Institutionalized Madness

The Interplay of Psychiatry and Society's Institutions

Edited by

Arnoldo Cantú, Eric Maisel, and Chuck Ruby

Institutionalized Madness is the sixth Volume
of the Ethics International Press
Critical Psychology and Critical Psychiatry Series.

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This book first published 2024

Ethics International Press Ltd, UK

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

Print Book ISBN: 978-1-80441-656-3

eBook ISBN: 978-1-80441-657-0

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To all those willing to push back on ideological conformity.

-AC

Editor's Introduction

Eric Maisel

Why does a woman give birth on her back rather than standing up?

Because that is easier for the doctor.

Psychiatry makes things easier for everyone, except for the people who are suffering.

Psychiatry provides a rationale for locking up an angry "schizophrenic." Or someone who is suicidal. Or someone wandering the streets. What else are you going to do with them? Let's "hospitalize" them.

Psychiatry provides a pill for not liking your boss or your mother. A pill for anxiety. A pill for when your first pill isn't working. And a pill for when your second pill isn't working. Three pills for not liking your boss! That's a mouthful.

Psychiatry provides a label for that bored youngster who can't sit still in school, at church, or at the dinner table. It provides a label for people you don't like—they're borderline, passive-aggressive, and somehow otherwise "disordered." It even medicalizes your obesity, so that you can keep right on eating!

Psychiatry provides a way of dealing with political dissidents and other troublemakers. (Do you remember the mental disorder label given to runaway slaves? Coined in 1851 by American physician Samuel A. Cartwright, it was called "drapetomania" and stood for the "mental illness" causing enslaved Africans to flee captivity.)

Psychiatry creates impressive tests that are neither valid nor reliable. If you ask an anxious person in twenty different ways, "Are you anxious?" how astounding that he or she will "score high" on your anxiety scale! That's a setup for scoring high—and for creating "patients."

Psychiatry anoints as expert a witness who has no idea why the defendant did what he did. No wonder two expert witnesses can provide exactly opposite and contradictory testimony! One is being paid to make up one thing and the other is being paid to make up the opposite thing.

Psychiatry brushes away uncomfortable truths, like the truth of the placebo effect. Of course, the antidepressant is working! It couldn't possibly have been the placebo effect. We don't recognize or talk about the placebo effect. Never heard of it!

Psychiatry provides talking points for all sorts of professionals and pseudo-professionals, from school counselors to human resources personnel. It makes everyone's job that much easier. Why didn't we hire you? It's that "ADD" you mentioned. How can you possibly concentrate on your job if you have ADD?

Psychiatry ignores a person's circumstances and, by not pointing a finger at how poverty might bring one down or how scary schools might make one anxious, it colludes with those who would keep people in poverty and keep public schools underfunded. How convenient for the slumlords, oligarchs, and billionaires!

Psychiatry tells us who is normal and who is abnormal. How useful! It turns normal on its very head by, for example, calling abnormal coming home from exterminating an Afghan village and having nightmares and normal coming home and feeling nothing. Normal is the proud absence of a conscience!

All this lovely simplicity is fueled for completely obvious reasons. Big Pharma. Academic funding. Professional self-interest. Social control. And so on. But one reason is rather less obvious—and stands at the heart of the matter.

The psychiatric model has taken hold and grips us by the throat because it is authoritarian at heart. It is a lovely tool of the authoritarian personality—a personality that wants to control, humiliate, and punish.

The psychiatric model is essentially a punishment model, where made-up labels are used to put people in their place. Put that rowdy boy in his place.

Put that upset woman in her place. Put that immigrant living in poverty in his place. They are all sick. Sick, sick, sick. Let us drug them.

Why would a whole professional class want to punish? That sounds absurd on the face of it. But we are obliged to remember that a substantial portion of the human race exhibits features of the authoritarian personality. If you are that sort of person, why wouldn't you gravitate to a "medical specialty" where you get to lock people up and call them names?

We are calling this infiltration of psychiatry and the psychiatric model into everything "institutionalized madness." But, of course, it is not madness on their part. It is simply cleverness. Authoritarians know to use language to do their bidding. Nothing helps them more. A whole army isn't as valuable as the right phrase. What is the perfect phrase at their disposal? "Mental disorder."

It is flat-out impossible to defeat the phrase "mental disorder." You say that you are tired, sad, and dispirited, and I crow "mental disorder!" Not one person in a million will dispute my "diagnosis" or presume that I've done something tricky and illegitimate. Not one in a million. Not a television host, not a lawmaker, not your brother, not even your best friend. The phrase has done its work and virtually everyone is being held captive by it.

So, we, in this series and in this volume, are doing our one-in-a-million part. I, for one, do not expect that we will make much of a difference. But we are obliged to do our part. I hope that we will open your eyes a little bit and, better still, provoke you to take some action—even if that's just pushing back whenever you hear the phrase "mental disorder," "mental disease," or "mental illness."

Wonder aloud what is being meant. Put on your most skeptical face. And, if you are moved to do so, join us in critiquing psychiatry and in holding it accountable.

Moving Past Racial Categories: An Epistemological Comparison with Mental Disorder

Arnoldo Cantú

Abstract: *Mental disorders found in the Diagnostic and Statistical Manual of Mental Disorders (DSM) are ubiquitous in everyday discourse, research, and the field of mental health to help individuals access services such as psychotherapy. Mental disorders have also been critiqued for contributing to iatrogenic harm and stigma in addition to fundamental concerns about their validity and reliability. Concurrently, the concept of race is firmly embedded in everyday discourse with evident social, political, healthcare, and scientific implications despite its questionable validity. However, both concepts of race and mental disorder tend to be taken at face value by most people without regard to their shaky epistemological and ontological foundations. Therefore, this chapter will elucidate fundamental uncertainties that bind both race and mental disorder and will introduce several philosophical assumptions and positions held around both notions. It will speak about how people tend to wish to keep both race and mental disorder despite the harm the concepts can inflict onto people. It will also provide alternative critical perspectives, ultimately arguing for how culture and society can be envisioned where people do not have to be subsumed under either system of classification. This chapter will argue that they should be optional, at minimum, organizing and meaning-making frameworks with broad latitude to also be able to reject them.*

Acknowledgement: I am indebted to my good friend and intellectual sparring partner, Nathan Gallo, for providing his invaluable and helpful thoughts, feedback, and recommendations for this chapter.

> *When I use medical terms such as "diagnosis," disease," and "treatment" in reference to psychiatry or psychoanalysis, it is with the understanding that we are not dealing with real, literal diagnoses, diseases, or treatments. We are dealing with the* metaphorical uses of these terms. *However, this medicalized idiom is such an integral part of our contemporary culture that*

> *the terms are accepted on face value, as* literal *diagnoses, diseases, and treatment. Indeed, it is socially improper—embarrassing, offensive, insulting—to reassert their metaphorical character. Still worse is calling attention to the practical—legal and medical—consequences that follow, linguistically and logically, from identifying and "treating" nondiseases as diseases.*[1]
>
> – *Thomas Szasz, The Medicalization of Everyday Life: Selected Essays*

> *Language is the plasma of culture. Our crucial systems and signals of meaning are facilitated, bound together, nourished, and shaped by the words we use. When it comes to race, every time we matter-of-factly invoke the concept as a legitimate way of characterizing a human being, we further reify and concretize the illusion of subspecies within the one human species. The language of race has become so commonplace that it seems impervious to change. Calls to stop using the word "race" seem futile, if not heretical or dangerous. Referring to individuals as members of races seems too deeply rooted and intertwined in popular and technical parlance to be retired.*[2]
>
> – *Carlos Hoyt, The Arc of a Bad Idea: Understanding and Transcending Race*

Introduction

What is a chapter about the topic of race doing in a book with the title *Institutionalized Madness*? Aren't the two topics essentially apples and oranges with no overlapping commonalities? Isn't one topic more "medical" seeming and the other as "natural" as the air we breathe?

Not quite.

I believe race can be used as a helpful analog to illustrate the arguments put forth in this chapter—that is, both concepts not only suffer ontologically and epistemologically in very similar ways, but they can also be more harmful than helpful to many. Both ideas are also significantly prevalent in contemporary society given how "in our faces" they have been, espe-

[1] Thomas Szasz, *The Medicalization of Everyday Life: Selected Essays* (Syracuse University Press, 2007), vii.

[2] Carlos Hoyt, *The Arc of a Bad Idea: Understanding and Transcending Race* (Oxford University Press, 2016), xv.

cially as of late, through shaping discourse on a daily basis. And yet, we are not necessarily encouraged to question either idea, much to our detriment. This chapter attempts to correct that—as such, I'm going to bring them both along on this philosophical ride. Additionally, as you will see, I'll be a bit more heavy-handed when it comes to race given my fascination with the topic, the freedom to play with the philosophical ideas in a chapter of this kind, and because a reader of this volume will likely already have a bit more exposure to the critiques surrounding mental disorder.

Full disclosure: I don't proclaim to be a philosopher of race or philosopher of psychiatry or medicine, and as such I proactively ask for charitability of any misinterpretation, mischaracterization, or omission of the philosophical nuance—this is my amateurish attempt at applying E.O. Wilson's idea of *consilience*,[3] borrowing a framework from one field to use in another for making some sort of coherence between two deeply entrenched ideas. However, at the same time, I don't wish to contribute to the quibbling and pontificating about esoteric debates using nebulous language that I've found characterizes a decent amount of contemporary philosophy, especially when associated with my field and related disciplines (i.e., mental health, psychotherapy, psychiatry, psychology, etc.; see Barnes' chapter in this volume titled "Are Critics of Psychiatry Stranded in a 'Jurassic World'?" as another critique of philosophy).

Using "schizophrenia" as an example—the so-called mental illness considered to be the "sacred symbol of psychiatry" (Szasz, 1976), the "sacred cow" of psychiatry (Timimi & McCabe, 2016), and "the category of insanity, henceforth, most integral to institutional psychiatry" (Burstow, 2015, p. 42)—Boyle has pointed out:

> [A]s the literature surrounding schizophrenia becomes *more and more technical and obscure*, the power of the diagnosis to silence becomes greater. This silencing can only be *countered by open analysis and debate*, with contributions from as many people as possible. (Boyle, 2002, p. viii, emphasis added)

As such, I try to embody the "scholar-practitioner" model (Kyle, 2021), attempting to bridge the gap between what I read in the literature and

[3] Edward O. Wilson, *Consilience: The Unity of Knowledge* (Alfred A. Knopf, 1998)

seeing how it can realistically be applied in my practice. To be sure, my characterization of the literature may be an unfair assessment, but I am especially critical of it when I see firsthand in my day-to-day practice as a psychotherapist the *significant chasm* and hierarchy of knowledge between what is debated behind paywalled articles, expensive books, and the ivory tower versus how the general public thinks about their own suffering. In my view, I believe most of the public is being deceived when they are led to believe in "mental disorder" lock, stock, and barrel as the only way to explain their difficulties without being informed of alternative perspectives.

I became interested in the topics of race and mental disorder over the past decade or so in my work as a clinical social worker, and in earnest since 2020 and the "racial reckoning" that ensued. For the former, I've been a practicing psychotherapist for about a decade and have seen firsthand the putative "mental illnesses" all my clients have. I use scare quotes not to imply that their suffering is not valid but to give a nod to the healthcare system they are pigeonholed in that mandates the use of scientifically questionable psychiatric diagnoses just to can access support the minute they step into my office (Cantú, 2023b).

As for the latter, what spurred my interest was voluntarily participating in an electroencephalogram (EEG) study out of sheer curiosity to see what kind of waves the wrinkly organ between my ears were producing. At the outset when they collected demographic information, I remember attempting to skip the "race" question and selected "Hispanic" for ethnicity. None of the five races at that time seemed fitting for me: I was born in Mexico and grew up in south Texas, thus simply considered myself a Mexican-American of Hispanic descent. However, my skipping of the race question didn't bode well for the study coordinator, and I was compelled to answer it anyway. My selection? Lest I try to impersonate someone as I don't consider myself to be American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander,[4] I chose White.

[4] According to the US Census Bureau, from 1997 onwards, there have been at least only five races (see: https://www.census.gov/topics/population/race/about.html) and two ethnicity groups: Hispanic or Latino or Not Hispanic or Latino (see https://www.doi.gov/pmb/eeo/directives/race-data). I'm still not sure how someone can embody a "non-" category—what an ontological puzzle. However, to make matters more confusing, a recent update in early 2024 by the U.S. Office of Management and Budget (OMB) (the agency that sets the standards

That felt odd, to put it lightly.

I later chalked it up to the study coordinator potentially being uninformed about best practices for collecting demographic data (or, perhaps, being averse to flexibility). However, compelling aside, there was a lightbulb moment during which I realized—likely for the first time in my life—that I didn't fit into any of the five preset racial categories. *I was raceless*. Thus began my more recent preoccupation with race (with my philosophical interest in mental disorder remaining in the background):

> *So, not everyone fits into a racial category? Can people "opt out" of identifying with a race? Are they legally imposed, or do we have discretion? How can I convey to others that I am not only raceless, but also do not believe in the concept of race without being met with disturbed looks and concern for my well-being? And if I don't believe in race, is it even possible to stop others from assuming "mine" or is it a genie that is likely never going back into the bottle?*
>
> *Isn't it unfair for people to likely make unsolicited veiled snap judgments of me (that I may never know about) based on skin color without ever getting to know the "real" me? Wouldn't this be comparable to making characterological, social, contextual, or historical assumptions about someone because they* seem*, for example, Greek, or because they come off as "socially awkward," without ever really getting to know the person?*
>
> *If racial designation is seemingly based on phenotypical features (such as skin color), is there a biological reality to it where someone "black" in the United States is "black" while traveling in another country? Is this similar to how someone with diabetes in the US will still have diabetes while traveling in another country? If no, then is this just another form of US ethnocentrism?*[5] *And if these categories aren't fully recognized in other parts of the world, why should I use them here and why do others clutch to them?*

applied to Census Bureau data) added "Middle Eastern or North African" and lumped together "Hispanic or Latino" with the original set (see: https://www.prb.org/articles/race-ethnicity-categories-in-federal-surveys-are-changing-implications-for-data-users/ and https://www.federalregister.gov/documents/2024/03/29/2024-06469/revisions-to-ombs-statistical-policy-directive-no-15-standards-for-maintaining-collecting-and)

[5] This is typically defined as the application of one's own culture as a frame of reference for judging others (see https://www.merriam-webster.com/dictionary/ethnocentrism).

When the public imposes a race on another person (as most are quick to do automatically), at which point on the spectrum of light complexion to dark complexion is one person "white" and another a "person of color"? Is this simply an example of the Sorites paradox[6] *in which there is an indeterminate amount of melanin required to shift when a person is viewed as "white" versus a "person of color"? And why does it still feel like we are using a similar version of the "one-drop rule"?*

Or is a racial distinction also based on ancestral and geographical heritage? If so, then are those criteria commonly used to verify one's race? If yes, then why does the US allow someone to self-identify instead of ensuring additional verification measures—and how can people be allowed to identify as a different race than they were originally raised to believe?[7] *How are racial categories validated? And why do they sometimes seem to be lumped together with ethnicities and cultures as if they are all one and the same?*

Why is "black" usually capitalized and "white" isn't[8] *if they are both categories of the same kind (i.e., race) and putatively "tracking" similar things? Or are they tracking different things, if at all? And how can there be only a handful of races for a United States population of over 300 million? "Racism" is still considered the mistreatment of people based on their race(s), right? What is a "race" anyway?*

As the quotes opening this chapter illustrate, both race and mental disorder are concepts so firmly embedded, entrenched, and uncontested in contemporary society that not only affect nearly all of us, but also contain foundational weaknesses and harms that are regularly inflicted upon us all.

On second thought, if one is using the definition of "institutionalized" to be "established in practice or custom"[9] *and "madness" as "imprudence or fool-*

---

[6] This is a paradox produced by vague or "fuzzy" terms. One example is asking what makes a heap of sand a heap. If it is the accumulation of many single grains of sand, at which point will adding or removing single grains of sand make it a heap versus non-heap, respectively (Hyde, 2018)?

[7] See, for example, Tuvel's controversial 2017 article entitled "In Defense of Transracialism" published in *Hypatia.*

[8] For example: https://blog.ap.org/announcements/why-we-will-lowercase-white

[9] https://www.oed.com/dictionary/institutionalized_adj?tab=meaning_and_use#11666366

ishness,"[10] *perhaps this chapter is much more fitting for a volume of this kind than I originally thought.*

Setting the Stage

"Mental illness is nothing to be ashamed of. It is a medical problem, just like heart disease or diabetes" (Njoku, 2022); "'Institutional racism' and 'structural racism' and 'systemic racism' are redundant. Racism itself is institutional, structural, and systemic" (Kendi, 2019, p. 21). Depending on who is asked, these are two seemingly incontrovertible truisms in contemporary discourse, healthcare, and research—that is, mental illness (used interchangeably with "mental disorder") is akin to a bona fide medical condition, and a folk understanding of racism is the result of discriminating against people based on their race or group identification.

Additionally, odds are everyone will encounter these categories at some point in their lives as "race" and "mental illness" cut across the entire human experience. Data about a baby's race is typically collected at birth based on the mother's race (Bernstein, 2020); people's emotional and psychological distress are said to be increasingly under the purview of a "psychiatric hegemony" (Cohen, 2016) or "industry" (Ruby, 2020). However, despite the terms' embeddedness in present-day society, they should not be immune from being further unpacked and critically examined, especially when there continue to be implications for the well-being of society.

Some argue that racial categories should be abandoned due to their questionable biological underpinnings and diffuseness whereas others state there is some utility to the categories as they correlate to some "medically significant information" (Elliott, 2017, p. 131). In this chapter, I will extend the view of abandoning racial categories by drawing parallels to the controversial use of mental disorder in contemporary healthcare, research, and everyday discourse. I will introduce arguments for moving past the mental disorder paradigm not only due to the contentious socio-political nature enshrouding it since its inception (as racial categories have been), but also the harm its unquestionable use regularly inflicts onto others.

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[10] https://www.oed.com/dictionary/madness_n?tab=meaning_and_use

I will highlight the unstable (i.e., questionable reliability) and subjective aspects (i.e., questionable validity) that undermine both concepts and can concomitantly become "lies that bind" (Appiah, 2018) that affect nearly everyone. I will demonstrate how the harm associated with their increasing, entrenched use outweighs their utility, calling into question whether moving past both concepts and considering alternatives might be a worthwhile venture for the betterment of society.

Given the socially constructed nature (a moderately controversial position) of both race and mental disorder (though an alternative, perhaps more controversial—or lesser known—philosophical view will be provided that suggests the target of "construction" is elsewhere, masked *by* using race and mental disorder), my argument will be to suggest that their respective systems of classification should not be inflicted onto people. Rather, owing to the near-impossibility of discarding both frameworks, I propose that, at minimum, they should be *optional* organizing and meaning-making frameworks (like astrology or religion) we can choose to subscribe to, challenge, reject, or simply ignore—but not have thrusted upon us through the various social systems and cultural institutions we find ourselves embedded in.

I will not proclaim to know how to go about changing the various systems in which race and mental disorder permeate or how to pragmatically shift discourse in large-scale systemic ways—that is an infinitely complex end goal, and I consider this chapter still at the beginning stages of encouraging people to give each other permission to question these concepts. However, I will show how other thinkers and grassroots organizations are making attempts to influence contemporary discussions about race and mental disorder.

Given the seemingly controversial notions set forth in this chapter, it should be emphasized that the humanistic drive behind my argument stems from a wish for people to abstain from concurrently engaging in divisive practices (via using racial categories) and oppressing one another (via using psychiatric diagnoses). Being able to hold both concepts loosely, if not outright reject them, can lessen the current division and disdain in society that is predicated on questionable labels and, instead, recognize the continuum onto which we (e.g., how we look) and our experiences (e.g., how we experience distress) can be overlaid.

Crucially, I hope to convey that historical and contemporary intractable problems associated with both race and mental disorder are, paradoxically, maintained by the very concepts given their historical roots. And if we are aiming to improve the collective well-being of all people, it is worthwhile to invoke and adapt Audre Lorde's (1984) observation about how the master's tools will never dismantle the master's house: the commendable aim of improving the well-being of society will not be accomplished if we do not loosen the grip (and ultimately consider a wholesale rejection) on the use of race and mental disorder.

As such, this will require what Barbara J. Fields described in an interview as an *intellectual detachment* from contemporary thinking about race (and mental disorder, for the purpose of this chapter)—otherwise, it will be like "trying to lift something up while you are standing on it" (Denvir, 2018). Lastly, my critique aims to "plant a seed" in the contemporary debate and advocate for a sort of "cognitive liberty" (Cutler, 2017), allowing people to engage in more flexible and expansive thinking—to give people permission to think differently about both race and mental disorder than how the concepts are ordinarily conveyed in everyday life.

The Competing Views

Mason (2023a) delineates a handful of philosophical positions people tend to take in response to two questions: "What is 'race'?" and "What should we do with 'race'?" For the former, she puts forth the *naturalist* who believes "race" is biological; the *constructionist* who believes "race" is socially real; and the *skeptic* who believes "race" is neither biologically nor socially constructed. For the latter question, the *conservationist* suggests we should keep "race"; the *reconstructionist* believes we should change "race" and its meaning; and the *eliminativist* or *abolitionist* (as suggested by Livingstone Smith, 2023a) thinks we should discard the concept of "race" entirely and oppose racial categorization, respectively.

When it comes to the idea of "mental disorder," all six positions are regularly applied in contemporary discourse, practice and research. For now (and with arguments that will follow), this can be demonstrated by replacing "race" with "mental disorder" in the previous paragraph or as shown

Naturalist: "Races" and "mental disorders" are real (i.e., biological, hereditary, genetic)	Constructionist: The ideas of "races" and "mental disorders" are socially constructed, though not biologically real	Skeptical: "Races" and "mental disorders" are not real in any sense of the word
Conservationist: Since "races" and "mental disorders" are real, we need to "keep" them	Reconstructionist: The ideas of "races" and "mental disorders" are worth revisiting and revising in order to keep them	Eliminativist/abolitionist: Any notions about "races" and "mental disorders" should be discarded/resisted/ opposed

Table 1 *Philosophical Assumptions and Positions about Race and Mental Disorder*

in Table 1. Given space limitations, not all assumptions and positions will be covered as equally in-depth in this chapter.

The naturalist notion

When it comes to race, the *naturalist* assumption (also known as *biological realism* [Glasgow, 2009]) is common. It suggests race is grounded in biology as evidenced by differences in one's skin and hair color, other physical attributes, genetic variations, and correlation with certain diseases (Morning, 2007; Spencer, 2019). Concurrently, when it comes to mental disorders, some argue for their biological origins by invoking genetics, neuroimaging, and proclaiming they are equal to medical diseases or illnesses (Fritscher, 2020; Weir, 2012).

Two concepts commonly linked with mental disorder can elucidate the biological uncertainty of race: *reliability* and *validity* (Haslam, 2013). For example, if something is physically or biologically real (i.e., valid), there should be a way to identify or diagnose it objectively with a degree of reliability that could improve over time. However, the American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorder (DSM)* (APA, 2022) is known to suffer from low reliability; that is, the likelihood that two clinicians will agree on the same diagnosis for the same patient (Carney, 2013; Vanheule et al., 2014). This would not be an issue if mental disorders had identifiable disease processes that could be confirmed with the help of objective tests such as histology, blood work, imaging, and other laboratory measures (Kinderman, 2019). However, no biological marker has been identified for a single psychiatric disorder to validate them as medical diseases (Kirk et al., 2013).

Additionally, there has been an absence of molecular genetic findings to explain hereditary factors for any psychiatric disorder; likewise, possible genetic abnormalities tend to cross diagnostic categories, thus failing to uncover any specific genetic profile for any psychiatric disorder (Hahn, 2019; Joseph, 2004; The Council for Evidence-Based Psychiatry [CEP], 2014). Relatedly, brain scan technologies have not found notable brain differences associated with any psychiatric disorder (Banner, 2013; Timimi, 2021). These collective critiques prompted Thomas Insel, former director of the National Institute of Mental Health (NIMH), to pointedly state that the *DSM*'s weakness is its lack of validity (Insel, 2013).

Compounded by a lack of validity, mental disorders are, therefore, "diagnosed" subjectively given the reliance on self-reporting of "symptoms" by clients or patients (and lack of objective tools to verify or disconfirm a psychiatric diagnosis). In addition, others believe it is improbable for *DSM* diagnoses to correspond to reality (Kendler, 2021), perhaps due to the supposed existence of psychiatric diagnoses *a priori.* This has led to the suggestion by some philosophers of psychiatry to argue that the very definition of "mental disorder" is normative in nature—that is, the classification of mental disorders is more of a reflection of a society and culture's values and norms, which in turn can allow people to make negative value judgments about one another (Garson, 2022).

Similarly, others state there is a lack of compelling evidence to confidently say races are both discrete and valid categorical entities with boundaries. Some suggest that social (not biological) factors better explain correlations between medical conditions and race (Glasgow, 2019). Souaiaia and Mason (2024) contend that:

> [T]he completion of the [Human Genome Project] confirmed that humans are 99.9 percent identical at the DNA level and that there is no genetic basis for "race"…While there are important genetic differences among human populations, it is futile to attempt to describe human populations as "subspecies" or "races." As the genome has shown us, there is more diversity within these genetic "races" than between them, which renders them not only flawed but also incoherent. (p. 73)

Given that human beings are "not divided biologically into distinct continental types or racial genetic clusters" (Fuentes et al., 2019, p. 400), there

is also not a reliable way to determine what one's race is with certainty—lending itself to the subjective self-reporting of uncertain categories, as echoed by the Census Bureau (2022) stating that an "individual's response to the race question is based upon self-identification" (para. 8).

Presumably, this is why some individuals can self-identify as a particular race with ease, such as Rachel Dolezal and Jessica Krug who were both enshrouded in controversy after it was discovered that they were misrepresenting their own race, leading to resignations or dismissals from the universities in which they were teaching. Remarkably, Dolezal continued to identify as "black" in a 2015 interview (see Johnson et al., 2015) despite being unable to acknowledge any "black" ancestry, further undermining the naturalist notion of race. (See also the recent trend of "Race Change to Another" or RCTA [Tran, 2023 and Ekpunobi, 2023] that, arguably, a non-naturalist nature of race allows to occur.)

There is also a fallacy of conflating one's biology—that cannot be disentangled from the phenotype or experience, respectively, of race or mental disorder—with presuming the categories are *strongly and precisely grounded* in biology. As Maisel (2015) has stated when referring to mental disorder:

> To say that these distresses are biological and psychological is to say nothing…Everything human is biological and psychological…It adds nothing to the discussion of human affairs to call a phenomenon like distress biological or psychological unless we are very precise about what additional meanings we intend to add by saying that. (p. 12)

Relatedly, Glasgow (2019) has stated that:

> [T]he lines that separate those bounded categories [of race] are imposed by us onto a blurred image of humanity...Skin colors are biological traits. And we can divide ourselves up according to those traits. But our lines of racial demarcation are not discovered in the biology. Which means that racial groups themselves are not in the biology. (p. 119)

Although categorical thinking about race and mental disorder can have some heuristic utility (though the type of utility is questionable, as will be suggested later), thinking primarily in this way can obfuscate similari-

ties across said categories. Routinely engaging in contemporary categorical thinking "can wreak havoc on your ability to *think* about those facts…If you pay lots of attention to where boundaries are, you pay less attention to complete pictures" (Sapolsky, 2017, p. 6, emphasis in original). Both concepts suffer from fuzzy boundaries, which suggests human suffering and phenotypical differences can and should, instead, be effectively overlaid onto a continuum of normality (Cantú, 2023a) or a spectrum (Glasgow, 2019), respectively.

This "heterogeneity problem" pertaining to both race and mental disorder undermines the naturalist notion of both concepts consisting of discrete categories (Allsopp et al., 2019; Angier, 2000); they are not "mutually exclusive," a classification criterion put forth by Bowker and Star (2000). For mental disorder, heterogeneity results in a comorbidity problem, which is the presence of more than one condition co-occurring (see Hyman, 2010, pp. 167–169 for details). However, as Steven Hyman (a past director of NIMH) put it: "Many people get five diagnoses, but they don't have five diseases" (as quoted in Harrington, 2019, p. 269).

Similarly, some suggest multiracialism or biracialism to be "as antithesis of race itself…which relies on 'racial purity' to exist" (Mason, 2022, p. 3), let alone the reality of how there can be just as many differences *within* racial groups compared to across racial groups (Prontzos, 2019). Likewise, as with race, it is entirely plausible to invent invalid categories of mental disorder (Kinderman, 2019) such as homosexuality (Spiegel, 2004) and "drapetomania" (i.e., a slave's desire for freedom) (Cartwright, 1851).

The constructionist notion

Conceding that race fails to meet the naturalist notion, many believe race to be *socially constructed* (however, more on the philosophical alternative to this assumption later). Constructionism (sometimes used interchangeably with *constructivism*) suggests that our collective body of knowledge is more a result of social processes, not necessarily the product of what can be found "out there" in the world (Morning, 2011). The social construction of race suggests that different categories of race have been "the result of social ideas, values, and practices" (Zack, 2018, p. 47) of the time.

As Morning (2011) suggests, social constructionists of race believe that "racial categories are the intellectual product of a particular (albeit enduring) cultural moment and setting, and that *human biological variation does not naturally and unquestionably sort itself*" (p. 18, emphasis added). Said differently, race is an illusion maintained by language and our imagination. To borrow and adapt a view from Harari (2015) about how similar ideals can be collectively maintained: "Any large-scale human cooperation – whether a modern state, a medieval church, an ancient city or an archaic tribe – is rooted in common myths that exist only in people's collective imagination" (p. 27).

Concurrently, Murphy (2006) describes mental disorder constructivists as the following:

> The relevant facts, for a constructivist, are not facts about how human minds or bodies work. They are social. Societies share norms, and some people transgress those norms…Some people who violate norms are regarded as immoral, and others are regarded as mentally ill. (Others may be regarded as harmless eccentrics or seen in some other way.) A constructivist can concede that we look for distinguishing features in the biology or psychology of the deviants. But a constructivist will say that we do this only because we first decide on other grounds that these people are mentally ill and that we then cast about for something about them we can medicalize. (pp. 23-24)

Lacking any convincing evidence as to their etiology and absent the discovery of biomarkers for any psychiatric disorder suggesting they do not approximate reality (Kendler, 2021; Kirk et al., 2013), a less common view, then, is that mental disorders are also *socially constructed*. For example, archival- and interview-based research suggests that the "discovery" of many mental disorders found in the *DSM* likely occurred through the social processes of *voting* by members within the APA—not via scientific or empirical processes—thus reflecting the opinions of its developers and APA affiliates (ADisorder4Everyone, 2020; Davies, 2017).

Regardless, despite concerns voiced by even those who helped develop past versions of the *DSM* (e.g., Frances, 2014; Lynch, 2018; Spiegel, 2004), it remains firmly embedded in contemporary healthcare as codes attached to each mental disorder are used to allow third-party payors, such as insur-

ance companies, to reimburse for services, at least in the United States (Cantú, 2023b; Whelan, 2022).

The reconstructionist and conservationist notions

Despite these problematic origins and intractable issues, *reconstructionist* and *conservationist* positions toward both race and mental disorder continue to be commonplace. One view of race reconstructionism suggests that "race" should be purposefully used to reflect solely social categories, not biological ones (Glasgow, 2009). Similarly, I propose that one version of a reconstructionist view of mental disorder can be easily seen in the ongoing revision of various mental disorders' criteria (e.g., the *DSM-5-TR* published in 2022 revised the criteria of more than 70 mental disorders [Cherry, 2024]), as well as in the updates to the *DSM* itself as evidenced by its ballooning size: 130 pages and 108 mental disorders found in the *DSM-I* (1952) and, later, 947 pages and about 300 mental disorders in the controversial *DSM-5* (2013) (Khoury et al., 2014).

Recalling that the *conservationist* position suggests we should "keep" both race and mental disorder, I suggest this is yet another common view for a few psychosocial reasons[11]: both concepts can provide one with a sense of identity; a sense of validation; and a sense of belonging.

When thinking of identity, both race and mental disorder can influence how one thinks of oneself. It is not uncommon to hear people identifying as a "'black' man" or "Asian woman." Relatedly, social media regularly shows how youth commonly make statements such as "I'm so ADHD" or "I'm bipolar," with "self-diagnosing" being a common practice (see both chapters by Cunniffe in this volume).

Particularly when part of a minority racial group, race can help one feel validated and assured about "seeming different" when comparing oneself to the majority group, such as an Asian student residing amongst a predominantly "white" population in northern Colorado. Being labeled as having a mental disorder can help a person feel validated to "explain" why one is

[11] Obviously, not including broader political, cultural, societal, et cetera reasons, let alone encountering a possible sunk cost fallacy.

struggling or suffering in a particular way, presumably unlike how other people (without a mental disorder) are coping with similar challenges.

Lastly, race and mental disorder can provide people with a sense of belonging. Some appreciate being surrounded by people who might look like them or have a similar background, hence the development of organizations and affinity groups on college campuses for students who, for example, identify as "BIPOC." Concurrently, support groups are common for people who have received diagnoses of similar mental disorders.

The Harm Both Can Inflict: A Paradox

The reasons described for subscribing to the reconstructionist and conservationist positions are fair and understandable. One certainly would not want to take away a person's sense of identity, validation, and belonging. However, in addition to these views, examples of two contemporary, questionable approaches have taken a foothold in today's discourse for how to go about addressing socio-cultural problems associated with race and mental disorder.

With respect to race, there have been a plethora of anti-racism trainings; statements from academic journals, universities,[12] federal departments, and corporations about maintaining an anti-racist stance; and campaigns to "eliminate racism"—all arguably conveying a commitment for conserving race (or reconstructing race, depending on the philosophical assumption behind the initiative).

With mental disorder, "eliminate stigma" campaigns as well as the month of May (in the United States) being deemed as "Mental Health Awareness Month" have been implemented for years in the hopes of reconstructing mental disorder so as to not only reduce the stigma of being "mentally ill,"

[12] A shameless plug: the reader may be intrigued to read my forthcoming article titled "A Case for Intellectual Humility, Tolerance, and Humanism: Perspectives from an Ethnically 'Minoritized' Graduate Student" in the *Journal of Teaching in Social Work* as well as the journal's Special Issue: "Beyond Ideological Mandates: Critical Reflections on Anti-Racist and Anti-Oppressive Social Work Education." Ideas in that issue will speak to the importance in being able to push back on ideological conformity, such as the topic of race and how it's typically discussed in universities.

but also normalize the associated experiences (although depending on the level of pseudo-medical language used in the initiative, it can come across as also subscribing to a conservationist position).

Both approaches are insidiously problematic—and a paradox can illustrate why not only have they not helped, but in some cases have made things worse. The concept of race and, in particular, racism is regularly used to help explain intractable inequalities, disparities, differences of rank, class, and social divisions (Malik, 2023). However, others continue to remind us that *racism itself is what led* to the creation of different race categories.

Fields (1990) contends that during the Revolutionary Period, people both in favor and against slavery collaborated to pinpoint one's race as the *explanation* for enslavement—that is, the act of *racialization*, as will be expounded below, justified enslavement. In other words, racial ideology provided the explanation behind slavery to others who held substantially different worldviews (and for whom slavery was not the norm).

Hoyt (2016) asserts that the "history of the concept of race is the history of the process of racialization" (p. 40). He delineates a five-step process of racialization worth quoting at length to elucidate how it leads to the creation of races:

1. *Selecting* some human characteristics [e.g., skin color] as meaningful signs of racial difference;
2. *Sorting* people into races on the basis of variations in these characteristics;
3. *Attributing* personality traits, behavior, and other characteristics to people classified as members of particular races;
4. *Essentializing* purported racial differences [e.g., rank order, status] as natural, immutable, and hereditary;
5. *Acting* as if purported racial differences justify unequal treatment. (p. 39)

Malik (2023) picks up after step five when he suggests that "[A]ncestors of today's African Americans were not enslaved because they were black. They were *eventually* deemed to be racially distinct, as black people, to

justify their enslavement [emphasis added]" (p. 4; see also Brace, 2005). A notorious example of racist ideology rationalizing the use of race was that of the eugenics movement, one of its main goals having been to eliminate "inferior races" (Sussman, 2016; Yudell, 2014).

In sum, *racialization* is the "systematic practice of marking out groups of people as the subjects or presupposed perpetrators of violence and oppression based largely on ancestry and phenotype" (Mason, 2022, p. 9) and can be considered *synonymous for racism*. That is, the practice of racialization occurs in tandem with racism—with racism hiding *behind* race. Or as Fields and Fields (2014) contend:

> *Race* is the principal unit and core concept of racism…*Racism* is not an emotion or state of mind, such as intolerance, bigotry, hatred, or malevolence…*Racism* is first and foremost a social practice, which means that it is an action and a rationale for action, or both at once. *Racism* always takes for granted the objective reality of *race*, as just defined, so it is important to register their distinctness. The shorthand transforms *racism*, something an aggressor does, into *race*, something the target is, in a sleight of hand that is easy to miss. (p. 17, emphasis in original)

These counterarguments rest on the notion that as for racism, the explanandum (i.e., the phenomena to be explained) cannot be its own explanans (i.e., the argument), lest you'd like to find yourself in a sort of circular reasoning (Heideman, 2023). Consequently, the view suggesting that racism influenced the creation of race has led others to argue that the continued use of race, therefore, *maintains* racism—that is, the paradox—while obscuring other relevant factors (Hoyt, 2016; Mason, 2021; Livingstone Smith & Smith, 2023). Precisely, *racecraft* was collectively coined by Fields and Fields (2014) to describe the process of how racism is maintained and hidden by the illusion of race.

In a similar way, the first edition of the *DSM* was published in 1952 with the intention of classifying patients admitted to psychiatric hospitals (Horwitz, 2021). However, others have suggested that attempts to stigmatize and *control* "deviant," "abnormal," or "aberrant" behavior associated with "mental illness" (previously called "insanity" or "madness") *predated* the formal classification of mental disorders (Cohen, 2016; Horwitz, 1982;

Read & Dillon, 2013). That is, those perceived to be comporting themselves "abnormally"—a reflection of normative judgements from the culture of the time—were deemed to be "mentally ill" (Cummings, 2020), a practice that also suffers from its own kind of circular reasoning:

> If I were to ask why a particular child can't concentrate, is hyperactive, and shows impulsivity, and I were to answer that it is because they have ADHD, then a legitimate question to ask is "how do you know it is because they have ADHD?" The only answer I can give is that I know it's ADHD because the child is presenting with hyperactivity, impulsivity, and poor attention. Thus we end up with a circular argument where the behaviors are caused by the behaviors. It's a bit like saying my headache is caused by pain in the head. (Maisel & Timimi, 2016, para. 9; see also Timimi, 2017)

This is a practice whose vestiges remain in the most recent *DSM*'s definition of mental disorder that, ironically, states how an "expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is *not* a mental disorder [emphasis added]" (APA, 2022). Regardless, given the link between the creation of mental disorder and efforts to stigmatize and control particular thoughts, feelings, and behaviors (sometimes as a way to reduce suffering), I propose that the widespread use of mental disorder in contemporary discourse, healthcare, and research will continue to paradoxically *maintain* stigma and efforts to control unwanted everyday human experiences while failing to alleviate suffering on a large-scale (see The British Psychological Society, 2022).

A brief nod to skepticism

Returning to race, in case the reader didn't catch it yet, here is where the alternative, potentially more controversial view resides that can perhaps be better illuminated if one subscribes (though it is not required; see Carter & Mason, 2022) to the philosophical assumption of *skepticism* (i.e., the object of inquiry is not socially constructed or biologically real; Mason, 2023a; see also Klutsey, 2022): it is not race that is socially constructed, but *racism* itself—there it is, the target of social constructionism, hiding behind and peeking over race à la *racecraft* (Fields & Fields, 2014). Hoyt explains why this is pernicious:

> Race is a grammatical fiction…of a false entity, which when spoken of as if it is real becomes reified into a conceptual and perceptual trap… [B]ecause we accept its validity even while regretting some of its consequences, we cannot find out way out. Using the language of race to escape from the confines of race only results in so much banging up against its invisible walls. (2016, p. 8)

Livingstone Smith and Smith (2023) state it differently: "Trying to extinguish racism while shoring up race is like trying to put out a fire by pouring gasoline on it. It can only make matters worse" (para. 6). I suggest that trying to eliminate stigma and decrease suffering while shoring up mental disorder or illness rhetoric is also like trying to put out fire by pouring gasoline on it—all the while it continues to, paradoxically, reify and solidify both concepts. More on this counterpart to racecraft in the next section.

Additional Harms

There are other harms the use of race and mental disorder can inflict. Although it should be obvious by now, race categories allow for *racial essentialism* to occur, which has been found to be correlated not only with increased discrimination, dehumanization, and prejudice toward other racial groups, but also the endorsement of a social hierarchy (Mandalaywala et al., 2018; Tsai, 2022). The use of mental disorder is not immune from its own *psychological essentialism* which has been found to be associated with increased stigma and less favorable attitudes toward those who have been diagnosed with a psychiatric disorder (Haslam & Whelan, 2008; see also Schultz's chapter in this volume) in addition to decreased empathy (a crucial ingredient in psychotherapy) in clinicians toward the one diagnosed (Lebowitz & Ahn, 2014).

The use of race can enact blinders distracting us from other contributing factors of social problems. Some suggest that well-intentioned initiatives—such as Diversity, Equity, and Inclusion (DEI)—that keep race at the forefront not only entrench problematic racial categories but can contradict their original aims (al-Gharbi, 2020; Dobbin & Kalev, 2016; Frisby & Maranto, 2021; Livingstone Smith & Smith, 2023; Singal, 2023; Zheng, 2022; cf. Fryer, 2022).

Another example is when race is regularly employed to highlight disparate patterns in police violence—specifically, lethal acts—such as those towards racialized black people. However, not only has empirical research demonstrated otherwise (Fryer, 2019; Huemer, 2024; Reilly, 2020), but the hyper-focus on race continues to detract larger discourse from considering what might be other contributing factors and why there is increased police presence and responses to neighborhoods and regions with certain demographics in the first place.

This is not to suggest that racial bias in the form of *racialism* does not occur; it is only to suggest that in these kinds of instances, the consideration of other plausible contributing factors is vital for addressing social problems (McWhorter, 2023; see also Léger, 2023; Michaels, 2006; and Michaels & Reed, 2023). For example, higher-poverty neighborhoods (of which racialized black people experience some of the highest rates [Creamer, 2020]) tend to have higher rates of crime (Maranto et al., 2022), which can lead to higher exposure to police and can account "for the racial disparities in fatal shootings observed at the population level" (Cesario et al., 2018, p. 591).

After all, complex social phenomena have complex multivariable causes, some of which should not be relegated in the interest of prioritizing others for the sake of one's "socio-political commitments" (Ritchie, 2020, p. 118).

At the same time, the use of mental disorder occurs in tandem with *medicalization*, usually defined as the process in which everyday aspects of the human experience are repackaged as medical problems (therefore, pathological) and subjected to medical intervention (e.g., psychiatric drugs, electroconvulsive therapy) (Maturo, 2012). Medicalization and the use of mental disorders can make it more challenging to address environmental, contextual, and societal issues that contribute to problems and human suffering.

Instead, it's been suggested that mental disorders relocate the effects of social problems *within* the individual while reconceptualizing them as medical (Moncrieff, 2010). For example, economic factors, adverse life events (e.g., being a victim of child abuse), social status, and financial debt (in addition to numerous other factors) have been associated with the frequency of certain psychiatric disorders being diagnosed, includ-