New Zealand Sociology Special Issue: Theorising Mental Health
2023, Issue 38, No. 1, 81–94

A Queer Critique of Psychiatric Knowledge: Medicalising Queer Sadness

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Abstract
This article makes a queer critique of psychiatric knowledge based on psychiatry's use of normal/abnormal categorisations and queer theory's resistance to such ascriptions. Using the example of the medicalisation of normal sadness seen in increasing major depressive disorder (MDD) diagnoses, it will be argued that so long as its knowledge is grounded in this binary of normal/abnormal, psychiatry can be used to oppress queerness. The article first examines how happiness has become compulsory and articulates this as a normalising process facilitated by psychiatric knowledge. Sadness, as the corresponding abnormal, must and can be cured through psychiatric intervention. Here, psychiatry's account of increasing MDD diagnoses, especially amongst queer people, is outlined and then deconstructed following a critical account of the medicalisation of sadness. Finally, it draws these points together using queer theory to argue that expectable, socially induced queer sadness represents a double abnormality useful to queer politics but threatening to compulsory happiness as a normalising process. Thus, this sadness must be cured, and by medicalising queer sadness, psychiatry can 'cure' both sadness and queerness in the interests of power.

Keywords: depression; happiness; medicalisation; queer theory; psychiatry

Introduction

By *queer*, this article refers to people who resist and make apparent the constructed nature of the discourses that naturalise cisheteronormative assumptions of fixed linear connections between bodies and behaviour (Berlant & Warner, 1998; Butler, 1993, 1994; Jagose, 1996; Sedgwick, 1993; Warner, 1991). To be queer is widely recognised as destining one for unhappiness. Happiness in the conventional sense—self-contentment and the unconditional love and acceptance of others—appears to be rarely within queer reach (Ahmed, 2010). As queerness seems connected to sadness, perhaps it is expected that queerness has long been intimately entwined with psychiatry and considered pathological by the profession.

The dominant portrait of the relationship between queerness and psychiatry is one of advancement (Diamond, 2018). Queerness has become a famous example of *de*medicalisation within psychiatry (Diamond, 2018). Supposedly, queer people have been removed from subjection to harmful psychiatric practice, and queerness is no longer an inherently clinical subjectivity. Proponents of this argument point out that while homosexuality was considered a mental disorder in the first edition of the American Psychiatric Association's (APA) *Diagnostic and statistical manual of mental disorders* (DSM) in 1952 (American Psychiatric Association, 1952), it was removed in a reprint of the DSM-II (originally published in 1968) in 1973 (albeit after extensive efforts by queer rights activists) and absent from the DSM-III, published in 1980 (American Psychiatric Association, 1968, 1980; De Block & Adriaens, 2013; Wyatt-Nichol, 2014). Furthermore, others note that although transsexualism and gender identity disorder were included in the DSM-III (American Psychiatric Association, 1980), these have been removed in the latest DSM-5 (American Psychiatric Association, 2013) and replaced with gender dysphoria (Daley & Mulé, 2014; Lev,

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2013), an allegedly non-pathologising diagnosis necessary to obtaining gender-affirming healthcare, particularly in the United States (Diamond, 2018).

Critical scholars have, however, questioned this narrative of progress. As Cohen (2016, p. 157) writes, “Psychiatric diagnoses never really disappear but are instead recycled.” Accordingly, queer critiques of psychiatry have traced how pathological notions of queerness have not truly been eliminated as outlined above but instead have been reproduced less directly (Daley & Mulé, 2014; Diamond, 2018). For instance, queer critiques point to diagnoses such as ego-dystonic homosexuality in the DSM-III, the diagnostic family paraphilias in the DSM-IV and DSM-5, and gender dysphoria in the DSM-5. These diagnoses make minor semantic changes—namely, the removal of explicitly naming queerness as a mental disorder—but continue to reproduce the same pathological understandings about queerness as their predecessors (Lev, 2013; Wyatt-Nichol, 2014). Scholars also refer to the intensified practising of conversion therapies after the removal of homosexuality from the DSM-II (Goodyear et al., 2022) and their ongoing prevalence worldwide (particularly targeting non-cisgender people) as another example of the continuation of harmful psychiatric practice (Ashley, 2022; Goodyear et al., 2022; Pilling, 2022; Tosh, 2016). Furthermore, it has been noted that although being diagnosed with gender dysphoria enables access to life-saving treatment for non-cisgender people, it remains a pathological reading of queerness that leaves queers dependent on psychiatry (LeFrançois & Diamond, 2014; Pilling, 2022).

Such arguments are evidently well-grounded and necessarily problematise the legitimacy of psychiatry’s claim to scientific validity and objectivity. However, while they elucidate the contingency of the supposedly natural abnormalities/normalities (hereafter, ab/normalities) upon which psychiatric knowledge is based, the fundamental place of this binary remains unchallenged (Diamond, 2018). As Pilling (2022, p. 8) notes, a “narrow focus on the pathologising of specific diagnoses leads to the mistaken belief that once such diagnoses are removed from the DSM, gender and sexual dissidence … will no longer be pathologised.”

That ab/normality is the intrinsic categorisation upon which psychiatric knowledge rests directs this critique to queer theory. Queer theorists understand queer as intentionally and necessarily “defined against ‘normal’” (Warner, 1991, p. 16), invoking Foucault’s (1975, 1978) understanding that categories of ab/normal are produced through power’s obtainment of knowledge about subjects and populations through panoptical surveillance. These categories are made through discourse to appear natural and true, creating social order through producing populations that regulate themselves accordingly in the interests of power as if these interests are their own. Specifically, for Foucault (1978, p. 101), every such normalising discourse creates an oppositional “reverse discourse” which can be put to resistant use, of which queer is one form. In this sense, queerness is the resistant space opened by disrupting ‘normal’ linear connections between sex, gender and desire, gaining power from this unintelligibility (Berlant & Warner, 1998; Butler, 1993, 1994; Jagose, 1996; Sedgwick, 1993; Warner, 1991). Despite remaining underutilised in critiques of psychiatric knowledge (LeFrançois & Diamond, 2014; Pilling, 2022), queer theory, therefore, has the potential to illuminate that “socio-politico-cultural processes function within psychiatric discourse to produce docile and abject bodies” (LeFrançois & Diamond, 2014, p. 40) through the changeable, binary categorisations of ab/normality (Diamond, 2018; Kirby, 2014; LeFrançois & Diamond, 2014; Pilling, 2022).

As such, this article seeks to move beyond both the false narrative of progress and queer critiques of psychiatry that map its changes across time without challenging the legitimacy of its knowledge system. Instead, the article offers a queer critique of psychiatric knowledge on the basis that it operates according to the inherently anti-queer ab/normal binary. To do so, the article examines major depressive disorder (MDD) as an instance in which the categorisations ab/normality can be used to oppress queerness. Here, it returns to the initial observation wherein queerness suggests sadness, a double abnormality incompatible with and threatening to happiness. By making happiness normal, queerness can be ‘cured’ and remain oppressed through psychiatry.

Accordingly, this article begins by observing that happiness plagues the contemporary social imaginary, having become a compulsory affect and the drive to it a normalising process with psychiatry at its centre. Focus is then turned to sadness as the corresponding abnormal which must be cured, arguing that this is executed through the medicalisation of expectable, socially induced sadness and exemplified by increasing rates of depression, a diagnosis particularly notable for its historic use against women and, specifically, Black women (Beauboeuf-Lafontant, 2007; Lafrance, 2014; Stoppard, 2000; Ussher, 2011). Finally, queer lives are shown to be particularly elucidative of this process because they exemplify sadness, representing an inherent abnormality that opposes compulsory happiness.

The current state of happiness

Over the last two decades, happiness, and the drive to it, has become imbricated with politics, economics, science, academia, media, religion and everyday life (Ahmed, 2010; Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Davies, 2016; Duncan, 2019; Hyman, 2019; Illouz, 2008). Self-help books and magazine features fill the shelves, well-being gurus and pop-culture psychiatrists fill our digital feeds, and, for upper classes in the West, psychotherapy for personal development is *en vogue* (Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Davies, 2016; Hyman, 2019; Illouz, 2008). Happiness indices have replaced the tracking of material economic and social change, encouraging individualistic maximisation of happiness regardless of social circumstances and obscuring political failings to produce equity and social justice (Ahmed, 2010; Cabanas & Illouz, 2019; Duncan, 2019; van der Rijt, 2014).

Some have conceived this development as happiness having shifted out from its traditional residence in philosophy, experiencing a late modernity-fuelled resurgence as a lay term (McMahon, 2006; Schoch, 2006). More recently, others have argued that psychiatry makes a stronger claim to expertise on happiness and uphold its present-day socio-cultural primacy (Ahmed, 2010; Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Davies, 2016; Duncan, 2019; Illouz, 2008), given psychiatry's domination of the production of scientific knowledge on the mind and emotions since the late nineteenth century (Shorter, 2005). Indeed, *positive psychology*, a field focused on the scientific understanding of what makes life meaningful and happy, or psychological *well*ness, was spawned in the early 2000s as a rejection of past practice focused on psychological *ill*ness. Its enthusiastic uptake not just by academia but within politics, business and by popular media made positive psychology a dominant field of knowledge by the mid-2010s, and as a result, happiness has become a central object of individual and societal aspiration worldwide (Cabanas & Illouz, 2019, Cabanas & Sánchez-González, 2020; Duncan, 2019). (For critiques of positive psychology, see, for example, Burr & Dick, 2021; McDonald & O'Callaghan, 2008; McNulty & Fincham, 2012.) That the *science* of (obtaining and using) happiness is at the core of the examples listed above suggests that happiness enters the layperson's radar via psychiatric discourse. This apparent role of psy-professions as catalysts of the "happiness turn" (Ahmed, 2007, p. 7), and of psychiatry, in particular, as having domain over mental illness, is the point of analysis here.

Using scientific discourse to constitute a happy population, or a population driven to happiness as a natural desire, immediately evokes Foucault (1975, 1978, 2007). In particular, it evokes Foucault's concepts of disciplinary power (Foucault, 1975) and biopower (Foucault, 1978, 2007), which are interrelated techniques for, respectively, "achieving the subjugation of bodies and the control of populations" (Foucault, 1978, p. 140). If *disciplinary power* refers to using panoptical surveillance to create *individual subjects* who self-regulate unknowingly in the interests of power, *biopower* refers to the manipulating of biological knowledge to effectively manage *populations*. Through scientific, expert institutions—especially medicine in its widest-reaching sense—bodies as populations are organised to be optimised and naturalised through their association with biology. Effectively, politico-moral discourses of 'good' and 'bad' are superimposed upon

scientific discourses of 'normal' and 'abnormal', producing entire populations relegated to either position (Foucault, 1978). By regulating life at its most minute scale—like emotions and mental health—and teaching the population to think of itself in administered, scientific terms of ab/normality, government becomes constructive and participatory. Foucault's (2007) concept of *governmentality* refers to this positive, hyper-rational, modern process of government.

Foucault's work on power and government as indicative that a scientific discourse of happiness as normal is currently being used to produce a governable population has been previously explored. Psychiatry has an extensive history of diffusing its knowledge and therapeutic techniques into social institutions like the family and the workplace (Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Hyman, 2019; Illouz, 2008). Performed at the behest of interested socio-political powers, this produces subjects who function in the interests of said power as if these interests are their own (Cabanas, 2016). For instance, in industrialised Western states, psychiatric discourses such as efficiency, compliance and morality become workers' and parents' identities without their noticing that these are externally imposed (Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Duncan, 2019; Illouz, 2008). Psychiatry offers the ideal intermediary through which to pass this governmentality because scientific discourse legitimises its claim to expertise on the individual and their emotions, making subjects understand these to be normal, natural desires (Johnson, 1995).

More recently, psychiatry has extended into more intimate realms of life. Through the means listed above, modern psychotherapeutic notions of the constant pursuit of self-betterment and well-being as crucial to living the good life have become central to how populations understand their emotions. Here, happiness becomes a natural state of normality, and psychiatry *again* creates governed subjects who seek it out, seemingly in their own interest (Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Duncan, 2019; Hyman, 2019; Illouz, 2008). This turning of focus to the most intimate workings of the self is a highly efficient means of government and is explicitly enabled through happiness's construction as a biologically normal, individual state of being (Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Duncan, 2019; Illouz, 2008).

Although Foucault (1978, 2007) is arguably the natural place to first look when critically investigating the happiness turn, Foucault's explanations are not the only ones offered. For instance, some scholars assert that happiness is central to the functioning of neoliberal capitalism (Cabanas, 2016; Cabanas & Illouz, 2019; Cabanas & Sánchez-González, 2020; Davies, 2016; Duncan, 2019). Happiness is an easily commodifiable 'thing', either as happiness itself or mediated through various material objects. When positioned as an ideal, happiness reinforces the individualist logic of neoliberalism by necessitating and sustaining the consumerist drive which upholds it (Cabanas, 2016; Cabanas & Illouz, 2019; Davies, 2016). Psychiatry becomes useful because it claims the ability to provide happiness through its knowledge. Subsequently, this knowledge becomes commodifiable (Cabanas & Illouz, 2019; Davies, 2016). Furthermore, psychiatry has strength as a vessel for dispelling and upholding this discourse because it scientifically legitimises the notion that happiness is a naturally desirable and individually obtained and experienced state.

Regardless of one's critical position towards the current state of happiness, however, two things are common to every perspective: first, the contemporary push for happiness is tied to oppressive power channelled through psychiatry, and second, the idea that an objective normality as derived from psychiatric knowledge is scientific fact is central to this power's efficacious use of psychiatry to its own ends. Therefore, the ultimate basis upon which a critical view of happiness rests is in a challenge against the ab/normal underpinnings of psychiatric discourse. If the good, governable subject is the happy subject, the happy subject is also the 'normal' subject (Conrad, 2007). Here, we are returned to Foucault and can see that happiness, in becoming a compulsory affect, also becomes a normalising process—an extension of

biopower that creates a governed population (Foucault, 1978, 2007). A logical next question must be what, then, becomes of those who are abnormal—who are unhappy?

A psychiatric account of (queer) depression

As outlined above, psychiatric knowledge constructs and reinforces the notion that happiness is a marker of normal mental well-being within the population (American Psychiatric Association, 2013; Dowrick & Frances, 2013; Horwitz & Wakefield, 2007). As the scientific authority on mental health, psychiatry has legitimised this categorisation by pathologising sadness as depression, a mental disorder. Therefore, psychiatric knowledge also posits itself as central to curing depression, or making the abnormal normal. As psychiatric knowledge develops in line with scientific breakthroughs, depression rates will increase as psychiatry evolves its understanding of the disorder and is better able to define and locate it. Similarly, the already known association between queerness and sadness suggests that queers will have high depression rates as a social group (Borgogna et al., 2019; Hall, 2018; Rothblum, 2020; Steele et al., 2017; Wilson & Cariola, 2020). As understanding sadness as abnormal is central here, an outline of psychiatry's account of (queer) depression must be examined.

The APA is the leading contemporary psychiatric authority, and as the primary collation of its body of knowledge, the DSM shares this influence (Kirk & Kutchins, 1992; Whitaker & Cosgrove, 2015). The DSM-5 defines *major depressive disorder* (MDD; colloquially, depression) as the abnormal presentation of at least five of nine possible symptoms over two weeks where at least one is "depressed mood" or "loss of interest or pleasure" and none are attributable to another medical condition, causing "clinically significant distress" and "impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2013, pp. 160–161). The DSM-5 also reiterates that "pervasive unhappiness" and a general inability to be happy or anticipate happiness are diagnostic indicators of MDD (American Psychiatric Association, 2013, p. 161). MDD is the most common mood disorder (American Psychiatric Association, 2013; Liu et al., 2020). In 2017, approximately 163 million people worldwide were living with diagnosed MDD, a prevalence rate of around 2.2 per cent of the global population, though this proportion varies by geographic location (James et al., 2018). For instance, the DSM-5 states that the prevalence of MDD is around 7 per cent in the United States (American Psychiatric Association, 2013), and by comparison, the prevalence of MDD is around 3.7 per cent in North America, 4.1 per cent in Australasia, and 5.6 per cent in the Asia/Pacific region (Ferrari et al., 2013)

Psychiatry recognises the aetiology of MDD to be largely biopsychic. The DSM-5 lists MDD as likely to be caused by having a certain temperament or personality type, having a genetic predisposition to or having actively inherited MDD, and having a pre-existing other mental disorder, chronic illness or medical condition (American Psychiatric Association, 2013). The APA acknowledges that "environmental" factors, specifically adverse childhood experiences and major stressful life events, heighten the risk of developing MDD (American Psychiatric Association, 2013, p. 166). Environmental factors are, however, framed as less relevant than internal factors. Furthermore, it has been noted that in practice, environmentally caused MDD is likely to be treated with pharmaceutics regardless of the absence of biopsychic factors (Horwitz & Wakefield, 2007). This psychiatric understanding of MDD as internal and scientifically objective is widely upheld within everyday discourse (Whitaker & Cosgrove, 2015).

Since around 1990, there has been a significant global increase in the incident cases of MDD diagnoses (Horwitz & Wakefield, 2007; James et al., 2018; Liu et al., 2020), from approximately 162 million in 1990 to 241 million in 2017, a rise of 49.3 per cent (Liu et al., 2020). That MDD rates are increasing is widely acknowledged in everyday discourse and has become a focal point for mental health organisations and campaigners (Horwitz et al., 2017; Horwitz & Wakefield, 2007). Psychiatry explains this rise as either owing to advancements in understanding MDD, excavating cases that may previously have been missed

(Horwitz & Wakefield, 2007), or the biopsychic failure to adapt to dramatic cultural changes in recent decades, such as the growth of social media (Liu et al., 2020). These explanations reflect the profession's aetiological understanding of MDD.

Recent research, overwhelmingly focused within the West, indicates that queers have a significantly higher likelihood of being diagnosed with MDD than their non-queer counterparts (Borgogna et al., 2019; Hall, 2018; Rothblum, 2020; Wilson & Cariola, 2020). This fact is widely recognised by queer rights and community organisations and in everyday discourse (RainbowYouth, 2021; The Trevor Project, 2021). Precise rates vary between particular identities, but LGBTQIA+ people are more likely to be diagnosed with MDD than cisgender and heterosexual people (Borgogna et al., 2019), with non-cisgender people having the highest likelihood of experiencing depression (Borgogna et al., 2019; Steele et al., 2017). These rates are higher again in racial and ethnic minority LGBTQIA+ people (Borgogna et al., 2019; Velez et al., 2017). This higher incidence of depression is typically explained according to minority stress—the notion that marginalised social groups experience greater exposure to social stressors such as discrimination, harassment and isolation, in tandem with less secure social support systems and internalised mental distress (Borgogna et al., 2019; Hall, 2018; Rothblum, 2020; Steele et al., 2017; Wilson & Cariola, 2020).

A critical account of (queer) depression

Critical scholars have remained sceptical of psychiatry's explanations for increasing depression rates. As outlined, psychiatry claims that rising MDD rates are attributable to either scientific advancements or a failure of biopsychic coping mechanisms in the face of unprecedented social changes (Horwitz & Wakefield, 2007; Liu et al., 2020). These explanations can both be called into question, especially when considering, as previously noted, that happiness is currently compulsory. First, in tracking the evolution of depression prior to its first appearance as MDD in the DSM-III (American Psychiatric Association, 1980), it becomes increasingly evident that scientific knowledge of MDD has not advanced so much as its definition has been broadened (Dowrick & Frances, 2013; Horwitz et al., 2017; Horwitz & Wakefield, 2007; Lawlor, 2012). MDD rates are not increasing, but sadness—which can be expected given the sufferer's circumstances and experiences (such as someone experiencing oppression)—is being increasingly captured within its scope. Second, if MDD *is* an endogenous illness curable through psychiatric intervention (American Psychiatric Association, 2013), then it should follow both that expectable responses to social stressors would not result in a diagnosis *and* that MDD diagnoses should be in decline. Again, it appears that expectable sadness is being treated as MDD. These issues are particularly notable given the association between queerness and sadness, and high queer depression rates.

Sadness in the DSM

As outlined above, depression first appeared as MDD in the DSM-III (American Psychiatric Association, 1980). Given that the production of the DSM-III was primarily spurred by the APA's desire to rid itself of a reliability and validity crisis plaguing it since the first edition of the DSM, the third edition of the publication has consistently piqued the interest of scholars whose focus is on sadness (Dowrick & Frances, 2013; Horwitz & Wakefield, 2007; Kirk & Kutchins, 1992; Whitaker & Cosgrove, 2015). Upon publication, the APA presented the DSM-III as a significant scientific breakthrough. At no other point in history, the APA touted, had there been such scientifically sound psychiatric knowledge of mental disorders (Kirk & Kutchins, 1992; Whitaker & Cosgrove, 2015). With some emergent validity issues dismissed by the notion that validity would come through practice, the DSM-III became an immediate bestseller (Kirk & Kutchins, 1992; Whitaker & Cosgrove, 2015). However, there remained a significant and less acknowledged issue with the DSM-III: although its reliability scores represented a marked improvement upon the DSM-II, this did not owe to actual greater reliability but statistical manipulation wherein the score threshold for satisfactory

reliability was considerably lowered (Whitaker & Cosgrove, 2015). Put simply, psychiatry, no closer to having scientifically confirmed the existence of MDD, manufactured its prevalence through statistics.

MDD's appearance represented a notable change in the treatment of sadness by psychiatry. Effectively, in seeking to improve reliability, the APA collated symptoms that had previously constituted two separate diagnoses (Dowrick & Frances, 2013; Horwitz & Wakefield, 2007). Studies of historical medical knowledge demonstrate that practitioners understood that experiences of sadness must always be contextualised according to the patient's life. Unless it persisted for an exceptionally long time or manifested as physically dangerous, sadness was not a medical event (Horwitz et al., 2017; Horwitz & Wakefield, 2007; Lawlor, 2012). This knowledge is reflected in both the DSM-I and DSM-II, where sadness takes one of two primary forms: reactive depression, the onset of mild depressive symptoms after a notable loss or stressful life event, or melancholia, a severe, seemingly reasonless and endangering experience of sadness (Dowrick & Frances, 2013; Horwitz et al., 2017; Horwitz & Wakefield, 2007; Lawlor, 2012). Only melancholia required psychiatric treatment (American Psychiatric Association, 1952, 1968). In other words, it was recognised that sadness was often expected and only sometimes pathological, and that diagnosis and treatment required contextualising the sadness (Dowrick & Frances, 2013; Horwitz et al., 2017; Horwitz & Wakefield, 2007; Lawlor, 2012). By combining these different diagnoses of sadness within MDD, the DSM-III effectively erased the differentiation between expected and pathological sadness. Except for a clause noting bereavement as firmly exclusionary, all instructions to consider context when diagnosing an experience of sadness had been removed from the DSM-III (Dowrick & Frances, 2013; Horwitz et al., 2017; Horwitz & Wakefield, 2007; Lawlor, 2012).

Definitional broadening of MDD is also observable in the DSM-IV (American Psychiatric Association, 1994) and the DSM-5 (American Psychiatric Association, 2013), which parallel the time span in which MDD diagnoses have rapidly increased and happiness has become compulsory. In the DSM-IV, bereavement no longer *always* precluded an MDD diagnosis. Instead, the expectable sadness experienced after bereavement was considered abnormal if it persisted for longer than two months after the event or was overly severe (Horwitz & Wakefield, 2007; Lawlor, 2012). In the DSM-5, despite replacing this with "responses to a significant loss", not limited to but including bereavement (American Psychiatric Association, 2013, p. 161), the 'normal' window for resultant sadness was reduced to two weeks and it had to be be milder again. Even though the DSM-5 includes measures against false positives like having to meet five of nine criteria for an MDD diagnosis, as Horwitz & Wakefield (2007) and Horwitz et al. (2017) point out, they are so broad that expectable sadness often meets these requirements. Thus, the DSM-5 widened the definition of and decontextualised MDD further (Dowrick & Frances, 2013; Horwitz et al., 2017). Additionally, Dowrick and Frances (2013) point out that depression diagnoses in Western psychiatric practice are implicitly influenced by a cultural import placed on happiness and by restrictions on which negative emotions are considered normal. To explain the phenomenon of turning expectable, socially induced sadness into a medical event, critical scholars point us to the concept of medicalisation, which in turn can be connected to compulsory happiness.

The medicalisation of (queer) sadness

Medicalisation is the "process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders" (Conrad, 1992, p. 209). As Conrad (2007) notes, medicalisation is a problem of definition, the making medical of features of social life through their being defined and understood in medical language and requiring treatment through medical practice. As noted earlier, homosexuality is perhaps the most cited example of medicalisation, not least because homosexuality also represents a rare instance of *de*medicalisation. Crucially, such an example further illuminates that the

medicalisation process is typically worked upon by instances of social deviance, making deviance 'curable' through medical discourse (Busfield, 2017).

For Foucault (1978, 2000), medicalisation is affected through biopower, producing a population that understands itself and its experiences in medical terms. Like the production of the happy subject outlined earlier, medicalisation functions in the interest of power because the population thinks and acts according to the discourse as if these interests were their own (Foucault, 1978, 2000). This conception has been contested because it implies that the extension of medicine into social life is never legitimate nor good, and that it assumes a passive recipient population (see, for example, Abraham, 2010; Parens, 2013; Rose, 2007). However, although not every instance of medicalisation is invalid or oppressive, some are. Likewise, medicalisation does not necessitate nor assume passive recipients (Busfield, 2017). Indeed, this article examines how resistance against medicalisation does not preclude it happening. As Busfield (2017) points out, these criticisms can dismiss the value of careful and specific analyses of medicalisation.

Here, we return to Conrad (2007), who argues that medicalisation is a problem of definition, and Foucault (1978, 2000), who enables the understanding that medicalisation occurs through using scientific discourse to produce governable populations. Accordingly, expectable sadness has been medicalised, so rising MDD rates are attributable to sadness being rendered endogenous and abnormal through psychiatry (Horwitz & Wakefield, 2007). The medicalisation of expectable sadness would seem to function in the interest of compulsory happiness. Queer lives make this process especially salient because they are connected to sadness and are therefore antithetical to compulsory happiness.

Queer lives are often framed in terms of sadness, loneliness and loss (Ahmed, 2010). This pattern is consistent across almost every discourse that queerness encounters. Ahmed (2010) and Love (2007, 2009) point to many examples: to be queer is to have a genealogy of loss defined by the HIV/AIDS crisis, earlier medical mistreatment and criminalisation of queerness, a history of forbidden loves captured in film and literature, to grieve expected life paths revolving around love, family and cultural participation, and to be hated as evidenced in news and law. These flow into the quotidian, visible in timeless responses to a coming out such as "I just want you to be happy". Psychiatry's understanding of queerness as sadness is visible, for example, in Husain-Krautter's (2017) case study wherein a patient's queerness becomes a symptom that validates their MDD diagnosis. What is articulated here is a widely possessed and reiterated knowledge of queerness as effectively synonymous with sadness.

Perhaps expectedly, then, and as noted, queer people are far more likely to be diagnosed with MDD than non-queer people (Borgogna et al., 2019; Hall, 2018; Rothblum, 2020; Steele et al., 2017; Wilson & Cariola, 2020). However, it would be foolish to argue that queer sadness is not connected to systemic oppression and so could not be ameliorated by restructuring the social order. Queer theory illustrates how the social order is explicitly structured to oppress queers because queerness represents an abnormality that threatens it, and that this naturally causes sadness over the denial of one's existence, basic rights and desires and attempts to alter these to become normal (Halberstam, 1993; Love, 2007, 2009; Sedgwick, 2003; Stryker, 1994). Likewise, research indicates strong links between queer experiences of structural and interpersonal discrimination and oppression and sadness, considering broad factors like systemic violence and the particular experience of this by racialised queers, alongside narrower factors such as marginalised groups tending to be socially isolated (Borgogna et al., 2019; Hall, 2018; Rothblum, 2020; Steele et al., 2017; Velez et al., 2017; Wilson & Cariola, 2020). In everyday discourse, too, there is understanding based on lived experiences that queerness causes sadness because queers are a minority social group (RainbowYouth, 2021; The Trevor Project, 2021). Each of these sources of knowledge indicates some recognition of a connection between queerness and sadness caused by the abnormal or marginalised social position of queerness, and that this sadness is an expected response to social stressors—that queer sadness is social rather than inherently clinical.

Here, medicalisation of expectable sadness is visible specifically as applied to queer sadness. Socially induced queer sadness is being diagnosed as MDD, a supposedly endogenous disease. This phenomenon is similar to other uses of depression diagnoses against marginalised groups, including women. Feminist scholars point to the historic institutionalisation of women unhappy with their social roles, and the more recent over-diagnosis of depression in women as compared with men because their experiences with gender oppression and expectations can cause sadness which is then medicalised as abnormal (Neitzke, 2016; Stoppard, 2000; Ussher, 2011). Furthermore, as Beauboeuf-Lafontant (2007) notes, Black women in particular, being also subject to racialised social expectations and experiences, are uniquely pathologised through discourses of 'strength' which can cause 'depression' in those who cannot meet such a standard. Therefore, as Neitzke (2016, p. 70) writes, "depression should be understood in terms of power and oppression."

Depression, especially amongst marginalised groups, is evidently understood as social within multiple realms. However, the conventional response to disproportionate queer diagnoses is to advocate for better access to mental healthcare rather than an interrogation of how the social world is structured (Ahmed, 2010; Anand, 2014), something that queer theory has neglected to do but has the capacity for (Diamond, 2018; Kirby, 2014; LeFrançois & Diamond, 2014; Pilling, 2022). Although psychiatrists argue that decontextualising sadness is to offer anyone "the same careful [psychiatric] attention that any person suffering from major depressive disorder deserves" (Zisook et al., 2013, p. 386), there is evidence that an MDD diagnosis does not increase access to help (Friedman, 2012). These responses reify and demonstrate an interpellation of psychiatric knowledge into everyday discourse, where queer sadness becomes medicalised, internal and curable through psychiatric intervention.

This contradiction returns us to compulsory happiness: if an MDD diagnosis does not equal receipt of healthcare, perhaps requiring subjects to understand themselves in psychiatric terms is to constitute a population whose oppression is participatory and subtle (Foucault, 2007). This argument appears to be increasingly convincing when the medicalisation of normal sadness is observed as having occurred in parallel to happiness becoming a compulsory, normalising process intertwined with power and driven through psychiatry. Although Horwitz and Wakefield (2007) and Horwitz et al. (2017) argue that the reason behind the medicalisation of sadness is the self-interested expansion of the psychiatric project, they fail to consider a second important tenet of medicalisation—that it typically affects behaviour considered to be socially deviant (Busfield, 2017), like queerness. Returning to the notion that queerness connects to sadness—a double abnormality incompatible with compulsory happiness—it becomes evident that psychiatric knowledge, functioning on the binary categorisations of ab/normal, can be used to oppress queers by curing their sadness.

Queer oppression through normalising happiness

The ascription of psychiatric normality to happiness enables psychiatry to continue its dominance over queerness even if queerness itself has been formally adjudicated normal. Queer theory makes clear that the happiness that has become compulsory is cisheteronormative and that sadness is inherently queer, particularly insofar as it has political use (Ahmed, 2010; Love, 2007, 2009). As such, compulsory happiness as a normalising process driven by psychiatry serves the double function of curing sadness and queerness. Curing queerness is necessary because it represents abnormality and sadness, making it a threat to the project of constituting a governable, happy population. Thus, because it has been broadened to include expectable queer sadness, MDD is revealed as a diagnosis through which queerness remains oppressed.

Queer theorists have long considered experiences of negative affect as woven into queer being, an instinctive response to the injustice of the social world (Ahmed, 2010; Halberstam, 1993; Love, 2007, 2009; Munt, 2007; Sedgwick, 2003; Stryker, 1994). However, in contrast to psychiatry and everyday discourse

where this queer sadness is seen as (necessarily) curable through psychiatric intervention, queer scholars use queer sadness to locate flaws in the organisation of the social world and agitate for political action. Halberstam (1993) and Stryker (1994) write about the experience of sadness due to one's social position morphing into anger and being nursed for political motivation. Sedgwick (2003) and Munt (2007) discuss how being shamed for being queer, or the shame of being queer, naturally causes sadness, but reappropriating shame can fuel political action. Notably, none of these theorists articulate any desire or necessity to become happy.

In discussing sadness directly, both Love (2007, 2009) and Ahmed (2010) make a particularly striking observation about the assumption that being queer destines one for sadness: if unhappiness is at the core of queerness, then happiness must be cisheteronormative. Once again, take Ahmed's (2010) example of the classic response to a coming out: "I just want you to be happy." There is an immediate and instinctive correlation made between the presence of queerness and sadness—the potential for it or a history of it—that should not necessarily be implied by the preceding statement of "I am queer", as well as a general mandate to become happy. Moreover, a second implication here is that the absence of queerness would equally rid one of some sadness or the likelihood of experiencing it. Even if the responder is affirming, their mentioning happiness indicates an implicit recognition that queerness has the potential to cause sadness, alongside rearticulating happiness as a goal.

This association presents two impossible paths to happiness for queers (Ahmed, 2010; Love, 2007). First, a queer can be *happily queer*, but this will usually, under current social conditions, cause another's unhappiness—be they, for instance, the disapproving parent or the evangelical neighbour—and in turn can make the queer unhappy again. Alternatively, a queer can become *happy*, except happiness does not equal queer happiness, but rather a 'normal' cisheteronormative happiness imaged after the good, obedient cisheterosexual subject. (For a discussion of homonormativity, see Duggan, 2002). Queer sadness, then, results from being trapped at this intersection.

If queerness and sadness are entwined and equally abnormal, happiness is a norm *and* a normalising process. *To become happy is to become non-queer*. Therefore, to be happily queer is to resist compulsory happiness by resting happily within unhappiness (Ahmed, 2010; Love, 2007), disturbing the production of a happy, governable population. This happiness is firmly queer because it is found outside the normal sites for doing so and is the happiness queers find in queer spaces and in the rejection of cisheteronormativity (Ahmed, 2010). In other words, queer sadness is political in and of itself, rendering queer subjectivity an inherent threat to the normalising process of compulsory happiness. However, this opportunity for resistance can only be observed when queer sadness is considered in context. The medicalisation of queer sadness via psychiatry, then, functions in the interest of compulsory happiness by removing this context, rendering it endogenous. The internalising of queer sadness, a site for resisting normativity and carving out a liveable and happily queer life, enables its 'cure'. Through medicalising queer sadness, queerness is once again made pathological. Here, it becomes evident that ascribing psychiatric normality to happiness enables the continued oppression of queerness through psychiatry. Therefore, so long as psychiatric knowledge is grounded in the binary categorisations of ab/normality, psychiatry can be used as an extension of biopower which oppresses queerness.

Conclusion

This article has demonstrated that the compulsorily happy subject cannot also be queer, and thus queerness must be cured to produce a governable population through compulsory happiness. In understanding biopower as harnessing politics to bodies through discourses of scientific ab/normality with the aim of constituting governable populations, it becomes clear that psychiatry functions as the site of producing such scientific discourse. A governable population is produced through its ascription of normality to happiness

and abnormality to sadness, which is treatable through psychiatry. Medicalising expectable sadness, synonymous with being queer, conceals the social context needed to reveal the subtle function of anti-queer power here, and how queerness inherently resists compulsory happiness as a normalising process. So long as psychiatric knowledge functions according to the binary categorisations of ab/normal, psychiatry will be able to oppress queers and queerness through indirect diagnoses such as MDD. Simply shifting the *explicit* label of psychiatric abnormality away from queerness has not eliminated the harmful uses of that categorisation (Diamond, 2018; Kirby, 2014; LeFrançois & Diamond, 2014; Pilling, 2022).

Therefore, a queer critique of psychiatric knowledge demands closer interrogation and challenging of the ab/normal binary guiding diagnoses of MDD in queer people. As I have argued, the mechanism that makes this medicalisation problematic is the decontextualisation of queer sadness, the intentional removal of social factors and the concealing of the role of power in structuring psychiatric knowledge and its uses. Consequently, mental health practitioners have a responsibility to deliver contextualised help to sad queers and understand that an MDD diagnosis and psychiatric embrace may be more harmful than redirecting queers to community-led social and material support groups. These non-pathologising resources are consistent with recommendations of professionals working with high-risk queer youth (see, for example, Hall, 2018), and equip queers for dealing with the immediate effects of their socially induced sadness alongside tools through which to understand it in a political sense. Likewise, queers should consider the root of their sadness themselves before turning to psychiatry for answers and assistance. (This is while also noting that the dominance of psychiatry over discourses of sadness makes this difficult, and that the organisation of Western systems often requires psychiatric diagnoses in order for queers to access social, economic and medical support.)

Furthermore, a queer critique of psychiatric knowledge that uses depression as a case study owes a debt to feminist scholarship on how depression has been used against women, and particularly Black women, by gendered power structures (Beauboeuf-Lafontant, 2007; Lafrance, 2014; Stoppard, 2000; Ussher, 2011). Although regrettably outside this article's scope, the utilisation of such scholarship can create a base from which more specific queer of colour and queer feminist critiques of the interaction between queerness, sadness and psychiatry might be launched. It also reiterates that queer scholars working in the space of critical mental health must pay attention to global discourses like compulsory happiness in which psychiatry may be present, shifting away from tracking queerness's explicit mention in the DSM to monitoring other psychiatric 'abnormalities' commonly diagnosed in queer people. Demonstrating that the ab/normal binary that psychiatry rests upon is constructed in the interests of anti-queer power, and offering queers accessible alternatives for using rather than curing sadness, remains necessary to ensure that psychiatry can no longer be used to oppress queerness.

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