Transforming Chemicals and Drugs into "Medication" and "Treatment": The power of language

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In this chapter[i] I will attempt to show how, through the power of language, the prescription of psychiatric drugs has come to be seen as a scientific process with straightforwardly positive outcomes despite the fact, as Lacey (Lacey, 1991, p.13) has put it, that psychiatrists are "fallible professionals whose tools are imperfect drugs" (Lacey, 1991, p.13).

The "discovery" narrative of drug research

A popular conception is that psychiatric drugs emerge out of straightforward basic scientific research into the causes of mental health problems, conducted without any bias. But the history of psychopharmacology is a story of serendipity and fruitful accidents (Healy, 2002) and of failure -- 90% of drug research projects fail (Kennedy, 2019).

Psychiatrist and psychopharmacologist David Healy (2002) observes that a drug would be developed for one purpose but then tried on psychiatric patients[ii] to see if it would be beneficial. For example, Chlorpromazine was originally developed as an anti-histamine (i.e., an anti-allergy drug) and its sedative effects on people with psychosis diagnoses were only found later whilst Imipramine (Tofranil) was originally synthesized to compete with the anti-psychotic drug Chlorpromazine but was unexpectedly found to improve mood (Braslow & Marder, 2019) and thus has since been marketed as an "anti-depressant[iii]." But when a drug has such an effect, it is often unclear why and psychiatric researchers have often gone down several dead-ends, developing hypotheses like the discredited dopamine theory of schizophrenia, a theory created because drugs like Chlorpromazine acted on the neurotransmitter dopamine (Braslow & Marder, 2019).

Drug companies are commercial entities focused on increasing profits for their shareholders and these commercial interests bias their research in a number of significant respects (Cosgrove & Shaughnessy, 2020). For example, they only invest in research where they think there will be a significant profit and Healy (2002) notes that these financial incentives have led companies to develop compounds to compete with those of other drug companies. These "me-too" drugs often offer little benefit (Aronson & Greene, 2020). Indeed, after making significant profits from psychiatric drugs over recent decades, many companies have reduced their investment in research and development in psychiatry (Braslow & Marder, p.46).

Marketing and the "magic bullet" metaphor of medication

Marketers consider branding essential for drug companies to differentiate their drugs from those of competitors (Harindranath & Sivakumaran, 2021) and this informs how drugs are marketed to physicians and to consumers. Although it is illegal to advertise to consumers in most countries, apart from the US, drug companies can still develop a brand narrative through articles in the popular media, hosting websites containing ostensibly unbiased information, funding apparently "grassroots" advocacy groups and so on (Goldacre, 2012). A brand narrative underpins adverts in professional journals and in promotional presentations made to doctors by drug company sales representatives. There is approximately one "drug rep" for every six doctors (Goldacre, 2012) and they visit them often. An article co-authored with an ex-drug rep details the strategies they use to promote their products, tailoring their message to the individual doctor (Fugh-Berman & Ahari, 2007):

I visit the office with journal articles that specifically counter the doctor's perceptions of the shortcoming of my drug … I play dumb and have the doc explain to me the significance of my article … Humility is a common approach to physicians who pride themselves on practicing evidence-based medicine. These docs are tough to persuade but not impossible. (Fugh-Berman & Ahari, 2007, p.0622).

The naming of a drug can be a key aspect of its brand narrative. Simon Luke, head of the Naming Team at the company Interbrand, Newell and Sorrell explained how they came up with the name Prozac for the chemical compound *fluoxetine hydrochloride* developed by drug company Eli Lilly:

One of the core benefits of fluoxetine was positivity, so we realized that pro (signifying "for" and "forwards" in Latin, as in "proceed") was a prefix that had connotations and suggestions of positivity and that worked in many languages … Then we also wanted the word to be quite hi-tech and modern because this was a new breed of drugs. Silly though it sounds, letters like "z" weren't very much used in pharmaceutical branding when we were working on this fifteen years ago, so we looked at z's and we looked at x's and we looked at y's, and that's how we got to "zac". (Elmes, 2000, p.36)

A common metaphor in how lay people talk about medication is that it is a "magic bullet" (Björnsdóttir, 2009), which is not surprising since this idea is prevalent in much drug advertising (Delbaere, 2013). Because it implies that there is a specific entity being targeted by the "bullet," this metaphor supports the disease model of distress. It also implies that the drug will only affect this disease and that there will be "a magical transformation from sick to healthy with very little effort on the consumer's part" (Delbaere, 2013, p.24).

The idea that drugs are specifically targeted is promoted by referring to them as "anti-depressants," "anti-psychotics" and so on. Categorizing drugs in this way is a successful example of a branding narrative. In the first 20-30 years of their use, drugs like chlorpromazine were referred to by a variety of terms, most commonly "major tranquillizers." Psychiatrist Joanna Moncrieff has described how the term "anti-psychotic" was initially rarely used but began to be promoted by drug companies from the 1980s onwards (Moncrieff, 2013a), finding favor as biological psychiatry enjoyed a resurgence. But psychiatric drugs are complex compounds with a range of effects. Healy, for example, points out that anti-psychotic drugs act on a range of other neurotransmitter systems not just

dopamine: “[t]hese drugs are Cocktail Compounds rather than Magic Bullets that select and hit one target” (Healy, 2016, p.11).

The general public also play a part in the dominance of medication. In Western societies, there is often a desire for an individualistic “technical fix” for mental distress – rather than addressing its causes -- and doctors are often asked for medication by their patients. Indeed, this is why drug companies are keen to advertise directly to the consumer as they are allowed in the US. As Rose points out, drug companies “explore and chart the experienced discontents of individuals, link these with the promises held out by their drugs, and incorporate those into narratives that give those drugs meaning and value” (2006, p.480).

Treatment = medication

Medication is generally seen as the primary and default treatment in psychiatry. This is especially true for more severe forms of distress where it is taken for granted that psychiatric treatment is synonymous with medication (or other physical treatments like Electro-Convulsive Therapy). For example, a guide for service users states that “[a]ntipsychotic medications are considered to be the foundation of treatment for psychosis” (Blake et al., 2015, p.10). This very common way of seeing medication implies that, even if other kinds of treatment might be appropriate, medication is still required as it is the foundation on which everything else rests.

Drug treatment is generally seen as the primary treatment with other kinds of help like talking therapies given a secondary status, as “adjunct treatments.” The primacy of medication is often justified on the basis of bio-genic causal theories where the cause of problems is regarded as biological or genetic in nature. Even where adversity or other social factors are acknowledged as playing a causal role, these will often be seen as simply triggering an underlying illness rather than as a cause of difficulties in their own right (Harper et al., 2021). Of course, the purported biological vulnerability thought to cause psychosis is still undiscovered despite decades of well-funded biological research.

A discourse of faith and optimism

Throughout the history of psychiatry there is a consistent pattern of overly optimistic claims for new treatments which are subsequently shown to be unfounded. In the 1980s and 1990s drug companies claimed that “atypical anti-psychotic” drugs like Clozapine were more effective and had fewer side effects than older drugs. I recall a senior clinical psychologist and researcher saying to me at the time that it was striking that drug companies only seemed to be publicly critical of their products when they had a new (and more expensive) replacement product to sell. Subsequently, reviews have found that, though some seem to produce fewer side effects, they are no more effective than the previous drugs (Braslow & Marder, 2019; Geddes et al., 2000).

Psychiatric discourse about drugs is often marked by a language of faith and optimism and this can be seen in the way in which biological researchers confidently claim that new ground-breaking discoveries lie just around the corner. The resurgence of biological

psychiatry and the rise of the disease model of mental distress in the US in the 1980s with the publication of DSM-III and the "decade of the brain" in the 1990s saw confident promises that fundamental discoveries were about to be made in the etiology, classification and treatment of schizophrenia. This discourse of "genetic optimism" was evident in the titles of books like *The biological basis of schizophrenia* (Hemmings & Hemmings, 1978) and was reflected in media accounts of psychiatric research (Conrad, 2001). But, as the historian Anne Harrington (2019) has pointed out, these promises remain unfulfilled and, having made significant profits, many drug companies are now withdrawing from the psychiatric drug market. Clearly, they are no longer confident that breakthrough biological research discoveries are imminent.

Medication and mystification

Much discourse about medication involves technical and scientific names and terms that can mystify psychiatric service users and prevent transparent discussions. For example, I asked one service user[iv], Peter, what medication he was prescribed: "Er <pause> Dofepin, is it Dofepin? <Interviewer: Dothiepin?> Oh aye, yeah, and something else, I can't think of it. It's a big name, like, blue pills." Peter's difficulty in naming the drugs he was taking (Dothiepin and Stelazine) reminds us of how unusual, technical and scientific-sounding they are.

Other technical language can be found in written medical prescriptions, in clinical records or in conversations with staff. For example, when I asked the junior doctor what she had prescribed Peter, Dr. Williams said "he's on Stelazine 5mg bd and Dothiepin." This is a good example of "shorthand" medical talk – the dosage (five milligrams) is conveyed succinctly. The term "bd" is medical shorthand for the Latin *bis in die sumendum* which means that the medication is to be taken twice daily. There are a lot of abbreviations and Latin and Greek terms in use in medicine – Wikipedia lists dozens of such terms (https://en.wikipedia.org/wiki/List_of_abbreviations_used_in_medical_prescriptions). Ordinary people can find such terminology inaccessible. Of course, the use of technical and scientific-sounding terms can make it seem that medication decisions are very scientific.

Objectifying language and downplaying agency and subjectivity

Medicalization in psychiatry is sustained by recourse to what discursive psychologists refer to as empiricist accounts, the kind of objectifying language used in scientific publications (Edwards & Potter, 1992). This kind of language is very evident in a study where psychiatrist and anthropologist Robert Barrett compared the transcript of a psychiatric assessment interview with the formal write-up of the assessment in the clinical records. Whereas what was said in the interview was often ambiguous and complex, the write-up in the case notes transformed the content of the interview into uncomplicated and objectified symptoms (Barrett, 1988).

In psychiatric interviews, the psychiatrist's inferences and judgements are transformed into symptoms and these are inferred to be surface indicators of an underlying illness. Agency is given to phenomena like "the illness," "symptoms" and "side effects" which are seen as having agency in their own right whilst people are seen as passive agents and the social

context is de-emphasized. Discussion of the role of medication is similarly objectifying and reductive. Psychiatric medication is an individualistic and reactive intervention – the social causes of distress are not prevented or resolved (LaFrance, 2009). Drawing on the "magic bullet" metaphor, psychiatric drugs are seen as acting directly on "the illness" or "symptoms," without involving the service user. Any positive changes tend to be attributed to the medication rather than to anything else that might be going on in a person's life (Johnstone, 1993). Psychiatric consultations are often brief as a result. Cyril, interviewed by Barham and Hayward (1995, p.66), said his psychiatrist never explained changes in medication or dosages and there was little discussion of side effects and, describing his consultations with his psychiatrist, he said, "You're in three minutes and out. 'Come back in twelve weeks!'"

Unsurprisingly, over time, this medicalizing approach can have an impact on how psychiatric service users view themselves and their lives. Sherlock and Kielich (1991) found in their interviews with 30 "long-term, mentally ill" clients that they had come to view their experiences through the lens of medication: "[l]iving problems were constructed not in terms of the 'illness' itself, but more in terms of under- or over-medication" (p.97). Moreover, for those who hold on to a non-medicalizing view, the dominance of a biological approach can be a continuing source of tension. Another of Barham and Hayward's interviewees, Ben, said "my contention is that I get mentally ill because of social problems" but he said his psychiatrists took a different view:

I believe that their heads are full of chemistry and my head is full of politics and social things. So that's a conflict that perhaps won't ever be resolved. (Barham & Hayward, 1995, p.68)

How drugs are explained

David Healy has stated that "[o]ne of the marketing advantages drug treatments have is that companies can appeal to biological mechanisms of action and, in so doing, create a scientific illusion" (2016, p.16). The notion that anti-depressant drugs fix a chemical imbalance in the brain is one such bit of biomythology, according to Healy.

In my interviews with psychiatrists, primary care physicians and community psychiatric nurses about medication and delusions, they explained the effects of medication in varied ways. Sometimes medication was ascribed almost magical qualities. Dr. James (Consultant psychiatrist) said that "[i]t takes the delusion away in most patients." Others said that it made delusions "go" (Dr. Smith, Consultant psychiatrist) or "clear off" (Dr. Williams, Junior Doctor). Sometimes, medication was viewed in a straightforwardly biological manner. Dr. Chapman (primary care physician) said "[b]asically it's a chemical treatment … I think it is a natural chemical illness and treated by chemical means." Alternatively, it was said to have "dulled" delusions or to have made them "less apparent" (Terry Reid, Community Psychiatric Nurse).

Another way of explaining medication was how it changed the way a person might feel about their problems. For example, it was said to make service users less "bothered" or "troubled" by delusions (Terry Reid) or "less anxious" about them (Edward Jackson, Community Psychiatric Nurse). In interviews with psychiatric service users, the effects

seemed more ambiguous. Mike said that medication "gets rid" of delusions and stopped his belief in them but that they were left in the back of his mind as a memory. John said that the medication made the delusions go away "to some extent" but when asked whether the medication altered his beliefs, he said that they remained, but he was less "bothered" or "troubled" by them and, that, in general, medication helped him "calm down" and feel "less anxious." These more pragmatic and less magical descriptions are consistent with Healy's (2016, p.13) explanation that neuroleptic drugs "produce a feeling of detachment – of being less bothered by what had formerly been bothering" but that hallucinations and delusions do not disappear, instead usually they remain but service users are "less worried by them" (p.14).

Most people are used to the notion of having "a course" of medication of a reasonably short and fixed duration. But in psychiatry, it is very common for people to be prescribed "maintenance medication." This involves taking psychiatric drugs for long periods of time, perhaps for the rest of one's life. As a community psychiatric nurse whom I interviewed put it, "a lot of our job is to give people maintenance medication" (Terry Reid). The notion of maintenance implies a chronic, long-term problem that is not being resolved in any fundamental way but is simply being maintained with the danger that it might unexpectedly recur. One of the Consultant psychiatrists I interviewed said that he would explain the need for this by telling service users that "[y]our treatment is only controlling your symptoms. Without treatment, what I can tell you is you are very likely going to relapse" (Dr. Smith). Here there is an acknowledgement that the drugs are controlling symptoms but not treating an underlying illness. Maintenance medication is often justified by making an analogy with the prescription of insulin to control diabetes. However, McMullen and Sigurdson's (2014) analysis of discussions between doctors and patients about anti-depressant medication revealed that there were lots of ways in which this analogy broke down in practice – for example, it was rarely clear whether the analogy was with Type 1 or Type 2 diabetes.

In passing, it is striking how often within psychiatry analogies are made with general medicine. I would argue that this reveals something about the anxiety of the psychiatric profession about its status within medicine. Surveys of medical students show that psychiatry is one of the most unpopular specialties, chosen as a career by less than 5% of medical students and, amongst the factors that make the profession less attractive is its "lack of scientific foundation … perceived low status, prestige" (Lyons, 2013, p.155). Thus, the psychiatric profession makes concerted efforts not only with service users and the public, but also with their medical colleagues, to appear as similar as possible to the rest of medicine (e.g., filling journals with unreplicated biological studies which have made little difference to practice).

Dealing with troublesome topics: Side effects and explaining medication failures

As we have noted, psychiatric drugs are complex compounds which have a wide range of effects, some which are wanted and some which are unwanted. The latter are referred to as "side effects" though these are as much direct effects of the drug as those which are wanted. Describing this effect as a "*side* effect" constructs these adverse effects as secondary and lesser in importance than the intended, wanted effects. Since side effects can vary from person to person, some element of the responsibility for them may be

implicitly ascribed to service users. In addition, the term is rather euphemistic and fails to convey that many side effects are unpleasant and often dangerous – some drugs cause tardive dyskinesia (Moncrieff, 2008) or contribute to the higher rates of mortality found amongst psychiatric service users (Chang et al., 2011; Moncrieff, 2013b). In other spheres there are similar euphemisms with similar functions – for example, the military's use of the term "collateral damage."

For those committed to a simplistic biological model, the failure of medication creates a problem. If medication is supposed to target and treat an underlying illness and its symptoms then why, in many cases, does it not have this intended effect? Analyzing my interviews with both professionals and service users, it was possible to identify a range of potential explanations and some recurring features, like how the locus of failure was placed at some point other than the medication -- like the dose, diagnosis or even the service user -- and how explanations often involved a re-definition of a good outcome or new classifications like "treatment-resistance."

Doctors occasionally acknowledged that they "didn't know" why a drug hadn't worked. Sometimes they attempted to rhetorically discount this by noting that there were "obviously odd exceptions" but usually they drew on one of the following explanations. Unsurprisingly, given the range of drugs and dosages and possible combinations between them, a number of explanations were drug-based:

+ The person was on too low or too high a dose

+ The person was on too many different kinds of drugs

+ The person was on the wrong drug (a variant of this was that the person was wrongly diagnosed and thus had been prescribed the wrong medication)

These explanations can be used to justify increasing or decreasing dosage, adding to or replacing the current drug or reducing the number of drugs. Prescribing dosages above recommended levels (so-called "mega-dosing" or "heroic dosing") and polypharmacy (prescribing multiple drugs of the same type like multiple anti-psychotic drugs) are relatively common practices (Latimer et al., 2014).

Another explanation was that the drug was working but it was just not working "fully." A related explanation was that the person was not responding "fully." Here the desired outcome was reframed, and no causal explanation was offered, the implication being that it must be something to do with the purported illness or service user. Sometimes the explanation was more explicitly located in the service user:

+ The person has chronic schizophrenia

+ The person is a non-responder (a contemporary variant is that the service user has "treatment-resistant symptoms" or "treatment-resistant schizophrenia" -- e.g., Kane et al., 2019)

Although terms like “non-responder” and “chronic” are simply descriptions – chronicity simply indicates that symptoms have persisted for a long time – these formulations are often treated as explanations. Since psychiatric medication is often stated to be effective, it is implied that failure to respond to drug treatment is rare, but that is not the case. Kane et al (2019) suggest that treatment-resistant schizophrenia “occurs in” 30% of those with a diagnosis of schizophrenia whilst Souery et al (2006) report that 29%-50% of people with depression diagnoses fail to reach full remission.

Chronicity narratives emphasize the permanence and severity of symptoms and illnesses and usually involve assumptions about the biological origin of problems within the person. They also locate agency within symptoms or illnesses which are essentialized, reified and abstracted from the person and the context of their life and relationships, yet located within them. The notion of “resistance” is a more active term than “non-response” and implies an active opposing of treatment attempts and thus connotes some moral blame. All these elements deflect responsibility for drug failure from the drug itself or the professionals who prescribe it and implicitly blame the person.

The ascription of moral blame for the lack of response to medication was most explicit in two other explanations I encountered:

+ Because some of the person's problems are due to manipulative behavior (a contemporary variant of this involves differentiating between symptoms that are caused by an illness and those which are “behavioral” -- Harper et al., 2021)

+ Because the person has not been compliant with their medication regime

Disagreeing with the doctor: compliance and insight

A common source of conflict is when service users do not take their medication prescribed as instructed by doctors. This is referred to as “non-compliance” or “non-adherence” with treatment. Kane et al (2013) report rates of “poor or non-adherence” of 25.8%-58.4% for people prescribed anti-psychotic medication. This is often presented as somewhat irrational, though it is intelligible if we consider the kinds of side effects reported by service users. For example, Moncrieff (2013b) summarizes subjective reports of people taking anti-psychotic medication as including: sedation; impaired thinking; emotional emptiness; Parkinsonian effects; agitated restlessness; loss of libido; increased appetite and weight gain. In addition, there are even more worrying effects like brain shrinkage and increased risk of early death (Moncrieff, 2013b).

The notions of compliance and adherence construct the prescription regime (drug, dose and so on) as taken for granted rather than as the product of a negotiation between doctor and service user, viewing it as an either/or matter (compliant or not compliant). If someone is not taking the medication as prescribed this might suggest that the service user feels that their views have not been fully taken on board by the prescriber, but attention is shifted away from this by viewing compliance and adherence as an inherent characteristic of the service user rather than signaling a breakdown in the doctor-patient relationship.

Critics have argued that the compliance narrative is an ideology that assumes and justifies medical authority since it defines adherence to a regime from the point of view of professionals (Conrad, 1987). In addition, non-compliance is often explained as resulting from a person's "lack of insight" (Novick et al., 2015). Since a lack of insight is seen as a "cardinal symptom of schizophrenia," (Lehrer & Lorenz, 2014, p.10) then such perceptions of the service user will only confirm the accuracy of the diagnosis to professionals.

I asked Dr. Smith (Consultant Psychiatrist) why some persons stopped taking their medication at various points whilst he was seeing them and he replied:

Well, obviously, in general I think people <pause> er don't like having any treatment erm and erm they believed that they shouldn't be on any treatment on a longer-term basis er quite often they have difficulty in accepting that they have got an underlying illness and they need the treatment to remain.

If professionals view patients as lacking insight, they may feel justified in disregarding what they say and, may be prepared, if necessary, to treat them against their will (Perkins & Repper, 1996, p.167). Professionals thus have the power to define what the correct prescription is and what being "well" means and if service users take a different view, then they are non-compliant and lacking insight. As with the compliance/adherence narrative, insight is defined from a medical point of view. In contrast, Day and Bentall (1996) recognize that the situation is that a person simply has "a theory which is different to that of the relevant health professionals and at variance with the prevailing scientific paradigm of the psychiatric establishment" (p.251).

The notion of compliance/adherence ignores the complex views which service users have about medication and the varied ways in which they actually use it in their everyday lives. Day et al (1996) reported that four different positions could be adopted by service users taking neuroleptics: having a somewhat dependent attitude towards the medical profession with little complaint about medication; emphasizing personal autonomy and skepticism about medication; appraising the advantages and disadvantages of medication; and emphasizing the positive benefits of medication but with a skeptical attitude towards medical advice. In addition, service users often use medication in a pragmatic way. Since anti-psychotic drugs have their effect on the body within an hour (Healy, 2016) they can be used in this manner. Some service users actively weigh up pros and cons in particular contexts, as can be seen in this extract from my interview with Sharon, a service user who was prescribed Prozac and Stelazine:

Sharon: I don't take Stelazine that much actually, I only take it if I'm going anywhere or I feel paranoid, 'cos that's one of the paranoid symptoms but, I get these depression erm I do feel a lot more relaxed, I think it's the Prozac really that's done that, yeah I used to have problems with my family erm I used to be like really angry with my family, I used to argue and everything, and <pause> I think because I was so highly strung.

From a medical perspective, Sharon is non-compliant with respect to Stelazine as she is not taking it on a regular basis. However, from Sharon's perspective she is making pragmatic choices based on her understanding of her problems. She sees Stelazine as useful to take

when she is feeling paranoid or, when going out, to reduce the likelihood of becoming paranoid. Similarly, she takes Prozac to help her feel more relaxed and so avoid becoming angry with her family. Sharon views her drugs as having specific effects which are useful at particular times rather than as treatments of some underlying illness.

Talking differently about psychiatric drugs

Since drugs may be helpful for some people some of the time, we need to find better ways of talking about them that avoid the kinds of problems I've identified. Psychiatrist Joanna Moncrieff (2008, 2013b) suggests that, rather than seeing drugs as treating an underlying illness or symptoms (what she calls a disease-centered approach) we should see them as having particular effects like reducing feelings of anxiety (what she calls a drug-centered approach). Service users need to have conversations with professionals which enable them to make a balanced appraisal of the costs and benefits of drugs and to take them in ways that work for them rather than according to a non-negotiable schedule. Professionals should be more open to the fact that prescribing drugs is an uncertain trial-and-error process where there may be benefits but where adverse effects are common and outcomes are uncertain. The risks of adverse effects mean that the service user should be fully involved in monitoring and feeding back about their effects.

Given their dangers, drugs should be a last rather than first resort and service users, including those who experience the most severe forms of distress, should first be given an informed choice about a range of alternative forms of help. Cooper et al (2021) have recently advocated for a minimal medication approach to helping those with psychosis diagnoses and there is emerging evidence that psychological therapy without medication is an acceptable and safe alternative to anti-psychotic medication (Morrison, 2019).

However, as seen throughout this book, a key problem to be overcome is the dominance of drug treatment and a simplistically reductive biological model. As I have argued elsewhere (Harper 2020) there is a need to re-balance the public conversation about mental health which is still dominated by medicalization.

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[i] The chapter draws on my PhD thesis (Harper, 1999a) and some previous publications based on it (Harper, 1998, 1999b, 2002).

[ii] Terms to describe people receiving care from mental health services are contested. Here I will generally use the term "service user" as that is in common usage in the UK where I am based but the term "patient" will occasionally be used if it seems more appropriate.

[iii] As noted in the chapter the terms "anti-depressant" and "anti-psychotic" are problematic but I have retained them here as they are readily understood.

[iv] Throughout the rest of the chapter, I draw on some interviews I conducted in the 1990s with British health professionals and service users for my PhD. All names used are pseudonyms.