Critical Analysis of the Medical Institution With Special Focus on Madness

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“Speaking requires a language but dominant vocabularies may lack the resources necessary to express perspectives of subordinated groups, because language is essentially public creating new vocabularies is necessarily a collective rather than an individual project” (Jaggar, 1998)

Introduction

The marketisation of society (Bakan, 2019; Bakan, 2021) has given rise to an industrial-medical complex (Magee, 2020; Perkins, 2004) that acts as a catch all for a range of phenomena which ultimately impact on mood, cognition and behaviour – the effects of these phenomena are given the identities of 'madness' and other epithets (American Psychiatric Association, 2017; Frances & Boehmer, 2017). This results in a fallacy of category similar to a modernisation of 'metaphysics' esoterising heterogeneous phenomena preventing understandings from developing. The fallacies of category of mental health happen where misunderstood psychological phenomena get bundled into a single identity similar to the way that the curation of Aristotle's work gave rise to a portmanteau subject which he had not intended.

The term metaphysics has been associated with Aristotle however he never used the term. It was coined by a first century C.E. Editor to denote a collection of Aristotle's smaller works brought into a single treatise. It was named according to its place in the curated volumes which he had chosen; 'metaphysics' meaning literally 'after the Physics' (Cohen, 2022). This communicates what I mean by relating a modernisation of metaphysics to creating of psychiatric identity. Mental health has become an agglomerating identity for psychological and behavioural phenomena which do not easily fit, and therefore challenge, the cultural rubrics for perceiving the world and people which are in common usage.

In this essay I explore some of the problems of how madness is perceived, medicalised and how the medical model of privilege has shaped the discourse. I explore possible anthropological roots for cultural perceptions surrounding mental illness. I argue from this that the subject of Mad Studies has emerged as a part of a constellation of critical philosophical and epistemological correctives in response to structural power imbalances forged in old and dominant political myths which alienate people from human rights and agency. I suggest that these political myths are hindering the progress and evolution of medicine and society in ways which prevent contributions to the tackling of complex problems ultimately factoring into their recreation.

In the first section I offer a general account of 'madness' and introduce how

medicalised identities are misidentifications of bundled disparate phenomena. I go on to discuss how the lack of cohesive logic esoterises the unknown bringing about experiences of dehumanization, disadvantage and injustice. In the subsequent section I suggest how material and non-material forms of mental illness interrelate feeding into each other as positive feedback loops. I then scrutinize how the paradigm of privilege and impunity in medicine and examine how power imbalances lead to iatrogenic harms.

The Conflation of Ideas in Madness and Hermeneutical Disadvantage

I frame the word 'madness' as a conflation of ideas brought to spaces of common 'unknownness'. Foucault in his Madness and Civilisation speaks to this idea: “this liberation derives from a proliferation of meaning, from a self-multiplication of significance weaving relationships so numerous, so intertwined, so rich, that they can no longer be deciphered except in the esotericism of knowledge. Things become so burdened with attributes, signs, allusions that they finally lose their own form. Meaning is no longer read in an immediate perception, the figure no longer speaks for itself.” (Foucault, 1967)

Madness is multivalent; it has so many meanings and is so heavily invested with values that it becomes unmoored from the individual superseding them in the world with an idea. For me madness is both expression of emotion – I am mad at the way I have been and am treated – and what I call a vacuum concept. What I mean by a vacuum concept is a situation in which a vacuum exists where a cohesive idea should be which is related to as something of substance holding an internal logic; a vacuum of understanding draws people to project exoticising hopes (Nieto & Bode, 2018) and demonising fears onto the unknown, as people do with darkness and experience of otherness (Staszak, 2011).

In effect I argue that madness is a concept without concrete identity, it is an idea which becomes imbued with the purposes of the user; in many ways a medium for superstition (Vyse, 2014). Individuals who experience ails related to mood, cognition and behaviour - and who, as a result, require support, are simultaneously bound to culturally encountering primitive hostile responses of human beings to the unknown. As a result they experience various forms of injustice perceived as an 'other'.

The war-like nature of humans is intimately associated with processes of dehumanization which are common and everyday, both inside and outside of professional spaces (Haslam, 2006; Cahill, 2012; Bastian & Haslam, 2011). These processes of dehumanization lead to justifications of moral disengagement resulting

in injustices perpetrated on the targets (Bandura, 1999). What is especially problematic about the psychiatric support/need juncture is that medicine has incorporated and normalised forms of dehumanisation within its institutional practice (Haque & Waytz, 2012) beyond frank devaluation (Capozza, Falvo, Boin, & Colledani, 2016).

Ailing people who are at a disadvantage must negotiate and absorb the injustices engrained and/or embedded in the psychology and structures of society. From the outset individuals are overwhelmingly at a 'hermeneutical disadvantage' which Miranda Fricker describes in the following terms:

"If, for instance, someone has a medical condition affecting their social behaviour at a historical moment at which that condition is still misunderstood and largely undiagnosed, then they may suffer a hermeneutical disadvantage that is, while collective, especially damaging to them in particular. They are unable to render their experiences intelligible by reference to the idea that they have a disorder, and so they are personally in the dark, and may also suffer seriously negative consequences from others' non-comprehension of their condition." (Fricker, 2011)

Material and Non-material Harm, and the Paradigm of Privilege

In this section I discuss material and non-material causes of mental ailment. I then suggest a scheme of how they reinforce and lead to each other generating positive feedback loops which Hofstadter describes as tangled hierarchies (Hofstadter, 2006). I go onto critically discuss how the medical approach is flawed, bringing about significant iatrogenic harms. Finally I identify key issues with the institution of medicine and how it is protected from vitally needed change.

Material Causes of Mental Illness

To flesh out the notion of material causes of mental illness I offer some examples that offer clarity due to their now well documented nature. The neurological and psychological effects of a range of chemicals which the population are exposed to may not be recognised or acknowledged (Salinger, 2013). Three examples are the exposure of people to cholinesterase inhibiting pesticides and herbicides (Bradwell, 1994; Takahashi & Hashizume, 2014), the impacts of ethyl mercury as an excipient in once widely used medicines (Huang et al, 2014; Dorea, Farina, & Rocha, 2013) and the impacts of heavy metals in mercury-silver amalgam (Siblerud, Motl, & Kienholz, 1994; Siblerud et al, 2019).

Each represents a large evidence base for physical factors that have distinct ramifications on mental health but which are culturally silenced through evoked controversy (Gillam, 2019) protecting the industry and the institution of medicine; therefore they represent examples of agents involved in hermeneutical disadvantage.

Non-material Causes of Mental Illness

Acting as compliment to the material harms of mental health there are a range of sociological harms which can be visited upon an individual by themselves, by others, by cultures, communities and/or by structural violence. These kinds of non-material cause result in mental illness which can be understood as responses to psychological trauma (which are physiologically measurable) (Cohen, Janicki-Deverts, & Miller, 2007; Slavich et al, 2019). These sociological phenomena are esoterised as collectively demarcated forms of mental illness (psychiatric labels) and treated dominantly as biochemical imbalances of the brain (Cohen & Cohen, 1986) with powerful, and sometimes disabling, life shortening drugs (Breggin, 2011; Harris & Barraclough, 1998; Jones, Howard, & Thornicroft, 2008).

This speaks to cultural deficits in publicly recognising sublegal forms of violence which may ultimately manifest as biochemical differences in the brain brought about by specific sociological configurations and actions – to illustrate this I suggest the example of gaslighting (Sweet, 2019). In context, psychological abuse by a partner or family member can generate large releases of adrenal hormones (Bremner, 2005), cortisol (Kandhalu, 2013) and opiates (McCubbin, Surwit & Williams, 1985) as a response to the trauma affecting how the individual apprehends, feels and acts in the world.

This material response to the social stimulus acts as a medium for tautological/self-referential accounts of mental illness in the medical model used as justification for prescription of psychoactive drugs. Relatedly, disadvantaging bureaucratic and legal double binds (Bateson, Jackson, Haley, & Weakland, 1956) can produce similar psychological and neurological changes in an individual through mechanisms such as learned helplessness (Maier & Seligman, 2016; Tennen & Affleck, 1998). Large and small cultures of double bind can result in a person dehumanising and harming themselves through a range of means; for example, a man may come to despise himself in the image of 'patriarchy' resulting in his engaging in problem drug use and self harm as means of dissociation.

The Interaction Between Material and Non-material Causes of Mental Illness

The interrelationship of material and non-material causes of mental illness is largely unacknowledged. It is essential to understand that the material and non-material courses of psychological ailment are inextricably linked leading to each other (Akiskal, 1985). If a person experiences the toxic effects of a psychology-affecting substance their behaviour will change and they will be treated differently sociologically as a result. Once medicalised, they may be overshadowed by their label and its associated rubric having the person they were known by displaced (Reiss, Levitan & Szyszko, 1982; Bradley & Hollins, 2006).

If the person receives a label which dehumanizes them (Fiske, 2012) they will be further traumatised having their behaviour affected on a second order level; if a person is chronically or acutely brutalised sociologically the physiological responses to trauma will change their behaviour as the psycho-physiological responses alter their perception, capability and mode of interacting in the world. What is set up here is a positive feedback loop which penultimately sets up information which can be used to evoke the societal response of prescribing mind altering drugs leading ultimately to social reactions to these altered states of mind. The lack of comprehension and understanding of the cause of ailment underlines particular demands on medicine as a science – namely the need to expand its borders of involvement and interests and to reality check its values base.

Signs and Symptoms in the Privileged Model of Medicine

An explicit core of the privileged model of medicine can be seen by analysing and comparing the tenets and the practice of medical diagnosis. It is helpful to use the framing of Principal-Agent theory developed by Jenson and Meckling (1976) and others to clarify the positions and roles in the power juncture which are experienced. They describe “an agency relationship as a contract under which one or more persons (the principal(s)[patient] engage another person (the agent)[medic] to perform some service on their behalf which involves delegating some decision making authority to the agent”.

In medical science the understanding of a problem generally requires the confluence of two sources of information through which an identification of malady and corresponding appropriate therapeutic avenue is forged. It is the combination of signs (observable by the agent/medic) with the information of the symptoms (observed by the principal/patient) which inform the identification of ailment and subsequently appropriate attempts at remedy (Nessa, 1996). To abandon one is to

compromise the other. Thus the abandonment of patient knowledge we find in the privileged model of medicine are key contradictions anathema to the foundational philosophy and science of medicine.

In medicine and professional support in general, the concentration of power in the agent/medic with institutional in impunity results in 'moral hazard'. Moral hazard describes a situation where an agent/medic has an incentive to increase the principal/patients exposure to risk because the agent/medic does not bear the full costs of that risk (Dembe & Boden, 2000). An exploration of the roots of medical and institutional impunity can be found in Appendix A. Power corrupts the capacity for self criticality and obscures the needed opportunities for professionals to be critiqued by their citizen peers as principals of their own health management.

Medical Dehumanisation, Dementalisation and Iatrogenic Harms

In this power imbalance Medical Dehumanisation is trained into the agent/medic (Leyens, 2014) effectively negating the principal/patient as knowledgable and cognate beings, especially in the psychiatric realm, where doubt about the capacity and mind sits central to consideration of the agent and their circumstances. This is known as dementalisation and it typically accompanies dehumanisation processes (Haslam & Loughnan, 2014). The combination of dehumanized perception and alienation of rights reinforced in this juncture results in a dementalization of the principal/patient on the back of which extraordinary alienation of rights and recognition take place. The result of this is the occurrence of moral hazard in the support/need juncture which produces iatrogenic impacts on people who exist under the psychiatric gaze (Fava & Rafanelli, 2019).

The tautological/self-referential medical model(s) of psychiatry represent a species of flawed theory related to solipsism. The prevailing paradigms provide status to medical/care actors which is heavily invested in by institutions and cultures partly because people have their identity and cultural status based on the knowledge. This is typical of the institutionalisation of any area and also not typical to our age, for example we can see a similar investment in 'phlogiston' like theories of medicine in the age of Vesalius who battled with the hierarchical medical cultures over-invested in the outdated conceptions of Galen (Siraisi, 1997; Nuland, 2005).

The non-engagement of medics (and those working from the auspices of the medical model) in discussion of the science and evidence bases underlying treatment rationales is a problem for medicine, care and support. Significant insights needed for advancement of understanding are located outside of the gate-kept habitas of the

medical orthodoxy. The medical model and institutionalisation of power suffers considerably from the Streetlight effect - observational bias expressed as when people only search for something where they can easily see (Freedman, 2010).

Iatrogenic illness literally means illness that is 'induced by the physician' and it has come to be recognized as a significant source of patient risk (Sharpe & Faden, 2009). It is not uncommon that symptoms are treated rather than causes, and the treatments which are used to treat the symptoms are themselves not uncommonly iatrogenic in nature – that is, they cause pathologies which get misidentified and mystified as the psychiatric diagnosis; the idea replaces the person and it then is responded to as their cultural identity. A chief example of this is the production of tardive dyskinesia by medicines and the cultural misidentification of symptoms of tardive dyskinesia as the original mental illness (Bahiya & Sujith, 2017; Narsi Reddy et al, 2010).

The level of iatrogenesis involved in the area of psychiatry is exceptional (Meadows et al, 2019; Mulder, Rucklidge & Wilkinson, 2017) due to the alienating nature of medical privilege and the extreme devaluation of the principal/agent knowledge. On top of this it gets placed behind a veil of invulnerability due to the protected nature of medicine as an institution (Finnis, 2011).

In Appendix A I offer an analysis of the construction of protected professions relating this to old lineages of alienation and cultural dominance. In this I also suggest potential accounts for the semiotic patterning of the social model of mental illness. The protected profession of medicine has become a medium to modernise various mythologies surrounding people who have become 'other' as cultural targets of malevolent behaviours (Warnock, 2019). We can see the impacts of the othering of individuals and groups by examining the patterns of diagnosis in social groups who are excluded and displaced from the socio-economic institutions of society and who are, as a result, denied their voices in the body politic (social groups also known as the subaltern). The name subaltern derives from the work of Italian theorist Antonio Gramsci. The original Italian usage, ‘subalterno’ translates as ‘subordinate’. The term carries in it class analysis with Gramsci originally referring to peasants and the lower working classes; over time it has expanded in use to designate the general attribute of subordination (Lehner, 2014).

Typical examples include intersecting realities of gender (Richards, Sayres & Van Niel, 2017), race (Bignall et al, 2019), and sexuality (The Trevor Project, 2019) but necessarily must also include ideological targets of societal extreme out groups – that is, drug users (Drugscope, 2015), homeless populations (Local Government Association, 2017), people caught in the criminal justice system (Duncan, 2016), and emigrants (Pumariega, Rothe & Pumariega, 2005). Susan Fiske identifies extreme

outgroups (Harris & Fiske, 2006) as encountering dehumanized perception three orders of magnitude greater than other cultural outgroups. Her work indicates this includes psychiatric labels like Schizophrenia (Fiske, 2012).

Critique of Medicine as an Institution and Body Politic

Medicine as a body politic imposes itself as the privileged convenor of subordinate groups using tautological/self referential accounts of mind, feeling and behaviour reasoned as biochemical imbalances whilst disregarding its duty of candour to acknowledge and address environmental, toxicological, financial and social causes of mental illness. A duty of candour refers to statutory governance which states if something goes wrong with your treatment or care, health and social care organisations have a duty to you or the person acting on your behalf to: apologise; be open and honest; involve you in a review of what happened; let you know how they will learn from what has happened (UK Statutory Instruments, 2014) .

This mystification of identifying the causes of measurable harms is negligence of duty of care (Goldberg, 2021) as it plainly involves avoiding confrontation of inconvenient societal issues such as toxic exposure to chemicals, psychological brutalisation in families, workplaces and in institutions; intervening in the stark exploitation and deliberate political production of poverty related harms in societal groups. In tort law, a duty of care is a legal obligation which is imposed on an individual, requiring adherence to a standard of reasonable care while performing any acts that could foreseeably harm others (Steele, 2020).

Due to the privilege and power it claims, medicine must necessarily be political when society wide issues are causing health problems which in turn necessarily involves critiquing other protected professions such as the criminal justice and law. In the context of corporate parenthood government and the protected institutions such as medicine must be held to account for their actions and omissions of action in relation to public health if they are to evolve beyond their mistakes and be effective in meeting their claimed remits (Scottish Government, 2015; Cockett, 2016; Access All Areas, 2017; Llywodraeth Cymru, Welsh Government, 2009).

Appendix A

Alienation of Human Rights in The Political Construction of Protected Professions

A significant part of the problems in psychiatry and medicine are related to the impunity they enjoy and the resistance these institutions have to 'outsider' involvement and change. To understand this cultural configuration it is important is to make an examination of how and why people have been alienated from the discussion of medical science and evidence bases in relation to healthcare, especially psychiatry. For this I am examining the role of alienation in political myths which structure and shape our society. Over centuries and millennia people have become increasingly alienated from ancient means of subsistence and existence (Dunedin, 2021).

No longer is it possible to independently draw shelter or subsistence farm, land having become significantly enclosed by the privileged elite since the 11th century in Britain, and the practice acutely intensifying from the 16th century onwards, exemplified in the lowland (Aitchison & Cassell, 2019) and highland clearances of Scotland (Devine, 1999; Devine, 2011). This alienation from land was paralleled by an alienation from human capabilities – that is, the opportunities to exercise skills, practices and trades. An instrumental moment in this was the introduction of Labour Law of 1563 put into place by William Cecil in the Statute of Artificers (Heckscher, 1994). Amongst other mandates this law imposed the reservation of superior trades for the sons of the better off and the control of entry into the class of skilled workmen via compulsory seven year apprenticeship (Atiyah, 2003); note the altogether exclusion of women who were chattel (property) under the laws of Coverture having their human rights subsumed by men.

This had the effect of crystallising privilege into a hierarchy which enclosed and protected professions such as medicine and law. It was from this that we see an expanded cultural dominance of the patriarchal aristocracy on human capabilities. The result has been that the world views of aristocratic patriarchs have overbearingly shaped who and what was/is deemed to be mad – or of 'unsound mind and character' - by dint of medical orthodoxy. The conflation of character and the relationship of mental health with carceral and prison systems requires scrutinization parallel to the critical examination of the mental health system as they are intimately related (Sapolsky, 2017; Kupers, 2017).

I argue the convergence of the privileged profession of medicine with financialism driven by ideologies such as 'shareholder democracy' acts to transform a relationship based in public value (healthcare) to one of cost effectiveness calculations of utilitarianism and profit we see dominating the professional management of

wellbeing. Legacies of Hobbesian Authoritarianism rooted in mythologies of monarchist patriarchalism (Tully & Skinner, 2009) pattern the management of expectations in the medical support/need juncture with behaviours of martial imperial colonialism. In political language this represents a long history of alienating people from their human rights to autonomy and agency. Over time this has embodied shifting baselines of attitudes to wellbeing manifesting large cultures of adaptive preference and growing populations experiencing psychological harms from structural violence. Adaptive preference describes damaged or maladaptive responses to oppressive circumstances affecting individuals' sense of who they are and what they can be and do (Mackenzie, 2014).

In the work of Thomas Hobbes we see the political mythology of patriarchalism repackaged into social contract theory as a diachronic form of the divine right of kings (Hobbes, 2021). Arguably the most famous rendering of this is that of Robert Filmer's book Patriarcha in 1680 (Filmer, 2008). Filmer, a barrister, argued the government of a family by the father is the basic archetype of all government. Hobbes argued that human rights are alienated to an absolute monarch who has complete impunity in ruling; he privileges males by arguing it is fathers not mothers who have founded societies. Thomas Hobbes and Robert Filmer were the same age, being born in 1588, and both went to the privileged colleges of Cambridge University.

I suggest that the power invested in the structure of psychiatry is representative of the unusual privilege of patriarchal monarchism which pervades all so called protected professions and as a result reinforces an exclusionary imperialism characteristic of an archaic archetype. Anthropological examination of these political myths can be explored through Frazer's Golden Bough which exemplify vertical dominance structures in the king myths (Frazer, 2009).

'Those whom the gods wish to destroy they first make mad' is an anonymous ancient proverb, wrongly attributed to Euripides that holds a motif reiterated throughout the ages about madness. This offers some testimony to what madness is in one cultural aspect; the response of the dissident mind to harms inflicted by violence – structural or otherwise. This semiotic places dominance through display of strength at the apex of societal structure and forges alternative qualities as othered weakness; as disability subservient to the functioning prime. This configuration offers a semiotic basis for the social model of mental illness (Beresford, 2002), one that illustrates myths of supremacy that act as charters for action (Malinowski & Redfield, 2013) but also create pathogenic culture through the traumas of dominance customs.

This anthropological look at dominance customs can offer accounts which are

helpful in viewing both the intersecting disadvantages in peoples lives and how the realities of these traumas are theoretically erased in the dominant cultures accounting of other existence; non-privileged existence (Crenshaw, 1989).

A trauma model of mental illness may reconcile and unite siloed accounts of ailment which affect mood behaviour and capability. It may integrate personal violence, structural violence and environmental, cultural and existential violence. A trauma model of mental illness is capable of tangibly implicating a range of stressors in negatively impacting someone's psychological wellbeing and offers practical insights for therapeutic action. Take, for examples, the effects of an abusive partner, the impacts of hostile city planning, the depletive actions of drugs/chemicals, exploitation by employers, the prejudice of a community.

The intersecting traumas can be seen to compound and overwhelm an individual's capacity to cope. The fact that stressors aggregate and interact and the way that people are dealt with through categorical lenses amount to the erasure of the whole person in the their sociological setting. Psychiatry as a line managed professional specialism exemplifies this kind of erasure and alienation of a person negating the human rights of the subject (George J. Alexander, (1997).

Appendix B

Summary Conclusion

I have argued that madness and forms of mental illness are diverse heterogeneous phenomena which get homogeneously categorised as medical tautological/self-referential identities. I argue that madness is something of 'unknownness', a concept which lacks substance and as a result is culturally projected onto. Its misunderstood nature places people at a disadvantage where they are dehumanised and dementalised. I contend that mental illness is caused by material (physiological harms) and non-material (sociological harms) which interact in positive feedback loops that get responded to dominantly by psychoactive drugs with mystifying tautological rationales. In the support/need juncture the medic/agent significantly discounts the knowledge and involvement of the patient/principal exposing them to risks through an asymmetry of power and as a result iatrogenic harms come about. The iatrogenic harms further displace the individual caught in the psychiatric gaze as their psychology, behaviour and mood are further affected via positive feedback.

To understand the alienation of individuals from their principality of their own healthcare I argue that over-investment in the status of the medical institution has anthropological roots which confer political myths of impunity subordinating people to damaging ideologies. The greater the subordination, the greater the dehumanisation and harms brought upon the people who have been erased from the discourse through alienating theories. Finally I put forward that the institution of medicine embodies a dereliction of duty of candour and duty of care, like other protected professions, to dealing with society wide issues which show up as forms of madness.

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