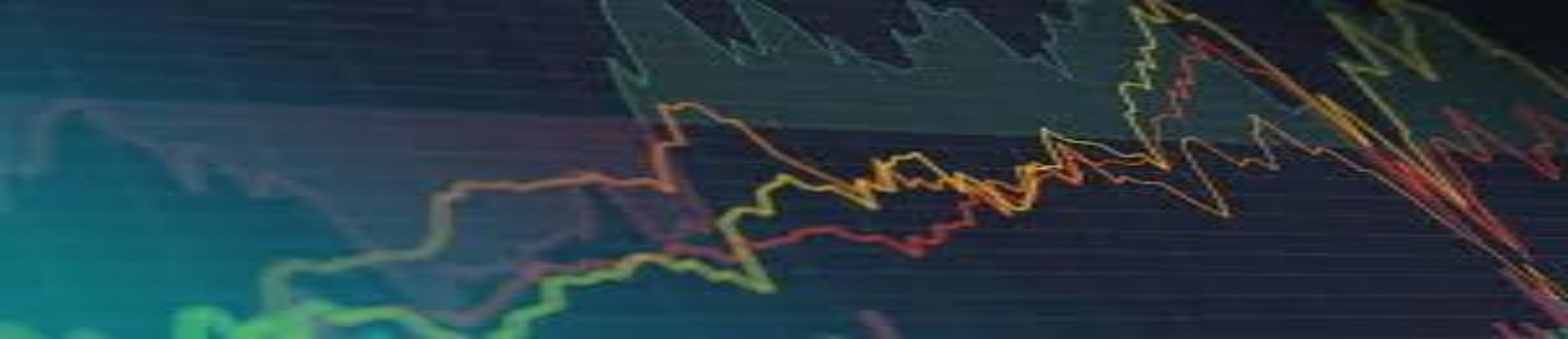
Transformations in the late 19th century led to a consensus amongst theorists, such as Lyotard (1984), that society had abandoned modernity's inauspicious organisation of human narratives and arrived in a 'postmodern' society (Lewis, 2000). Although the name differs between theorists, they unanimously suggest society's increasing amounts of uncertainty stems from fragmentation of modern grand theories and rigid social structures.

Giddens (1991a) discusses reflexive modernisation within his conceptualisation of

'late-modernity', suggesting the removal of social structures allows for reflexive creation of the self and of broader institutions. Similarly, Beck addresses structural reflexivity in his 'Risk Society' theorisation, focusing specifically on scientific institutions and management of increased risk (Beck et al., 1994).



R I S K



Risk is bound to reflexive modernisation through the systematic handling of insecurities established within modernity and the globalisation of doubt (Beck, 1992). Members of contemporary society are required to remain flexible and actively engaged with the copious choices, adjustments and improvements to navigate social life and improve oneself (1992).

The production of information coincides with the re-examination and reformation of social practices; therefore, categories of 'being' are reflexively modified (Giddens, 1991a). Alterations to the nature of social worlds suggest that knowledge production cannot yield transparency; rather, its ability to create varying human narratives pertains to society's fundamental 'juggernaut-like quality' (Giddens, 1991b).

Risk's existence is only possible through human identification, categorisation and assessment of their impact and cannot be constructed haphazardly (Garland, 2003). Risks are necessarily manufactured to combat potential threats previously unestablished or invisible, placing those able to define them in key social positions despite the malleable and interpretive nature of risk (Adam and van Loon, 2000).

Conventional risk assessment is a socio-cultural response to anticipated problems by calculating the probability and intensity of harm to produce 'logical' and 'certain'

classifications (Adam and van Loon, 2000). Scientific language is employed to cement 'rationality' and affirm that any digressions from dominating risk determinations are irrational and hostile (Beck, 1992).

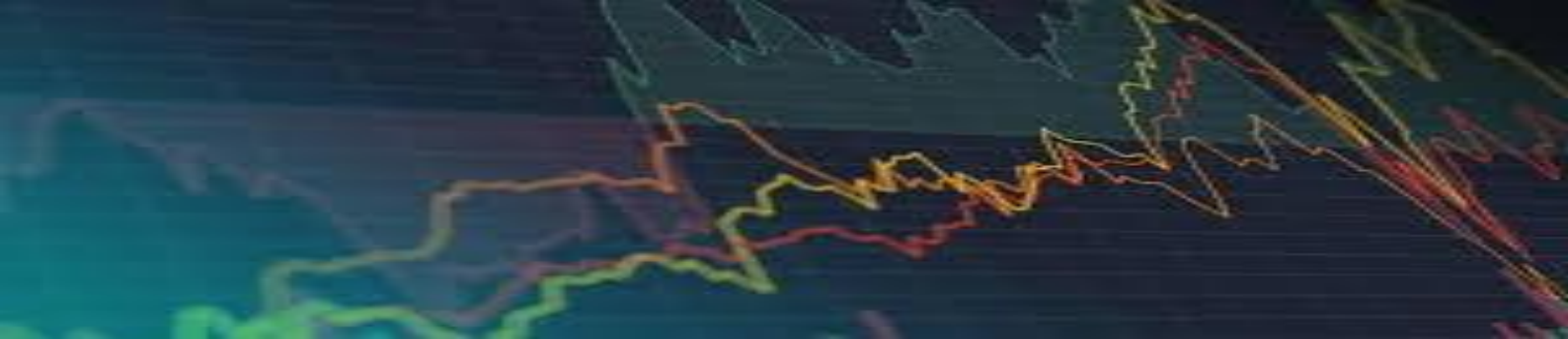
Politics, industry and media are dependent on scientific outcomes; however, the circulation of this knowledge is only possible if public perception regards it as 'true' and representative of reality (ibid., 1992). The universalisation and subsequent threats to health culturally elevate its status as a risk that must be overcome but attempts to characterise uncertainty within medical contexts often result in ambiguous classification methods.

Governmental and clinical aspirations of the 20th century amalgamated, resulting in numerous classification systems and conceptual models of mental illness (Rose, 2003). The 'wake of psychiatry'

during wartime led to the production of the first DSM in 1952 (ibid., 2003).

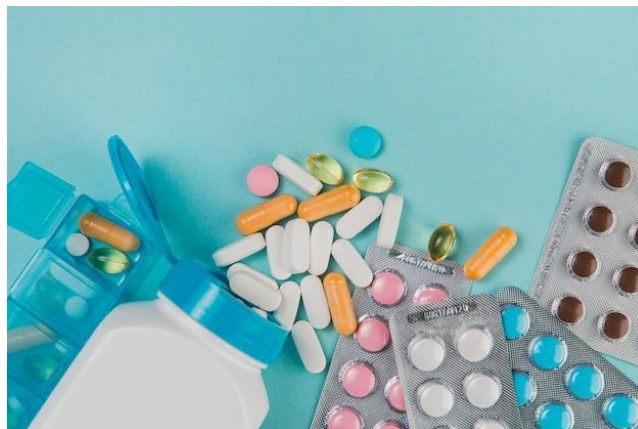
This manual intended to produce comprehensible and categorisable explanations of previously invisible struggles through 'scientific expertise'. However, the expansion and multiple revisions to the DSM exposed its use as a risk management tool within a society, constantly generating more risk. The 1968 publication of the DSM-II presented 134 pages interpretively framing





180 categories of disorder through psychoanalysis (ibid., 2003).

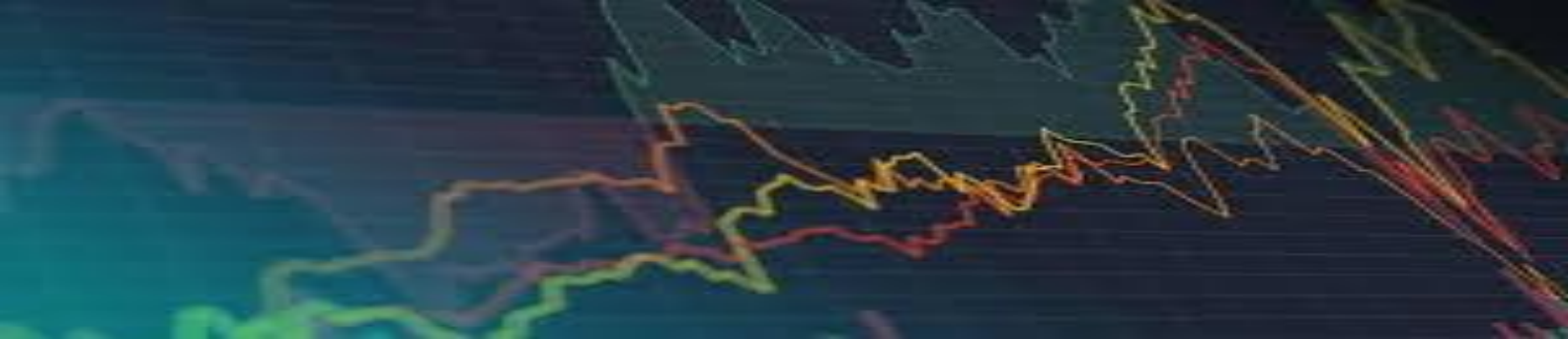
Following this in 1980, the DSM-III built upon previous categories producing 500 pages with its revised 1987 version containing 292 categories, reflecting a new application of objective criteria, prognoses and treatments for mental disorders (ibid., 2003). This expansion was considered a response to growing public concerns with treatment eligibility that emphasised the classical medical model of disease (Rose and Abi-Rached, 2013). In 1994, the DSM-IV continued this trend, containing 886 pages and 350 distinct disorders (ibid., 2013). The emergence of new categories now made the distinction between a personality trait and a 'mentally ill' state undividable prompting the argument that no ontological disparity exists (ibid., 2013).



The broad categories established in early 20th century became dissected pathologies producing refined categories that reflect a molecular psychiatric gaze (Rose, 2003). According to its criteria, the diagnosable psychiatric population is ubiquitous, increasing the social demand for 'experts' to handle the 'burden' (Rose and Abi-Rached, 2013). The critique of psychiatric diagnosis is not only their failure to identify certain disorders but with the incorrect presentation of its content as purely clinical and objective (ibid., 2013).

Risk assessment implies certainty and calculability, offering a degree of fatalism that ignores society's susceptibilities (Rose, 2003). 'Scientific knowledge does not represent the totality of knowledge' but is often seen as superior knowledge (Lyotard, 1984:7). Categorisation of healthy or pathological is often presented as 'biological truth' outweighing its dependence on clinical observation. The medical establishment dominates government policy within a risk society through its power to define, signifying the entanglement of medical knowledge and 'sub-politics' (Denney, 2005).

However, the pursuit of one-dimensional, comprehensive understandings of risk does not accommodate for the complexity of a postmodern existence nor does identification of risk account for the patterning of disease (White, 2017). Inability to account for both singularity and multiplicity in risk means that universal laws are impossible as their meaning is too specific or too general (Adam and van Loon, 2000). In its expansion, science, therefore, reveals its unstable foundations and becomes demystified through its questions of validity (Beck, 1992). Scientific and social rationality become indistinguishable as scientific interest is reliant on social demand whilst social perceptions of risk are dependent on scientific arguments (ibid., 1992). Therefore, risk mediation and their reflection of a specific social reality suggest risk definitions are not reliant on scientific validity (ibid., 1992).



Risk management techniques focus on producing knowledge which is socially interpretable as methodical and objective depictions of risk, rather than on its removal from society (Beck, 1992). Social agents ensure that science holds power to define risk, whether for minimisation, distraction or dramatisation, regardless of methodological disputes (ibid., 1992). Even with 'good data', our capacity to identify, evaluate and manage unknown risk is limited (Garland, 2003).

Sciences claim of objectivity is based on speculative assumptions moving within a framework of probability dictated by social interest rather than experimental logic (Beck, 1992). There can be no expert on risk as at the centre of scientific knowledge, definitions and explorations are reliant on social expectations (ibid., 1992).

Political and social interference results in a capitalisation of 'truth' not only through manufacturing cost-intensive risk management but through risk solutions embedment within the institutions that define them (Rose, 2003). As a professional power, medicine situates itself as self-governing producing definitions of 'medical progress' and creating solutions that monetarily benefit their industry (Beck, 1992). The medicalisation of social problems through diagnostic categorisation and the inclination to use pharmaceutical intervention becomes an apparatus of social control (Rose and Abi-Rached, 2013).

Once psychiatry's idealisation of science is eradicated, there remains no reason to limit its

practices to scientific knowledge based upon premodern concepts and unfounded probabilities (Lewis, 2000).


Postmodernism problematises diagnosis as a social act, casting doubt over the accounts and universal presentations of truth (Holmes and Warelow, 1999). The insecure nature of contemporary society suggests that distinctions between 'normal' anxieties and 'neurotic' anxieties should be questioned (Giddens, 1991a). Notions of 'madness' have been actively defined as a social inability or unwillingness to conform (ibid., 1991a).

The collapse of security previously found within stable societies means that most individuals in postmodern society can identify with criteria used to diagnose such pathologies. Language divides the world through binary oppositions

like mental illness and mental health, which are further divided arbitrarily into more 'specific' categories that constrain subjective meaning and enable labelling of an individual against societal norms (Lewis, 2000).

The tendency to pathologically treat biological phenomena and present it as evidence of 'disorder' within superficial psychiatric classifications is illogical (Holmes and Warelow, 1999). The need for legitimacy within psychiatry and the inability to separate it from its political origins has evoked appeals to remove psychiatry's standing as an objective, legitimate science (Saunders et al., 2008).





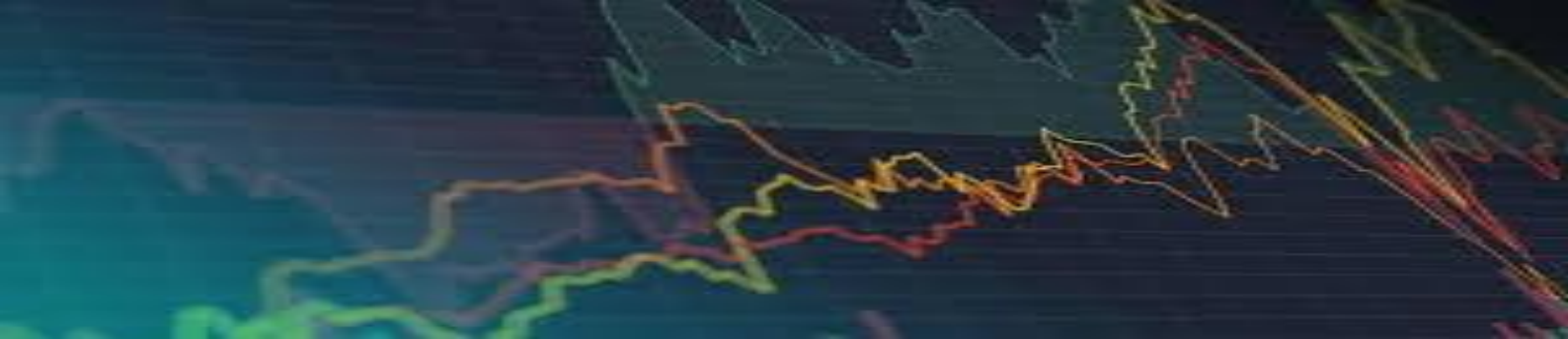
The dissolution of the dichotomy of health and illness means that the DSM's diagnosis categories are determined by comparing symptomologies to subjective interpretations of behaviour (Holmes and Warelow, 1999). It overlooks, however, phenomenological and narrative accounts of the patient, instead exerting their social control over risk classifications, resulting in a 'catch all' criteria seeking to fulfil their desire to expand psychiatry (ibid., 1999). Thus, the DSM's characterisation of lacking sustainable categories and immersion with 'hegemonic pseudoscientific authority' means its use in contemporary society is nothing more than an attempt to manage risk with little scientific foundation (ibid., 1999).

In a society abundant with risk, the perceived objective, scientific explanations and management of risks are always subject to political and economic obstruction as they arise from an intrinsically social realm. Therefore, it is evident that the categorisation of mental illnesses in a postmodern society is not a scientific explanation but a feeble attempt at risk management made possible through unfounded calculations from an institution that holds power to define.

The discreditation of traditional boundaries and risk management techniques are reflected within the DSM's self-dissolving categories (Holmes and Warelow, 1999). It is both with social expectations and norms that scientific definitions of mental 'health' and 'illness' prevail, coupled with due to scientific binary categorisation that society can enforce convention. As argued by Beck (1992:30): 'scientific rationality without social rationality remains empty, but social rationality without scientific rationality remains blind'.

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