Psychic policing: Surveillance and disease mongering in public education

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Abstract:

The policing of students' psyches has become institutionalized into education: a number of systems and structures have been put in place to identify, investigate, and intervene on individuals' 'bizarre and unusual' behavior in the name of greater 'school safety'. In this presentation, I consider if, how, and with what implications these circuits enact a form of 'disease-mongering'. Specifically, I shall present the surveillance materials of the 'Behavioral Intervention Team' of a college campus in New York City; one that explicitly draws upon the nationwide Homeland Security campaign, 'If You See Something, Say Something'. In doing so I shall open a discussion about whether 'securitization' might be a useful theoretical lens to explore practices and politics of disease mongering in a post-9/11 U.S. context.

Transcript:

In November last year, Adam Lanza walked into Sandy Hook Elementary School and shot 27 people. Described last week on NPR as, "to schools like 9/11 was to airports," this shooting has triggered another call for increased surveillance and security within schools. And, following a

long (contested, and politically convenient) tradition of making individuals' psyches accountable for violence, psychiatric diagnoses and interventions have become central to these practices. The ghosts of Sandy Hook have materialized into the Obama administration allocating one and a half billion dollars toward the identification of youth "at-risk" for mental illness.

This attention resonates with the December call by Dr Oz on CNN's Piers Morgan Tonight that, "We need a Homeland Security approach to mental illness". Notably given as an interruption to the interviewer's point about gun control, Dr Oz argued that "guns we can debate over and I'll let the politicians do that" before going on to complain that (unlike heart surgeons) psychiatrists' "hands are bound" as "so many rules govern what they're allowed to do [that] it makes it almost impossible for them to provide broad scale support".

In this talk, I would like to raise the possibility that this "Homeland Security approach to mental illness" may equate to disease mongering. This disturbing assertion has emerged from my ongoing projects – both academic and activist – regarding how, and with what implications, psychiatric diagnoses intersect with the politics of terror that have come to dominate our post-9/11 US context. In essence, my work considers the intersection of medicalization and securitization. I believe that the burgeoning practice-cum-industry of psychic policing in schools offers a useful analytic site to explore these dynamics, and to push our critique (our outrage, and our *urgency*) around the business of selling sickness.

First up then, let's turn to this phrase itself: what exactly is "disease mongering"? According to the online Oxford dictionary, *monger* denotes someone who deals in or trades a specified commodity, and/or who promotes a specified activity, situation or feeling, especially one that is undesirable or discreditable. It comes from the Old English, *mangere*, from the Germanic *mangian* 'to traffic', based on Latin *mango* 'dealer'. So, can the Department of

Homeland Security be said to deal in, trade, promote, or traffic, disease? To answer this question, one needs to gaze toward the circulation of psychiatric diagnoses with/in national security measures.

And for this, I turn to school shootings. The Virginia Tech shooting in 2007 marked what Randazzo and Cameron call a "critical turning point" in higher education; it triggered an "intense focus" on campus security, including the development and proliferation of practices to identify, investigate, evaluate, and intervene on "at-risk" students in the name of violence prevention and school safety. Originating in a curious post-Columbine collaboration between the US Secret Service and the Department of Education and taken up by a dozen or so schools, after the Virginia Tech shooting these practices – known as "Threat Assessment" – spread to 80 percent of colleges and universities across the country.

Skip forward a few years, and "the classroom", as Reiss argues, "is in danger of becoming "a barely acknowledged zone of quasi-psychiatric surveillance, risk assessment, and preventative intervention". For example, in Fall 2011, I attended an orientation for new faculty at a public university in New York City. The first presentation for the day was from the campus "Behavioral Intervention Team" (or "BIT") telling attendees to be constantly on the look out for students showing "bizarre and unusual behavior", and to report any such thing for investigation and intervention. Taking a look at their homepage, objectives, and surveilled behaviors, four things stand out to me: First, is the immediate assumption that school shootings emerge from mental health issues; Second, is that the intervention emphasized is mandated, and psychological or medical; Third, that the BIT aims to mitigate risk and facilitate early intervention; and Fourth, that an overarching goal of these measures is to protect campus safety.

These practices can be traced to NaBITA, an association that provides support and

professional development for BITs, with more than 800 active members and more than 180 model policies, training tools, templates, and other BIT-related materials. While proudly "independent and not-for-profit", it's of note that NaBITA's upcoming 3-day training in Dallas costs $1500 a person; that their "partners" – including for-profit companies that produce administration software, training videos, assessment tools, and consultancy – have to pay a fee to be listed on the NaBITA website, and in doing so have the opportunity to receive the "NaBITA Endorsement of Excellence"; and that a standard campus NaBITA membership costs $639 per year (times 800 members, this means that the association brings in half a million dollars annually through dues alone.) What does all this have to do with anything? At the very least: it suggests that psychic policing is a burgeoning industry of expertise and technologies. Indeed, according to NaBITA, one of the elements that distinguishes the BIT model and makes it particularly "advanced", is its capacity for, and emphasis on, intensive administration for the heavily coordinated, long-term tracking of risky individuals.

The second element that NaBITA claims distinguishes the BIT model and makes it particularly advanced is its focus on identifying threats *before* they manifest. This emphasis on *risk* also dominates contemporary mental health. "Early intervention" for example, was named in 2009 by the Editor in Chief of *Current Psychiatry* as one of the top six trends in psychiatric practice. And we can see this in the DSM-5. While at the last minute moved to Section III for further study, Attenuated Psychosis Syndrome uses what are called "Ultra High Risk" criteria to isolate a cluster of symptoms that are hoped to eventually identify and intervene on people "at significantly increased *risk* of conversion to a full-blown psychotic disorder".

Elsewhere I have come to refer to these dynamics as "synaptic peace-keeping", arguing that the diagnosing and drugging of people based on their *potential* madness is a biopolitical

apparatus that mimics Agamben's observation that our post 9/11 US political climate is characterized by an increasing move toward security, or "regulating disorder", alongside and beyond discipline, or "producing order". Following Foucault, such moves are enacted through mechanisms (including, I believe, contemporary psychiatry) that work to manage, contain, and/or prevent the unexpected and the threatening – in effect: psy technologies of security patrol our borders of "good citizenship" for risk, in the name of protection, safety, and… freedom.

These linkages between psychiatry and post 9/11 politics are not entirely new. In remarks given at the University of New Mexico in April, 2002, then President George W. Bush launched the US New Freedom Commission on Mental Health by calling upon "soldiers in the armies of compassion" who are committed to "fighting evil" to "make America a welcoming place for people with disabilities". The Commission went on to recommended TeenScreen – a program of "mental health check-ups" to identify and intervene on young people at risk of becoming suicidal, which (while recently withdrawn) was soon implemented in primary care and high school settings across the US. Citing the US military's "liberation" of the Baghdad mad, Howell too argues that post 9/11 the "securitization of medicine" and the "medicalization of security" are emerging with/in contemporary global politics via a variety of techniques to contain and manage "the ill, the contagious, or the disordered".

Arguably then, politics of terror contribute to the affective and discursive backdrop of psychic policing in schools. Indeed, several months after the new faculty orientation mentioned above, all university personnel were sent an email flagged with "high importance" that listed what "bizarre and unusual" behavior faculty should be on the look out for, and closed with the well-known slogan from the Homeland Security campaign, "If you see something, say something". In addition, the *Report to the President* on the Virginia Tech shootings was co-

authored by the then US Attorney General, Alberto Gonzales – whose tenure included warrantless wiretapping and the authorization of torture. As Reiss points out this Report – notably the one that pushed for, and succeeded in, the widespread adoption of Threat Assessment on college campuses – "reads as a somewhat more chilling document when viewed in the context of national security more broadly".

Perhaps most significant for our purposes in this room, however, is that the creation of an at-risk population is also the creation of a market for technologies of classification, surveillance, and intervention. For example, in it's January counsel to US Secretary of Homeland Security Janet Napolitano on Sandy Hook, the influential Aspen Homeland Security Group argued that: it's individuals with mental illness who are not "properly treated" that pose the greatest threat of gun violence; and that while one in five children are affected by some mental health issue, it often takes eight to 10 years for them to be "properly diagnosed". Drawing upon the work of the 9/11 Commission, they thus advocate for the use of security measures, public education campaigns, *and* "validators" (including clergy members, celebrities and grassroots organizations) to "broadcast … mental health indicators" as a means to protect society from potential violence.

Sound familiar? Psychic policing is ripe for the medical-industrial *and* security-industrial complexes. Especially because it is based on *potential*. As Rose argues, in prevention efforts, "what is treated by doctors and drugs … is not disease but the almost infinitely expandable and malleable empire of risk". Massumi too documents how pre-emptive practices mean that threat can never be falsified, thereby propelling people into long-term, self-perpetuating, interventions. Interventions that reproduce the very fears and insecurities that fertilizes their execution in the first place. This profitability is maximized if the at-risk population is considered not only treatable, but also incurable. Hence the benefit in mobilizing discourses that school shootings

come from a chronic, biological illness: if people are forever potentially mad, then they require life-long preventative treatment. All this, then, is what Clough would call the "bio-value of risk" generated and circulated through the "Homeland Security approach to mental illness". As Rose argues, the "combination of the idea of susceptibility, the emergent technologies of screening and the promise of preventive medical intercession with drugs is potent".

Thus risk is stretchy, loopy, and profitable. Indeed Elliot argues that we are witnessing new industries of risk that make "millions of dollars … through product development, advertising, and market research … construct new problems and market new solutions for risk-fighting individual agents". It follows, he continues, that this "commodification of risk" has become "a kind of safe house for myths, fantasies, fiction and lies". Otherwise known, perhaps, as "disease-mongering"… And so, it should come as no surprise that anti-psychotic drugs have been explicitly named as the "treatment of choice" for the aforementioned Ultra High Risk population constructed through the DSM-5's Attenuated Psychosis Syndrome. A flight of studies have been examining the efficacy of prophylaxis (or long-term, preventative, drug treatment) for people in the "pre-psychosis" period. As Yung and colleagues argue, "for this ultra high risk group, early introduction of neuroleptic medication may also be warranted, especially if attenuated psychotic symptoms worsen or functioning deteriorates. This may delay, minimize the impact of, or even prevent psychosis".

This emphasis on drug treatment rings with the presence of the pharmaceutical industry throughout efforts to predict and prevent potential psychosis. The Ultra High Risk studies, for example (including those done by Yung) receive considerable funding from a number of drug companies – most especially Janssen Pharmaceuticals, Astra-Zeneca, Bristol-Meyers Squibb and Eli Lilly – all of which have a vested interest in the creation and/or inflation of markets for their

anti-psychotic products. In addition, seven out the 11 Psychotic Disorders Workgroup members for the DSM-5 had financial ties to the industry. And advocates for the Attenuated Psychosis Syndrome diagnosis in part argued for its inclusion because it would *facilitate* large studies of pharmaceutical treatment and programs of pharmaceutical development.

Zooming back out: I hope here to have argued that alongside our more established analyses of disease-mongering vis-à-vis medicalization, securitization offers an important theoretical lens for thinking through the practices and politics of selling sickness in a post 9/11 US context. Psychiatric diagnoses and treatments are being peddled through a medico-security industry in the name of protection. The freedom of some, dependent on the "unfreedom" of others; "Others" that – especially under politics of terror – are coded as threats in ways that are deeply raced, nation-ed, classed, gendered. To resist disease mongering is thus to join with broader, contemporary projects that not only refuse the corporate, imperial occupation of our psyches, bodies, and lives, but also our incessant incorporation into regimes of "un-seeing". That is, those elements of medicine and security that draw our compassionate and critical gaze away from systemic injustices; encouraging us, for example, to locate problems and solutions in broken brains rather than sick social structures. Which is why I strongly believe that our work here, today must be witnessed as part of a collective and determined struggle; one that is ever-more needed *and* supported, during (what Fine calls) these "revolting, revolting" times of global repression *and* unrest.

References:

Agamben, G. (2001). On Security and Terror. *Frankfurter Allgemeine Zeitung, September 20th, 219*: 45. Translated by Soenke Zehle.

Clough, P., & Willse. C. (2010). Gendered security/national security: Political branding and population racism. *Social Text, 28*(4): 45-63

Elliot, A. (2002). Beck's sociology of risk: A critical assessment. *Sociology, 36*: 293-315.

Fine, M. (2012). Troubling calls for evidence: A critical race, class and gender analysis of whose evidence counts. *Feminism & Psychology, 22(1)*: 3–19.

Foucault, M. (1978). *The History of Sexuality, Vol. 1: An Introduction*. New York: Random House.

Foucault, M. (2003). *Society Must Be Defended: Lectures at the Collège de France, 1975-76*. New York: Picador.

Foucault, M. (2009). *Security, Territory, Population: Lectures at the College de France, 1977 – 1978*. New York, NY: Picador.

Grewal, I. (2003). Transnational America: Race, gender, and citizenship after 9/11. *Social Identities,* 9(4): 535-561.

Howell, A. (2010). Sovereignty, security, psychiatry: Liberation and the failure of mental health governance in Iraq. *Security Dialogue, 41*: 347-367.

Liebert, R. (2010). Synaptic peace-keeping: Of bipolar and securitization. *Women's Studies Quarterly, 38:* 325–342.

Massumi, B. (2010). The future birth of the affective fact: The political ontology of threat. In M. Gregg & G. Seigworth (Eds), *The Affect Theory Reader*. London: Duke University Press.

Nasrallah, H. (2009, February). Psychiatry's future is here. Here are 6 trends that will affect your practice. *Current Psychiatry, 8(2)*.

Psychotic Disorders Work Group (2012). Rationale: Attenuated psychosis syndrome (proposed for section III of the DSM-5). *DSM-5 Development*. American Psychiatric Association.

dsm5.org/proposedRevisions/Pages/proposedrevision.aspx?rid=412#. Acessed August 21st, 2012.

Randazzo, M., & Cameron, K. (2012). From presidential protection to campus security: A brief history of threat assessment in North American Schools and Colleges. *Journal of College Student Psychotherapy, 26*: 277-290.

Reiss, B. (2010). Madness after Virginia Tech. *Social Text, 28* (4): 25-44.

Rose, N. (2007). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. New Jersey: Princeton University Press.

Thompson, A., Nelson, B., & Yung, A. (2010). Predictive validity of clinical variables in the 'at risk' for psychosis population: International comparison with results from the North American Prodrome Longitudinal Study. *Schizophrenia Research, 126*(1-3): 51-57.

Woods, S., Walsh, B., Saksa, J., & McGlashan, T. (2010). The case for including attenuated psychotic symptoms syndrome in DSM-5 as a psychosis risk syndrome. *Schizophrenia Research, 123*(2-3): 199-207.

Yung, A.R., Phillips, L.J., Yuen, H.P., McGorry, P.D. (2004). Risk factors for psychosis in an ultra high-risk group: Psychopathology and clinical features. *Schizophrenia Research, 67*: 131-142.