Annastiina Mäkilä // The 21st century could be labeled the century of diagnostic culture.**[1]** During the last few decades, cultural understandings of depression in the West have undergone a homogenization toward biological and DSM-based frameworks. This is undoubtedly because many aspects of daily life are increasingly dependent on psychiatric diagnosis; not only is it required to access certain kinds of health care, but also institutions such as schools and insurance companies demand diagnoses as a condition of delivering essential services. Most researchers of this cultural norm attribute it to a triumph of psychiatry, or to the practical commercial interests of the pharmaceutical industry. But after undertaking a case study of archival materials collected from medical and psychological students at the University of Turku in Finland, I have come to find that in the wake of the current diagnostic culture in the late twentieth century, patients themselves had their own desires for classification that tend to be obscured when we only examine the roles of powerful institutions.

When we talk about psychiatry, we should bear in mind that it is not, nor has it ever been, a monolithic science. Contemporary diagnostic categories were originally created in the 1970s by middle-class, white male Americans who wanted to get rid of psychoanalysis and replace it with biological psychiatry.**[2]** They created new diagnoses, such as major depression, as well as a new paradigm in which the focus was on neatly defined symptoms instead of, for example, the etiology of the suffering. I mention American-ness here because the classification was made to answer the very specific demands of one society: psychiatrists in the U.S. wanted to secure their profession by monopolizing diagnosis, and the psychopharmaceutical industry and health insurance companies needed clear-cut groups of patients for their own interests.**[3]** Even though the DSM (Diagnostic and Statistical Manual of Mental Disorders) created by the APA (American Psychiatric Association) is now standard and is behind the classifications of depression in the widely used ICD (International Classification of Diseases by WHO), its influence has not evolved the same way in every Western country.

My case study is from Finland, and my research draws on materials from both scientific and everyday Finnish cultures in order to trace the development of popular understandings of depression in this particular country's history. This includes texts that students of psychology and medicine studied and produced during their education at the University of Turku from 1980 till 1995.[4] At the end of the twentieth century, there were five universities where students could study medicine in Finland and six that offered psychology. The University of Turku was one of a handful that offered both; moreover, it enabled specialization in psychiatry, and from 1987 onwards, in child psychiatry. Both the department of psychology and the faculty of medicine followed the international trends in their fields, yet maintained their own local schools of thought that were not necessarily dominated by diagnostic practice. For example, Yrjö Alanen, a professor of the psychiatry in the University of Turku from 1968 until 1990, chaired a project on developing a systemic psychotherapy and family-oriented way of treating severe psychosis in the 1970s and 1980s, which became the inspiration for the now widely known Open Dialogue approach. To understand the non-scientific surroundings of these local trends, I wanted to see how depression was understood in everyday culture, and to that end I also collected published and unpublished materials written on depression in the late twentieth century Finland. These materials include a women's magazine, five bulletins of mental health organizations, and responses to two autobiographical writing competitions organized by the Finnish Literature Society.

In the psychiatry department at the University of Turku, the DSM and APA were well known in the 1980s and 1990s. The DSM-III was translated and published in Finnish in 1981 (or in 1982 at the latest), and it is mentioned already in the beginning of the 1980s by medical students.[5] However, throughout my material on medicine and psychiatry, the DSM-III and its later versions remain only one approach and possible way of describing depression among others.[6] The official Finnish diagnostic manual was considerably revised and published anew in 1987, and the parts covering depression were heavily influenced by the DSM-III. Nonetheless, students' psychiatry theses used widely different theories and traditions while treating depression still in the mid-1990s—in some theses, the DSM isn't even mentioned. Throughout this 15-year time period it seems that the department of psychiatry was very aware of the different theories on depression and was not yet leaning toward or against any specific classification. At the same time, biological psychiatry was only one aspect of students' education, and still in the mid-1990s other aspects and etiologies of psychic pain were seen as valuable and essential. For example, etiology-based categories of depression—such as endogenic, exogenic, and reactive depression—were in use from 1980 to 1995. If the department of psychiatry was reluctant to change its views on psychic pain, even more stubborn was the department of child psychiatry and the department of psychology when dealing with the mental health of a child; there are texts about mental health of children written in the 1990s that contradict the DSM and biologically based views. Some texts challenge the use of exact diagnoses altogether,[7] and some from the department of psychology question even the benefits of the division between healthy and ill when a child is concerned.

At the same time, in everyday culture, there seemed to be a clear demand for neat classifications, explanations and solutions embedded in DSM-based diagnostic culture. In the case of the new and very inclusive category of major depression, the diagnosis offered many solutions for very different

problems. In my material I see at least two problems that major depression solved: first, it offered a label of illness and a recognizable reason to be exhausted for people who were under too much pressure either from too much work or not being able to find enough work. On the other hand, the diagnosis offered a less stigmatized way of getting professional help for people with unbearable psychic pain. Previously the label had been "mad" or "mentally ill," which were very loaded terms. The new diagnostic culture tried to introduce itself as a parallel system of somatic diagnoses that was perceived as non-stigmatized. For example, a 1995 Finnish mental health magazine featured an interview with a woman who had attempted suicide. In the mental health system, her main concern was whether she was "mad." So she asked the doctor, "Am I mad?" and, according to the woman, the doctor replied, "No, you are not ill, but your condition is caused by major depression that was evoked by long-term hardships."**[8]**

It is not evident, though, that psychiatric scientists were the foremost advocates of the new paradigm. Based on my research, medical professionals in training were inclined to see mental health issues holistically, but the pressure for simple categorizations and purely "natural" scientific answers increased from among patients over time. In a telling example from a medical student's 1989 case study, a nine-year-old boy was taken into a hospital for a psychiatric assessment, and the mental health professionals assigned to the case did not find it necessary to make a diagnosis. Instead, they saw his behaviors stemming from his environment and past life events, and accordingly offered the mother help in easing the everyday life of a dysfunctional family. The mother of the child, however, insisted that the problem was inside the boy's brain. According to the student who authored the study, "The mother was interested in Matti's EEG results. It felt like the mother had wished for a finding that would make it easier to understand and approve Matti's behavior. The assistant physician said that that kind of fault would be incurable, when we can actually have an influence on the current problems. [Professor of child psychiatry Jorma Piha] asked Matti whether he understood that there is nothing wrong with his head."**[9]**

It seems to me, then, that the culture of the general population in Finland was more eager to adapt this rising diagnostic culture than has been previously acknowledged—perhaps even more eager than medical professionals and the psychologists, at least at the University of Turku. No science, and especially the psy-sciences such as psychiatry and psychology, exists in a vacuum. The researchers and practicians live and work in a specific time, culture, and society, which have their own ideas about how the mind of a human being works—and, more importantly, should work. The ideology behind the DSM-III was not implemented as the sole authority in the education of the future psychologists, psychiatrists, and physicians in the 1980s and 1990s, and yet we see today how even psy-scientists speak of diagnostic categories such as depression as if they are natural classes instead of practical and polythetic ones. To have the whole picture of how this came to be, we must shed light not only on the sciences or psychopharmaceutical industry, and even not only on society's widening demands for specific categories of mental illness. For all these changes to take root, they needed also the approval of the culture that they exist in. For cultural and historical reasons, everyday culture in Finland at the end of the twentieth century had started to internalize the neoliberal vision of the ideal citizen with its implications of how the mind should work consistently and in a particular mood. People sought the simplest solution to obtain this ideal,

which meant natural-scientific explanations and solutions instead of holistic, life-spanning problematizations. While researching the cultural history of the psy-sciences and their practical work, we should always bear in mind that these sciences are in a constant negotiation not only with society and its institutions, but also with widely held cultural ideas and beliefs.

References

[1] Brinkmann, Svend: Diagnostic Cultures. Taylor and Francis 2016. Brinkmann uses the term in plural but I approach the phenomena as a singular culture from a historical point of view.

[2] Davies, James: How Voting and Consensus Created the Diagnostic and Statistical Manual of Mental Disorders (DSM-III). In *Anthropology & Medicine* 1/2017, vol. 24, pp. 32–46.

[3] Mayes, Rick and Allan V. Horwitz: DSM-III and the Revolution in the Classification of Mental Illness. In *Journal of the History of the Behavioral Sciences* 3/2005, vol. 41, pp. 249–267.

[4] The corpus includes text books, articles, lecture notes, course works, theses, and such. The corpus from the department of psychology is quite clear-cut as all of them became to be psychologists. From the Faculty of Medicine, I explore the education of the Licentiate of Medicine, which enables one to work as a physician. I have also investigated Specialist training of the psychiatrists and child psychiatrists and browsed through the material they were obliged to read for their exam. I have also included in my material the doctoral dissertations from the departments of psychiatry and child psychiatry.

[5] The DSM-III was in use e.g. in a student work from 1984. Korkeila, Jyrki, Antero Lassila, Päivi Pynttäri, Tero Taiminen and Juha Välimäki: *Lapsuuden autismi, seurantatutkimus*. Department of Paediatric medicine, University of Turku. 1984.

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