

Mad or normal?

Paradoxes of contemporary diagnostic cultures

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Psychiatric diagnoses are increasingly used by people around the world as a filter through which they experience their sufferings, unhappiness, and eccentricities. In what can be called the diagnostic cultures of our times, more and more people receive a psychiatric diagnosis, something that is often criticized as unwarranted medicalization and pathologization of human problems. Psychiatric diagnoses also appear in popular media, and this paper seeks to unfold some paradoxes of our diagnostic cultures by using a Danish TV show called "Mad or normal?" as an instance that can inform us of larger cultural issues about how psychiatric problems are understood and addressed in public media today. The show had the ambition of combating stigmatization of psychiatric illness and disorder, but can be seen as reinforcing exactly that. The manifest messages of the show were that mental disorder is just like physical illness, that people can in fact recover, and that the mentally ill are "just like us", but the set-up of the show latently worked against these messages, which is likely a more general problem in today's diagnostic cultures. The question is asked whether such a show can be considered as a vehicle through which non-contagious psychiatric diagnoses can nonetheless become contagious in a way that involves the paradoxical logics that are pointed out.

Introduction

To begin on the largest scale possible, the global cost of mental illness has been estimated at 2.5 trillion US dollars – a number that is expected to grow to a shocking 6 trillion dollars by 2030 (Kincaid & Sullivan, 2014, p. 1). Many studies estimate that around 25 % of the population in Western countries will suffer from at least one mental disorder in the course of one year (e.g. Kessler, 2010). The estimated life time prevalence for any psychiatric disorder is usually set around 50 %. According to many psychiatrists, this shows that their discipline has progressed to a stage, where professionals are finally able to find, diagnose, and treat the mentally ill that have always existed. Perhaps, for a few disorders, there are more afflicted people than before, but overall, the argument goes that the difference between the old days and contemporary times is that we can now finally locate the disordered. Some sociologists argue on the contrary that these numbers are proof that modern life in fact creates new epidemics of social pathologies (Keohane & Petersen, 2013). Many more people are in fact mentally disordered than earlier because we live in disordered times (Petersen, 2011). Something has changed with the changing cultural landscape roughly after World War II, and the high prevalence numbers of depression, anxiety, ADHD etc. are a sign that something is deeply wrong in our culture. People in the West are today rarely dying because of material poverty, hunger or appalling physical working conditions – as in the times of Karl Marx – but they are suffering from various mental disorders, ranging from depression and anxiety to eating disorders and bipolar conditions, because of terrible and alienating social life circumstances.

Without completely discarding these interpretations, this article is based on the hypothesis that something else has been happening in recent years that may explain the changes: The development of, what I call diagnostic cultures (Brinkmann, 2016). The concept of diagnostic cultures refers to the numerous ways that psychiatric categories are used by people – patients, professionals, and almost everyone else – to interpret, regulate, and mediate various forms of self-understanding and activity. Although psychiatry and psychology (e.g. psychoanalysis) have been influential before, the diagnostic understanding is today almost everywhere in modern society. In recent years, diagnostic cultures have become manifest in schools, work life and homes, leading to a situation where people increasingly interpret their sufferings in the light of psychiatric conceptions and diagnostic terminology. Consequently, as critical social and cultural researchers, we can no longer, like the anti-psychiatric movement from the 1960s and 1970s

(beginning with Szasz, 1960), simply accuse psychiatrists of promoting “medicalization from above” (saying that it is unidirectionally doctors and “the system” that stigmatize us as ill). Patients and citizens themselves are increasingly pushing for “pathologization from below”, seeking out diagnoses as explanations of various life problems and using the vocabulary of psychiatry as a preferred “language of suffering” (Brinkmann, 2014a), i.e., as a way of rendering meaning to experienced suffering. My point is that the recognition of the emergence of diagnostic cultures as a widespread and pervasive aspect of contemporary cultural life should lead us to discuss the prevalent explanations in a different light: The psychiatric (we can finally find the ill) and the sociological (modern society is the source of the rising prevalence of mental disorders). It is not that these arguments are faulty per se (indeed, both of them probably contain more than a grain of truth), but they might concern superficial aspects of a more profound historical and cultural development in our very conceptions of deviance and suffering.

It is understandable that there is, in an individualized and secularized age, a felt need to explain one’s suffering, discomfort, and problems in psychiatric terms since older horizons of meaning related to religion, tradition, and community have been questioned (Healy, 2012). The main problem of the emerging diagnostic cultures, however, might be that we risk losing vital resources of self-understanding if we continue to pathologize human suffering (Brinkmann, 2013). Existential, political, and moral concerns are easily transformed into individual psychiatric disorders, and we thereby risk losing sight of the larger historical and social forces that affect our lives (Conrad, 2007). It seems that we are today not only witnessing a “pathologization of the normal” – in the sense that diagnostic criteria and categories are constantly expanding to encompass evermore conditions that we used to think of as normal human conditions and reactions – but also a “normalization of pathology”, which means that we are no longer surprised or shocked when hearing about the disorders that people allegedly have. Paradoxically, it has become normal to be abnormal.

A whole new field is now developing in the social sciences to study the different kinds of impact that diagnoses have on sociocultural life, that is to say, the sociology of diagnoses (Jutel, 2011; Jutel & Nettleton, 2011). This field is primarily concerned with studies of how diagnoses are formulated and function to make the diffuse symptoms of people understandable, of how patient identities are formed around diagnoses, and of how patient organizations operate and fight for rights and recognition, for example. While being positioned on the fringe of this new field in the social sciences, the present article takes a more cultural approach

to study the role of diagnoses in the media and people's everyday lives today. Concretely, the goal in what follows is to analyze a TV show called "Mad or normal?" centered on psychiatric diagnoses that was aired on Danish television in 2012 and 2014. The show was a Danish adaptation of the BBC program "How mad are you?" (see Progler, 2009, for a brief description and analysis from a medical science perspective)¹. The reason for choosing this specific example is that it can hopefully lead to a way of opening up for a critical discussion of the problems of diagnostic cultures by focusing on how these cultural problematics become manifest in various cultural productions and articulations.

The analysis in what follows can also be seen as part of the current social science interest in understanding how non-infectious (psychiatric) diagnoses and disorders can be communicable (Seeberg & Meinert, 2015). TV shows such as this mobilize significant cultural discourses about mental disorder and subsequently feed back into the public sphere, presenting viewers with symbolic resources for self-interpretation in a process that gives rise to what Ian Hacking has called looping effects of human (or interactive) kinds (Hacking, 1995b). Looping effects represent interactions between classified (in this case people with possible mental health problems) and classifications (in this case diagnoses) mediated by systems of experts, forms of knowledge and institutions within what Hacking calls an ecological niche (Tekin, 2014). Looping effects are dynamic in the sense that they (the effects) cannot be predicted in advance, but result from a process in which all elements are potentially transformed.

How can such looping effects in our diagnostic cultures be studied by looking at a single TV program? How can this help us understand what is more generally at stake in diagnostic cultures? The answer is that it is possible to open up for an understanding of general cultural processes of looping by focusing on, what Denzin (following Psathas) has called, "instances" (what follows is described in greater detail in Brinkmann, 2012). Denzin says that we should take "*each instance of a phenomenon as an occurrence that evidences the operation of a set of cultural understandings currently available for use by cultural members.*" (Denzin, 2001, p. 63). An instance is an occurrence that is evidence that "the machinery for its production is culturally available" (Psathas, quoted by Denzin, p. 63). When faced with an instance in this sense – such as a TV show – we should ask what makes it possible. What underlying logics are at work? This question invites us into abductive reasoning since we have a single instance that puzzles us, but which we believe contains larger cultural beliefs and processes in a condensed form. In order to address the puzzle, we must employ *abductive* reasoning and employ what C. Wright

Mills called the sociological imagination (Mills, 1959). Abduction is a form of reasoning that we employ in situations of uncertainty; when we need an understanding or explanation of something that stands out as puzzling or mysterious. It has recently been conceptualized as breakdown oriented research (Alvesson & Kärreman, 2011). Good social science frequently springs from a breakdown (“I don’t understand this”), coupled with a mystery (e.g. the framing of the breakdown as a riddle) and then a possible resolution of the riddle – for instance based on a novel perspective on the matter that confused the researcher. I have previously employed the interpretative abductive approach to analyze medialized representations of guilt (Brinkmann, 2010) and shame (Madsen & Brinkmann, 2012), and the present analysis is based on the same paradigm of analyzing TV materials abductively and letting oneself wonder how it has come to make sense, and then, following this breakdown in understanding, build a new understanding by seeing the instance as symptomatic of larger cultural processes.

One final thing must be noted: The definition of ‘culture’ is notoriously tricky, but when I address “diagnostic cultures” in the present article, I do so from the perspective of cultural psychology, where ‘culture’ is taken to refer to semiotic and material mediators of human action in a broad sense (Brinkmann, 2016). That is, culture is not a variable, a context, or a place, but a way that humans relate to themselves, the world and others by using a range of mediators such as language and artefacts. Diagnostic cultures are thus sets of practices in which diagnostic categories play a significant role as mediators of action, thoughts, and feelings about life and suffering.

A diagnostic quiz show: “Mad or normal?”

In 2012 the national Danish Broadcasting Company aired the documentary “Mad or normal?”². The explicit idea was to challenge people’s biases about the mentally ill by showing that they are in most respects “just like you and me”. The show was run in an entertaining way, somewhat like a quiz, and hosted by a famous Danish “TV doctor”: Three experts (one psychiatrist, one psychologist and one psychiatric nurse) were confronted with a group of ten people they had not met before, and five of these people had different psychiatric diagnoses (*in casu* schizophrenia, eating disorder, OCD, social phobia and bipolar depression). Through the episodes, the experts were supposed to make a qualified guess and match the diagnoses with five of the participants. The viewers could also participate by voting on the

internet, trying to guess who among the participants were mentally ill. In order to help the experts (and also the viewers) in this guessing game, the participants had to go through a number of trials and tests that were supposed to provide clues as to who were ill and who were well. For example, the participants had to perform standup comedy in front of a live audience (the idea being that this would be difficult for someone with social phobia), and do a farm animal clean up task (possibly revealing the OCD sufferer because of her fear of filth). But in fact – and seemingly in line with the program’s hopes and intentions (at least the result was celebrated as a good thing) – the experts could *not* guess who were ill, or which diagnoses belonged with whom. And the viewers were also quite poor at the guessing game.

A book was published in continuation of the show – with same title (“Mad or normal?”) (Kyhn, 2012) – and, a couple of years later, in 2014, the show was followed up with two new episodes called “Mad or normal? At the job interview”. In the second season it was instead of mental health professionals acting as experts, three business managers who were confronted with disguised psychiatric patients in a group of job applicants. They were asked, who among the participants they would be most likely to offer a job. And, interestingly, they were very positive toward many of the people with diagnoses, and the “winner” of the program was in fact a psychiatric patient.

In what follows I shall concentrate on the first season and highlight three different paradoxes inherent in the show, the first of which I call “One of us?”

One of us?

Both seasons of the show, including the second with its concrete theme of psychiatric diagnoses and work life, demonstrate one of the central paradoxes that I find inherent in our diagnostic cultures: On the one hand, it is surely very positive that people who are diagnosed are “one of us” (which was the name of the national campaign in Denmark that accompanied the TV show to raise public awareness about psychiatric disorders) to the extent that experts and business leaders cannot recognize them in a group of people (see Oute, Huniche, Nielsen & Petersen, 2015, for an analysis of the larger campaign). This can be seen as a demonstration that “they” are indeed “like us”. However, on the other hand, they are still “they”, and paradoxically included as excluded through the diagnostic label. Furthermore, the argument or demonstration of just-like-us-ness can quickly be turned on its head to become a demonstration that if “they” are “just like us”, then why do they need special welfare benefits, pensions, and other rights guaranteed by the state?

The accompanying book in fact asks this question directly: “If the three experts in the program are incapable of guessing who among the ten participants suffer from which disorders, then how on earth should the rest of us be capable of guessing it?” (Kyhn, 2012, p. 9; my translation). It might be a good thing that viewers discover that psychiatric patients are not dangerous, but in fact commonly nice people and, like most people in general, without visibly dramatic problems, but the downside is that it might at the same time become difficult for patients to explain and justify their sufferings to others within the context of a welfare society. This illustrates a broader dilemma concerning psychiatric diagnoses in our times: Diagnoses may be stigmatizing and pathologizing (and thus represent something one might wish to avoid), but, at the same time, the labelling they provide can give certain advantages in the diagnostic cultures of the welfare state. This dilemma is made visible in the TV show with its just-like-us discourse.

Just like somatic illness?

Another powerful discourse about mental disorder in the TV show – which is more generally advocated by many psychiatrists, researchers, and the psychopharmacological industry – claims that a psychiatric problem is an illness “just like somatic illness”, as it is often said. The show and the accompanying book repeatedly use the term “mental illness”, and there is a constant comparison with visible somatic illness (especially fractured bones), which is allegedly easier to handle because of its visibility. In principle, the message is that there are no differences between somatic and psychiatric problems, and the two ought to be equal in the health care systems of the welfare state. Recently, in Denmark, a “diagnosis guarantee” has been established by the government, which means that patients have the right to obtain a diagnosis within one month after contacting the medical system. At first this guarantee did not pertain to psychiatric diagnoses, but from September 2015 this has been changed, so that all kinds of health problems are put on an equal footing. On the one hand, this can be seen as a very positive development guaranteeing the rights of the mentally ill, but, on the other, it has the downside that a diagnosis can be prematurely formulated and stigmatize the individual very quickly.

Alongside the explicit message of the show that mental disorder is just like somatic illness, the underlying logic of the show interestingly seems to go against this discourse of “illness equality”. This can be seen if one tries to imagine a similar show with people suffering from somatic illnesses. Would such a show be

aired with the participants having to go through trials that would bring forth their symptoms? This is very unlikely. Think of people with osteoporosis being forced to play hockey, for example, or diabetes patients being asked to eat loads of sweets. But for some reason it does not lead to public outcry (in fact quite the opposite) that people with mental disorders engage in activities that are meant to disclose their illnesses and activate their symptoms. This can be said to reveal the contradictory understandings of psychiatric problems that we have in our diagnostic cultures: On the one hand, they are “just like somatic illnesses”, but, on the other, they are clearly thought of as something else at the same time.

Psychiatrists have had an interest in depicting mental disorder as equivalent to physical illness, and many patients and patient organizations accept and promote this agenda. They believe that a diagnosis can serve as an explanation of underlying pathology just as in cases of physical illness. However, here it is often overlooked that it is difficult within psychiatry to make the necessary distinction between disorder (or pathology) and symptoms. This is much easier with regard to somatic problems (a tumor is thus something different from the symptoms it may cause). Studies show that patients do in fact use diagnoses as explanations of their problems (Young, Bramham, Gray, & Rose, 2008). In a study of adults diagnosed with ADHD, I have also described some of the ways in which people use their diagnoses as explanations of their problems - even if the categories are not strictly speaking explanatory (Brinkmann, 2014b). No psychiatric diagnosis can be formulated on the background of biomarkers (e.g. blood samples or brain scans), but exclusively by counting and evaluating symptoms, for example as they appear on various symptom check lists. So if the diagnoses are used as explanations, it becomes circular because the diagnosis is formulated with reference to problematic behaviors, and the same behaviors are explained with reference to the diagnosis. First, the person is identified (either by him or herself or others) as problematic, for instance because of impulsivity or inattention, and seeks help or gathers information from various sources (notably the internet). Second, if the problems are severe enough to count as symptoms of ADHD, for example, then this diagnosis is formulated to account for the problematic behaviors. Finally, if one asks how we know that ADHD is in fact the problem, the answer is that this is evident from the symptoms (Timimi, 2009). The symptoms thus warrant the diagnostic category that is in turn invoked to explain the symptoms in a circular, and ultimately empty, process. Interestingly, this ought to speak against a chronicification of the disorder (because when the symptoms disappear, so does the

disorder), but this is in fact much more complex, as we shall now see when turning to the third paradox.

Chronic or not?

Related to the point about just-like-somatic-illness, it was noteworthy that the people with diagnoses in the “Mad or normal?” program were said to be “not ill” at the time when the show was made. Of course for ethical reasons it seems reasonable to only enroll people who are not overly vulnerable, which represents a sort of protection against the tests in the show, but, given this, it is hardly surprising that the experts and viewers were unable to guess who were suffering from the various mental disorders. Also in the book, which accompanied the TV show, we hear for example that Kirstine (diagnosed with OCD) “is now cured”, and she refers to her remaining problems as “bad habits, which everybody has” (Kyhne, 2012, p. 46). Again, to compare with somatic illness: If someone had once suffered a fracture, or had once had a tumor, which had been cured, then no one would ever expect that people (including medical experts) could come up with accurate guesses regarding these matters. So, returning to the first paradox, although the program meant to transmit the message that “they” are “just like us”, it paradoxically came to implicitly suggest that “once a psychiatric patient, always a psychiatric patient” – even when the symptoms have disappeared. The premise of the show was that it should be possible to guess the disorders even though the (former) patients were now symptom free, so, contrary to its surely good intentions, the show implicitly came to reinforce a discourse of chronicity concerning psychiatric problems.

This point relates to the overarching contradictory logics operating in the diagnostic cultures as we have seen: On the one hand, psychiatrists define and identify mental disorders on the basis of symptoms. This has been the case globally since 1980 when DSM-II was replaced by DSM-III, and psychiatry moved away from its older aetiological approach, where psychiatrists had formulated diagnoses on the basis of the history, background, and personality of the patients. The current diagnostic psychiatry is instead based on an assessment of actual symptoms within a designated period of time (Horwitz, 2002). This means that a disorder or illness is equated with its symptoms. But, on the other hand, as we have also seen in the show, we have a widespread social representation (probably also among many psychiatrists) that mental disorders may somehow persist even in the absence of manifest symptoms. Otherwise the whole set-up of the show would hardly make sense.

Diagnostic paradoxes: Summing up

What does a show like this tell us about the diagnostic cultures and our complex cultural attitudes to mental illness today? Initially, it can be observed that a show like this would be quite unthinkable (at least in Denmark) just a few years ago. Psychiatric diagnoses were not publicly visible and would not be the center of attention in a popular entertainment show on TV. Superficially at least, this indicates that psychiatric problems are no longer taboo to the same extent as before and that stigmatization due to diagnoses might have decreased. Of course, it may also be related to a certain “sensationalism” concerning mental disorders, but the intentions of the show are explicitly to go against the tendency to separate “them” from “us”. To sum up, we have seen that a number of paradoxes are likely to emerge when dealing with psychiatric diagnoses today: (1) Through diagnoses psychiatric problems appear as “nothing special”, because many of us could be diagnosed – and yet normalizing the disorders may cause problems for people if it means that their problems cannot be recognized as sufficiently serious. (2) Through diagnoses psychiatric problems are addressed as medical problems – and yet they are simultaneously enacted as not just that. (3) Through diagnoses psychiatric problems are equated with manifest and sometimes transient symptoms – and yet diagnoses have a tendency to reinforce chronicity. Such paradoxes inherent in the logics of current diagnostic cultures might in themselves add to the suffering felt by those who live in these cultures and are diagnosed.

The medialized commodification of diagnoses

The fact that psychiatric diagnoses have entered the entertainment (or ‘edutainment’) industry, in prime time on the largest TV station in Denmark, represents one significant aspect of our diagnostic cultures. More generally, people routinely appear on various talk shows to talk about their psychiatric diagnoses, and celebrities also often come out and reveal that they suffer from some condition or other. There is little doubt that such pop cultural representations of psychiatric problems have a significant impact on how the phenomenon of psychiatric disorder is approached and talked about, contributing to the looping effects that Hacking has emphasized. This is a process that goes back and forth. In our modern medialized world, human experience is co-constructed through the stories that circulate in the different media and by the symbolic resources that are offered

there, which afford certain kinds of self-interpretation. Through the media, our social imaginaries are formed, and it is often through media stories that we are socialized into specific patterns of thinking and feeling – also concerning psychiatric problems. From a critical interpretative perspective, Denzin has outlined four goals of the mass media as an entire complex in our culture:

“The prime goals of the mass media complex are fourfold, to create audiences who (1) become consumers of the products advertised in the media, while (2) engaging in consumption practices that conform to the norms of possessive individualism endorsed by the capitalist political system, and (3) adhering to a public opinion that is supportive of the strategic policies of the state [...] The fourth goal of the media is clear, to do everything it can to make consumers as audience members think they are not commodities.”(Denzin, 2003, pp. 1000-1001).

According to this critical perspective, the mass media work by subjectifying people to think of themselves as consumers and even commodities, while simultaneously covering over this very function by making people believe that they are free to choose - in the present case between different understandings of psychiatric diagnoses. Relating Denzin’s observations to the “Mad or normal?” show and the diagnostic cultures more broadly, we can say the following: Concerning the first point, psychiatric diagnoses can indeed be thought of as ‘products’ and patients as ‘consumers’. This is pushed in particular by the medical industry, which has an interest not only in selling drugs to help alleviate people’s symptoms, but also in “selling sickness” by making diagnoses publicly visible (Moynihan & Casseles, 2005). This is one significant aspect of the looping effects, pace Hacking. If the industry succeeds in convincing doctors and patients that something is a disorder for which they have a remedy, then a market appears where the companies can sell their drugs. In the US, companies are even allowed to engage in Direct to Consumer Advertising (this was made legal in 1997, and New Zealand is the only other country in the world, where this is permitted), where the adverts often end with the message “Ask your doctor!”, whenever the troubled person can recognize the advertised “symptoms”. But also the more subtle “product placement” of psychiatric diagnoses in the media is a significant component in the process of “selling sickness”. Although the TV show in Denmark was aired on a national and non-sponsored channel, highlighting the various diagnoses offers the viewers or consumers various ways of “performing” their disorders, as Emily Martin has put it (Martin, 2007); it gives them the possibility to begin “living under the descrip-

tion” of the different diagnostic terms (Hacking, 1995a). However, we should also bear in mind that the possible positive side of this development is the form of de-stigmatization that may occur when diagnoses enter the public sphere, in the best case reducing the taboo that traditionally have been attached to people’s mental problems in the imagined hemisphere of the West.

Concerning Denzin’s second point, the psychiatric diagnoses are generally reinforced by the popular media as belonging exclusively to the individual (cf. the notion of possessive individualism), even in cases when the representations have the intention of taking a de-stigmatizing approach to mental disorder such as in “Mad or normal?”. Even though social scientists will argue that what we call mental illness often results from problematic living conditions, it is, according to diagnostic psychiatry, the individual that “possesses” the problem, is diagnosed, and treated with drugs in the standard case (Kutchins & Kirk, 1997). Thus, a diagnostic approach to people’s problems risks hiding the social conditions of people’s sufferings, which is in line with the reigning neo-liberal order of making people responsible through the belief that they are free to choose (cf. Denzin’s third and fourth points cited above). It is noteworthy that the TV show did not include a discussion about changing life conditions (that could possibly explain the prevalence of mental disorder) or a critical awareness of the role of psychiatric diagnoses in human lives, including their possible pathologizing effects. The diagnoses were seen as referring solely to problems residing in individuals.

Conclusions

In this article, I have focused on merely one instance of the current diagnostic cultures of a late-modern nation state such as Denmark. Although I have zoomed in on just one small example, I believe the concrete example displays some contradictory or paradoxical logics that are operating on a much broader scale today. These logics put the notion of mental disorder in a precarious place – somehow between a “real” somatic illness and a construction – and also diagnosed individuals themselves, who are rarely just included in social arenas as legitimate patients, but almost always included as excluded. The contradictory nature of the diagnostic logics makes the looping effects between classified and classifications quite complex. It is not simply the case that distressed individuals (e.g. some of the viewers of the TV show) learn how to designate their misery by appropriating a diagnostic vocabulary, but rather that they – in fact all of us who are exposed to a show like

“Mad or normal?” – learn that mental disorders are many things at the same time. What is communicated in the medialized processes of looping, then, are not just specific and discrete classifications, but an entire (complex and contradictory) way of thinking about human beings, their minds and their disorders. This has not been given much attention by Hacking (who has focused on specific categories such as autism, fugue and Multiple Personality Disorder), or most other observers of diagnostic cultures, but I hope that the small steps taken in the present article can contribute to an understanding not just of *which* categories that enter the looping games, but also of *how* and *how much* besides the categories themselves that is communicated. In short, a TV show like “Mad or normal?” can be seen as a vehicle through which non-contagious psychiatric problems can become contagious, but also communicates an entire view of diagnoses and problems as such.

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Notes

¹ Information on the Danish version can be found on the webpage of the national Danish broadcasting company, a public service TV channel: <http://www.dr.dk/sundhed/Sygdom/Psykiatri/Psykiatri.htm>

² I provide a very brief analysis of the show in a text box in Brinkmann (2016), but here I have significantly revised and expanded the example.

Referencer

- Alvesson, M. & Kärreman, D. (2011). *Qualitative Research and Theory Development: Mystery as Method*. London: Sage. <https://doi.org/10.4135/9781446287859>
- Brinkmann, S. (2010). Guilt in a fluid culture: A view from positioning theory. *Culture & Psychology*, 16, 253-266. <https://doi.org/10.1177/1354067X10361397>
- Brinkmann, S. (2012). *Qualitative Inquiry in Everyday Life: Working with Everyday Life Materials*. London: Sage.

- Brinkmann, S. (2013). The pathologization of morality. In K. Keohane & A. Petersen (Eds.), *The Social Pathologies of Contemporary Civilization* (pp. 103-118). Farnham: Ashgate.
- Brinkmann, S. (2014a). Languages of suffering. *Theory & Psychology*, 24, 630-648. <https://doi.org/10.1177/0959354314531523>
- Brinkmann, S. (2014b). Psychiatric diagnoses as semiotic mediators: The case of ADHD. *Nordic Psychology*, 66, 121-134. <https://doi.org/10.1080/19012276.2014.926227>
- Brinkmann, S. (2016). *Diagnostic Cultures: A Cultural Approach to the Pathologization of Modern Life*. Farnham: Ashgate.
- Conrad, P. (2007). *The Medicalization of Society*. Baltimore: The Johns Hopkins University Press.
- Denzin, N. K. (2001). *Interpretive Interactionism*. (2nd ed.). Thousand Oaks, CA: Sage. <https://doi.org/10.4135/9781412984591>
- Denzin, N. K. (2003). Cultural studies. In L.T. Reynolds & N. J. Herman-Kinney (Eds.), *Handbook of Symbolic Interactionism* (pp. 997-1020). Walnut Creek, CA: AltaMira Press.
- Hacking, I. (1995a). *Rewriting the Soul*. Princeton, N.J.: Princeton University Press.
- Hacking, I. (1995b). The Looping Effect of Human Kinds. In D. Sperber, D. Premack, & A. J. Premack (Eds.), *Causal Cognition: A Multidisciplinary Debate*. Oxford: Clarendon Press.
- Healy, D. (2012). *Pharmageddon*. Berkeley, CA: University of California Press.
- Horwitz, A. V. (2002). *Creating Mental Illness*. Chicago: University of Chicago Press.
- Jutel, A. G. (2011). *Putting a Name to It: Diagnosis in Contemporary Society*. Baltimore: The Johns Hopkins University Press.
- Jutel, A. G. & Nettleton, S. (2011). Toward a sociology of diagnosis: Reflections and opportunities. *Social Science & Medicine*, 73, 793-800. <https://doi.org/10.1016/j.socsci-med.2011.07.014>
- Keohane, K. & Petersen, A. (2013). *The Social Pathologies of Contemporary Civilization*. Farnham: Ashgate.
- Kessler, R. C. (2010). The prevalence of mental illness. In T. Scheid & T. N. Brown (Eds.), *A Handbook for the Study of Mental Health: Social Contexts, Theories, and Systems* (pp. 46-63). (2nd edition). Cambridge: Cambridge University Press.
- Kincaid, H. & Sullivan, J. (2014). Classifying psychopathology: Mental kinds and natural kinds. In H. Kincaid & J. Sullivan (Eds.), *Classifying Psychopathology: Mental Kinds and Natural Kinds* (pp. 1-10). Cambridge, MA: The MIT Press.
- Kutchins, H. & Kirk, S. (1997). *Making Us Crazy - DSM: The Psychiatric Bible and the Creation of Mental Disorders*. Chicago: University of Chicago Press.
- Kyhn, D. B. (2012). *Gal eller normal: Fortællinger om psykisk sygdom*. København: Lindhardt & Ringhof.
- Madsen, O. J. & Brinkmann, S. (2012). Lost in paradise: Paradise Hotel and the showcase of shamelessness. *Cultural Studies - Critical Methodologies*, 12, 459-467. <https://doi.org/10.1177/1532708612453011>
- Martin, E. (2007). *Bipolar Expeditions: Mania and Depression in American Culture*. Princeton, NJ: Princeton University Press.
- Mills, C. W. (1959). *The Sociological Imagination*. (This edition 2000). Oxford: Oxford University Press.
- Moynihan, R. & Cassels, A. (2005). *Selling Sickness: How the worlds biggest drug companies are turning us all into patients*. New York: Nation Books.

- Oute, J., Huniche, L., Nielsen, C.T., Petersen, A. (2015). The Politics of Mental Illness and Involvement: A Discourse Analysis of Danish Anti-Stigma and Social Inclusion Campaigns. *Advances in Applied Sociology*, 5, 273-285. <https://doi.org/10.4236/aasoci.2015.511026>
- Petersen, A. (2011). Authentic self-realization and depression. *International Sociology*, 26, 5-24. <https://doi.org/10.1177/0268580910380980>
- Seeberg, J. & Meinert, L. (2015). Can epidemics be noncommunicable? *Medicine Anthropology Theory*, 2, 54-71.
- Szasz, T. (1960). The Myth of Mental Illness. *American Psychologist*, 15, 113-118.
- Tekin, S. (2014). The missing self in Hacking's looping effects. In H.Kincaid & J. Sullivan (Eds.), *Classifying Psychopathology: Mental Kinds and Natural Kinds* (pp. 227-256). Cambridge, MA: The MIT Press. <https://doi.org/10.1037/h0046535>
- Timimi, S. (2009). Why diagnosis of ADHD has increased so rapidly in the West: A cultural perspective. In S. Timimi & J. Leo (Eds.), *Rethinking ADHD: From Brain to Culture* (pp. 133-159). Basingstoke: Palgrave Macmillan. https://doi.org/10.1007/978-1-137-02058-1_5
- Young, S., Bramham, J., Gray, K., & Rose, E. (2008). The experience of receiving a diagnosis and treatment of ADHD in adulthood. *Journal of Attention Disorders*, 11, 493-503. <https://doi.org/10.1177/1087054707305172>