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From discipline to risk assessment

A very brief history of psychiatry as social control

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In recent decades, discussions in and about psychiatry have predominantly focused on scientific advances and features which define it as a speciality of medicine. This emphasis is a reflection of two developments: first, the advances of molecular genetics and neurosciences at the turn of the century have had a considerable impact also in the field of mental health and behavioural sciences; second, psychopharmacology has taken a hegemonic position both in research and therapy of mental disorders.

The focus of my talk today is very different. I will be untrendy and approach psychiatry and mental health care as a form of *social control*, or as an apparatus of discipline (as Michel Foucault would have put it). Historically, the control of deviant or abnormal individuals is an important root of psychiatry as an institution, profession and even science, and for many, it is *the* root of psychiatry. My 20-minutes history is an outline, a very rough sketch of metamorphosis of the aspect of social control in management of mental illness, and I will argue that this aspect is important even today.

Why I emphasise that mental health care in its diverse forms is one of the most important social technologies which have shaped and is shaping modern societies, the mode of living and the individual persons? Isn't my discussion a return to themes passed decades ago?

There are two reasons for my emphasis. First, a profound analysis of the social dimension of mental malady and the role of psychiatry in society is marginalized in today's professional discussion although mental disorders are widely acknowledge to be a major public health problem. Second, my conviction is that understanding of the position, functions and impact

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of psychiatry in society – its political character – is the basis for discussion on moral issues and ethics of mental health care.

From punishment to control, or asylum extended

As well known, the first crystallization of institution, expertise and science that was to become psychiatry took place in asylums for ‘mentally insane’ during the 19th century. Equally well known is the shift by which the asylum physicians, or ‘alienists’, and their science acquired a role in juridical practice as experts to evaluate the mental state, capability to responsible action and dangerousness of heinous criminals in the mid-19th century. In addition, the isolation and overall management of these dangerous individuals were given to them, too. The alienists’ step out of the asylum was decisive for the emergence of psychiatry as a central institution and technology of control of the ‘deviants’ in society. Thus, forensic psychiatry became a paradigm, or an archetype, of the way psychiatry functions as social control. This control of ‘insane’ was extended from ‘inborn’ criminals to people with subtle ‘perversions’ and to the fractions of the poor in the late 19th and early 20th centuries – both inside and outside the asylum walls.

I’ll give an example from Finland how control and ‘neutralisation’ of deviant, dangerous individuals extended outside asylum to include wider sections of population. Development similar to Finland took place in all Nordic countries in the same period. In the mid-1920's, medical superintendents of public mental hospitals became the leading experts in the making of eugenic sterilisation policy in Finland. Two laws were passed, the first in 1935 and the second one in 1950, which provided the groundwork for a sterilisation system targeted at mentally deficient persons and also at those incapable of taking care of their offspring. Public mental hospitals were an important nod in the execution of sterilisation policy, and their medical superintendents had a great power because they made an initiative and applied for sterilisation of a person from the National Board of Medicine in a great number of cases.

Political and scientific reasoning behind the sterilisation policy had two explicit focuses. The obvious one was eugenics – or racial hygiene or genetic hygiene (*arvshygien*) as it was called

in the Nordic countries –, and the other one was forensic psychiatry. Especially in the 1920's and 1930's, these two lines of problematization were tightly entwined, so that concern over 'inborn' rapists, arsonists, violent assaulters, persons committing infanticides, as well as drunkards and generally asocial persons gave a great impetus for sterilisation policy. In practice, however, sterilisation procedures were mostly targeted at poor women. Thus, eugenic sterilisation policy functioned mainly as a supplement of poor relief, which was mainly taken care by the municipal administration. This was not a novel preoccupation of psychiatry, as it was closely linked with the management of the poor or the 'underclass' since the late 19th century, in Finland and elsewhere. With eugenic policy between 1920s and the 1960s, the control became more systematic and took place outside the asylum.

In retrospect, eugenic policy can be seen as a passing phase of psychiatry. However, disciplinary control of the abnormal and the poor in psychiatric institutions and by mental health experts was more persistent. In the late 1960s, the inmate of a Finnish mental hospital was perhaps ill but definitely poor, criminal, deviant or had all these qualities. By that time, however, the asylum psychiatry had reached the beginning of its end.

Psychiatry as social control: Extension of asylum psychiatry

- ▣ Context: Racial hygiene in Finland (1920's – 1950's)
- ▣ Target
 - Deviant individuals
 - 'inborn' criminals & asocial individuals
 - Poor women
- ▣ Function
 - Protection of social order and vitality
 - The nation state, the people (*folket*)
 - Supplement to (municipal) poor relief
- ▣ Mode of discipline
 - Surveillance
 - Incarceration
 - Sterilization

After asylum

Today, the paradigm of psychiatric practice is outpatient care, not asylum. In most Western countries, the number of beds in mental hospitals has dramatically decreased, institutions have been closed (in Sweden, for example, there are not anymore separate psychiatric hospitals), and patients by large have been 'deinstitutionalized'. The asylum walls began to crumble after the Second World War. By late 1950s and early 1960s, the hospital institution and psychiatry connected with it were harshly criticised by popular movements, social scientists and progressive psychiatrists and mental health workers in the U.S., Britain, France, Italy, The Netherlands etc. The critics said that psychiatric hospitals were ineffective, coercive and inhuman, similar to the prisons, and should be closed down. The demands were successful: massive dehospitalisation took place and mental health care was profoundly reorganised in the latter half of the century. In the current configuration of mental health care, psychiatric hospital has a limited, even marginalized role to play.

However, I claim that another development, parallel to dehospitalization, is more important regarding the metamorphosis of psychiatry and its control functions. After the Second World War, a mosaic of mental hygiene and psychotherapy was formed throughout the Western culture, starting from the U.S. This mosaic can be called mental health care. Its germs emerged in the late 19th century, and it was organized in a limited way by mental hygiene movement and therapy culture of the cultural elite between the world wars. During the wartime, especially in the Allied forces, a variety of psychotechnologies were deployed in management and treatment of combat forces, as well as in surveillance of civilian 'sentiments'. After the war, the psychocomplex started to emerge as the mentioned technologies invaded successfully to workplaces, family life, educational institutions, social work and medical care, and psychodynamic expertise was the most important facilitator of this dissemination. The work and influence of Tavistock Institute in Britain and the expansion of the expertise and institution of child psychology in Sweden illustrate this well. In addition, an intense psychopharmaceuticalization of everyday life began in the late 1950s and early 1960s, as the first blockbuster 'minor tranquilizers' – Miltown, Valium, Diapam in Finland – entered the market.

The emergence of mental health care provided psychiatry – as a profession and science -- a field of operation and expertise considerably distant from the asylum, which brought it closer to other professions of care (medical doctors, social workers, teachers etc.) and made it more visible in society. This has two consequences. First, psychiatry blended with medicine as a practice and started to resemble more clinical work which other physicians did. Second, and more importantly, psychocomplex became a major source of knowledge and means for management of personal conduct and life, for self-understanding and self-improvement for large numbers of people. In other words, psychotherapy became the dominant *ethical technology* for the masses of developed societies between the late 1950s and 1980s. With these changes, the way social control worked and was justified in the asylum era was cast out almost entirely. New functions of social control evolved along the lines of the mentioned transformations. On the one hand, psychiatry contributed remarkably to redefinition of many forms of deviant behaviour ‘from badness to sickness’, as the first critics of *medicalization* argued. On the other hand, control (or ‘normalization’) became increasingly individualized, even personalized as psychiatry and other modes of ‘psy’ expertise got hold of practices of self-reflection and self-formation through psychotherapies and chemical ‘cures’. The latter development can be called *psychiatrization* of the care of the self.

Out of asylum: emergence of mental health care

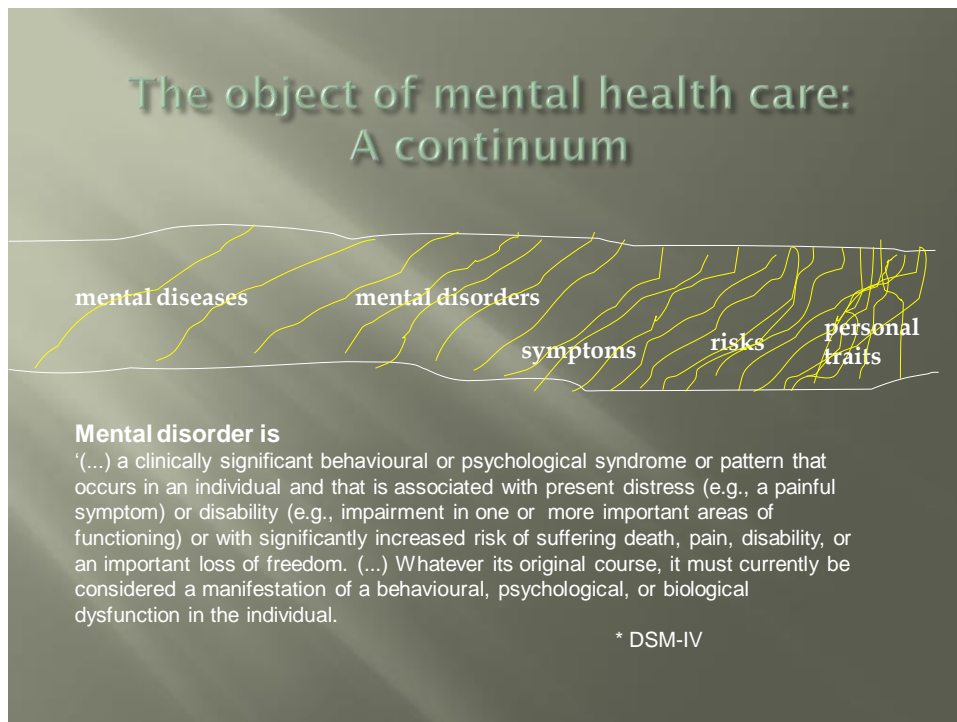
- ▣ Post II WW
- ▣ Dehospitalization
- ▣ Dispersion of psychiatric expertise in institutions of education, social work, health care and in workplaces and family life
 - A mosaic, rhizome of mental health care in society
 - Deviance, both major and minor, is medicalized
 - Care of the self becomes psychotherapeutic (and psychopharmaceutical, later)

Metamorphosis of psychiatry has resulted in complex, fragmentary and equivocal configuration of mental health care, a rhizome of sciences, treatment, control and care. Consequently, the object and the field of expertise have also become very different from what it used to be. In its early years of psychiatry focused on mental diseases from which mainly inmates of the asylums suffered. In the late 19th and early 20th centuries, milder forms of 'insanity' got a foothold as 'neuroses' and 'perversions' began to appear in the field of vision of the psychiatrist, now extending outside the asylums. Between the world wars and especially after the Second World War mental diseases were gradually eclipsed by mental disorders (anxiety, twists in personality development) and mental symptoms. Eventually, the object of psychiatry and mental health care was defined like this:

(...) a clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (e.g., impairment in one or more important areas of functioning) or with significantly increased risk of suffering death, pain, disability, or an important loss of freedom. (...) Whatever its original course, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual.

This is the DSM-IV definition of 'mental disorder', and thus the cornerstone disease model in psychiatry today. However, psychiatry and mental health care are not focused only on disorders but, and increasingly during the past four decades, on symptoms, risks and susceptibilities to mental illness. The latter object of research and treatment is related to the emphasis of prevention and early intervention, which, in turn, have been accompanied by the trend to psychological or pharmaceutical 'life coaching' aiming at normalisation, optimization or even enhancement of the self and personal life. It is quite obvious that mental diseases appeared to be rather rare in the population from the perspective of the asylum psychiatrists. But when mental health care proliferated and took syndromes, symptoms and risks as its objects mental abnormalities and disorders appeared rather common scourges among ordinary people. Becoming of depression a public health problem

is the most prominent example of expanding phenomena of psychic disorders, impairment and their potential which are the target of mental health care today.



In this context I would like to point out a paradox of the recent history of psychiatry. Parallel with change by which psychiatric expertise and practice have extended and become more diverse, attempts to make psychiatry more scientific – that is, more like medical science – have become more intense and also succeeded. The transformation began in the late 1950s in the U.S., France and Britain (also Sweden and Denmark had some niches of scientific psychiatry) resulting in the present situation in which it is practically impossible to discuss professionally about mental health issues without referring to facts based of epidemiological studies, randomized clinical trials or results in neuroscientific research. Now, it would be quite legitimate to assume that the object of psychiatry would be clearly defined and demarcated both in research and clinical practice. However, this apparently is not the case; on the contrary, there seems to be no borders for mental disorders (as Nikolas Rose would put it).

Psychiatry and the social reform

A noteworthy tenet in the process of dehospitalisation and formation of the mosaic of mental health care was attempts to modify psychiatry into a social technology that would promote the change towards happy, safe and equal society and, at the same time, oppose coercive and authoritarian forms of social control. This trend was actualized in campaigns of radical movement for psychiatric reform in the Netherlands, Britain, Italy or France, in large scale policy programmes for community psychiatry in the U.S, in experiments of therapeutic communities in Britain etc. Here I present an example from Finland where the most influential current of change raised inside the psychiatric profession. In the 1960s, some psychiatrists began to promote an idea that psychiatry should concentrate on recovering of the mental patients and on 'returning' them back to ordinary life by the means of rehabilitation, psychotherapy and social support. The ideological breakthrough happened, especially among the health authorities, in the 1970's, leading to a rapid change of orientation towards out-patient care – with the goal of supporting patients' autonomy and activity in everyday life and their community integration – throughout the mental health care system in the late 1970's and early 1980's.

Intellectually, this programme of psychiatric reform and the actual change were embedded in a broad context of reasoning that can be called *social psychiatry*. It approached mental health from the public health perspective and within it the object of psychiatry – or, more broadly, of mental health care – was re-defined as mental disorder and personal impairment. They were seen to be essentially problems in social interaction and involvement, problems that touched the individual person and people, institutions etc. living with him or her. 'Social' in this context referred to two things: society as an ensemble of political and social life and the sphere of personal interaction, mainly work and especially the nuclear family.

Mental health care as a social technology: Social psychiatry (1)

- ▣ Context: Making of the Finnish welfare state (1970's – 1980's)
- ▣ Target
 - Mental disorders
 - Personal impairment
 - ... as social phenomena
 - ▣ Society
 - ▣ Work
 - ▣ Family life
- ▣ Function
 - Prevention
 - ▣ Detection & counselling in primary care
 - ▣ Popular education
 - ▣ Social reforms

This concept of mental disorders and mental health as social phenomena was connected to the ethos of reformism. According to the advocates of the Finnish social psychiatry, psychiatry needed to be transformed into widespread mental health care involving institutions of health care, social services and education. The task of this network was not only to treat people with mental problems but, essentially, to prevent mental malady in population by the means of therapeutic and social interventions and popular education, and to promote general social reforms that would foster mental health. In the discussion of social psychiatry in the 1970's and early 1980's, the idea of comprehensive mental health care was summarised in three dimensions listed below. In practice, mental health care as a social technology focused on prevention mental disorders.

Mental health care as a social technology: Social psychiatry (2)

- ▣ Dimensions
 - Constructive
 - welfare society
 - policy making, administration
 - Preventive
 - health care, social service and other 'service sectors'
 - popular education, counselling
 - Therapeutic
 - specialised psychiatric and psychotherapeutic care

The breakthrough of these tenets of thought and practice coincided with the most intense construction period of the Finnish welfare system of public health, social and educational services. This process of building up welfare services by the state and the municipalities boosted dehospitalization and expansion of mental health care in welfare services. By the early 1980's, there existed a great potential in the emerging welfare state to spread therapeutic rhizome throughout society. To some extent this diffusion has happened – in depression treatment in particular – but today reformist fuel has evaporated almost entirely, because 'welfare psychiatry' crashed into economic depression, strict limitations in both the state and municipal health expenditure, and the introduction of the New Public Management in the institutions of public health care and social service in the 1990's.

Segmentation of care and control

The advocates of mental health care reform in the 1970s and early 1980s saw mental disorders as the problems in relationship between the individual and society and in interaction between the individuals. For that reason, they considered interventions in and improvement of society and social environment as the primary mode of mental health care,

equal to the care of the patients. after the 1990s, this idea has waned. Today, it seems that the social dimension of mental disorders is conceived of in a completely opposite manner: In current mental health discourse, the problem is an individual (a chronic 'service user', a female professional with an acute work exhaustion of depression, a schoolboy with ADHD etc.) who either actually or potentially harms his or her human relationships and social environment and causes economic losses and social problems. From this perspective, mental health care is targeted at the problem individuals and problems in individuals that may turn them into problem individuals.

Examples of this are numerous. When a paper mill was closed down in southeast Finland on 2006 and a great number of people lost their jobs, a special 'crisis counselling' was organised to 'strengthen personal resources find solutions and prevent sense of helplessness among the individuals', as a trade union website describes. This seems to have become a common practice when industries are downsized in small towns or regions. Also in the aftermath of school shootings in Jokela and Kauhajoki, the tragic events were seen from a perspective emphasising control of the 'loners' who may potentially become dangerous. Detection of alarmist signs in both immediate social environment and in the Web by policing and mental health authorities was particularly emphasized. In addition, probably the most obvious example is the promotion of personal, anticipatory surveillance of depressive symptoms through mood diaries and self-help test available in the net by current popular education campaigns related to the management of depression epidemic.

Both professional and lay approach to depressive disorders is a good illustration of the main trend in the late 19th century and early 20th century mental health care. The emphasis of prevention and early intervention in mental health problems moulds much of mental health care into predictive, anticipatory control, which increasingly put focus on potential problem individuals and on traits and signs of individual behaviour and experience that may cause problems and turn the person into a problem case. Predominantly, mental health is seen in the light of risks, susceptibilities, presymptomatic signs in the individual, and the task of mental health care has become to assess and manage these probabilities and potentialities. To fulfil this task, psychiatry provides clinical and epidemiological tools and borrows them from molecular genetics and neurosciences to divide person, their lives and biological and social environment into factors which can be calculated, evaluated and manipulated. Gilles

Deleuze would have called this 'dividualization', and an obvious direction in which psychiatry seem to develop is control of dividuals, instead of individuals. In this constellation, 'an individual' (or a person) is an intersection of factors of influence and, possibly, an agent of control of 'biopsychosocial' factors.

It would be tempting to claim mental health care has become a mode 'post social' control. This transformation can be understood in two senses. On the one, an ethos of social reformism has been replaced by the views which emphasise that risks and traits making people vulnerable to mental malady are personal and that the responsibility to care of mental health bears upon the individual persons. This rationale is claimed to be congruent with the *neoliberal* ethos and have spread wide in public health policy and health care in the West after the 1990s. On the other hand, control based on 'dividualisation' appears congruent with a tendency to biologize the problem individuals and individual problems. *Biologization* that eclipses social dynamics of mental malady takes place in two forms. In psychiatric discussion and research, it is commonplace or even a requirement to deploy of molecular genetics and neurosciences to provide explanations and reveal 'causes' of mental disorders and problem behaviour. In addition, the prospects of truly scientific psychiatry-to-come are embedded in neurosciences. The most important tenet of biologization in mental health practice is obviously the main form of psychiatric treatment, namely drug treatment which has disseminated all over mental health care in a manner well known from current mode of depression management. The hegemony of pharmaceutical solutions implicitly suggests that the primary target of mental health care is the brain physiology of the individual suffering from or at-risk of mental illness.

Characterization of current developments in psychiatry as a (post)social technology may well be very accurate. However, I'd emphasise the fact that mental health care has profoundly segmented as the result of expansion of 'psy' expertise in all corners or society, and, consequently, control related to mental health care has become diverse. On the basis research of mental health care scene in Finland by me and colleagues, I'd suggest that mental health care has been divided into three main segments. There are overlaps between the segments but any system of mental health services hardly exists, because institutional, professional and practical relationships and co-operation between the segments are contingent and equivocal.

The first segment is *everyday mood control*, and majority of individuals with mental health problems belongs to this domain. Within this domain, people manage with their 'nerves' in everyday life, are guarded up about personal mental 'resources', maintain or repair their normality or, in some cases, enhance their capacities by chemical or other therapeutic means. Mental health care is essentially *self-control* in this domain, backed up by physicians and, nowadays, by self-help networks, pharmaceutical companies and health educators. Contribution of medical profession comes primarily from the domain of primary care, and also counselling provided by social and educational services have an important role. It should also be mentioned that the most extensive markets of both psychopharmaceuticals, self-help literature and psychotherapies are related to this segment of mental health care.

Officially, the domain of specialized psychiatric care is embodied in outpatient care, but I'd like to call this segment of mental health care *'roller door' psychiatry*. The latter name reflects the fact that today hospital treatment is usually short and aim at stabilising the condition of the patient so that she or he can be discharged for 'remission' at home; in practice, the majority of psychiatric patients keep on circulating in and out the hospital. This segment covers many types of psychiatric hospitals and hospital services, prison hospitals included, and outpatient services. It is obvious that many forms of treatment, with drugs, talk and other devices, takes place in this domain. However, I'd like to point out another task by which specialized psychiatric services are increasingly preoccupied today and which is closer to its control functions. What psychiatrists do in psychiatric institutions and when providing expert consultation to courts of law, educational institutions or social services are *assessment* of individuals who have impairing mental problems or who are at 'high risk'. Assessment may have many purposes: psychiatrists may assess the degree of impairment of the person or her or his ability to work, and diagnose her or him according to assessment. Treatment options (like eligibility to psychotherapy) are assessed, as well as eligibility to social benefits. Within the hospital realm, psychiatric assessment is often focused on how risky or dangerous the individual is either to her- or himself or the other, when decisions over admission to the hospital or releasing from the prison are made. Methods of assessment are also numerous, and a noteworthy development is that clinical evaluation is increasingly geared to 'evidence based' methods leaning on epidemiological studies and global 'gold standards'.

Through assessment practices then psychiatry becomes a cluster of passage points through which people with symptoms of mental disorders or minor behavioural problems may be directed to a route that leads either to 'rehabilitation' and recovery or to a chronic condition, mentally and socially. Due to this, assessment provides specialized psychiatry an important practical interface with two other segments of mental health care.

There is yet a final segment of current health, the domain in which people become as chronic 'services users' are provided treatment and social assistance. It should be emphasized that this chronic condition is not only about mental illness but also social. Medical or psychiatric aspect of management of chronic patients is maintenance treatment by drugs. However, this management is mostly related to provision of special housing services, social assistance and social benefits like pensions, and thus it is primarily social work. Thus, mental health care is closely linked, or even transformed, into management of social exclusion and excluded by public social services, in a way resembling the function of psychiatry as a supplement of poor relief almost 100 years ago. I call this segment *exclusion management* because the public services work in the post welfare system in such a manner that they keep the 'services users' in marginalized position and reproduce their exclusion, despite good intentions of the system. A recent feature is the rise of patients' activism with critical voice within this domain.

Segmentation of care and control (2)

- ▣ Segments
 - Everyday mood control
 - Self-control
 - Personal maintenance of normality
 - Primary care, self-help, therapy market
 - Roller door psychiatry
 - Specialized psychiatric care
 - Assessment of individuals 'in trouble' or 'at high risk'
 - Passage points for recovery or chronic condition
 - Exclusion management
 - Maintenance treatment
 - Chronic 'services users'
 - Provision of special housing services, social benefits, social assistance
 - A form of poor relief today?

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