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## There's a Pill for That: Bad Pharmaceutical Scaffolding and Psychiatrization

**Abstract:** This paper brings the concept of affective scaffolding to bear on a much-debated controversy: the expanding use of psychiatric medications to treat an increasingly broad range of human discontents. ‘Affective scaffolding’ refers to the variety of ways that agents engage with, recruit or modify their environments to actively shape their emotions, moods, or other affective phenomena. Psychiatric drugs are designed, marketed, and prescribed as technologies that have the special power to transform affective life by intervening on the pathological underpinnings of distress and suffering to change how we feel. The paper develops an account of psychiatric drug use as affective scaffolding and examines how psychiatrization – the complex social process through which psychiatry comes to influence more and more domains of human life – impacts this form of scaffolding. I propose that psychiatrization influences affective scaffolding by biasing individuals toward psychiatric drugs to manage an expanding array of affective experiences. In some cases, I argue, this results in *bad pharmaceutical scaffolding*. Bad pharmaceutical scaffolding emerges when an agent is influenced to select and rely upon psychiatric drugs in attempts to exert individual control over distress and suffering where (1) at least some of the key determinants of these affective experiences are properties of the agent’s environment, in contrast to, in a strict sense, properties internal to the person, and (2) pharmaceutical scaffolding obviates the need for or displaces other non-pharmaceutical options that would better serve the agent's affective needs and interests.

**Keywords:** affective scaffolding; situated affectivity; psychiatrization; psychiatric drugs; psychopharmaceuticals; psychiatry

### 1. Introduction

Drugs are a powerful tool for realizing all sorts of affective experiences. Drugs allow us to radically transform how we feel in myriad ways, and drugs, whether prescribed or self-selected without formal medical guidance, are widely and routinely relied upon to do just that. Be it drinking caffeine for a morning mood boost, relying on a glass of wine after work to alleviate stress, or taking a daily prescription anxiolytic to manage anxiety, a whole range of substances that fall under the umbrella label of ‘psychoactive drugs’ can act as resources for strategically and habitually managing affectivity. Drugs are now pervasive elements of the environment that we draw on to modulate our affective states. The thought developed in this paper is that a situated theory of drug use – in particular, one in which drug use is understood as “affective scaffolding” – can help us to better understand the psychological risks of psychiatric medications. Affective scaffolding refers to the variety of ways that we engage with or structure the environment in order to alter our affective lives – to enhance, suppress, regulate, or induce emotions, or otherwise transform affectivity

(Colombetti & Krueger, 2015). When we take a hot bath to relax after a stressful day, play video games to access feelings of excitement or accomplishment, cook a meal with friends to enjoy social connection, display art that moves us on our walls, or, as will be the focus of this paper, consume psychoactive drugs for their various effects on our emotions and moods, we are interacting with affective scaffolding.

Scaffolding has predominantly been discussed in the situated affectivity literature, and in the situated cognition literature from which the concept earlier emerges (see e.g., Sterelny, 2010), as a positive mechanism, something that supports or beneficially transforms cognitive and affective states and capacities (Aagaard, 2021). This emphasis on beneficial cases is intuitive, insofar as we tend to seek out scaffolding that augments affectivity and cognition in ways that we desire and that we expect will serve our interests. We might, for instance, use a reminders app on our phone to simplify memory tasks and reduce cognitive demands, and we might put on a favorite playlist to cheer ourselves up when we want to get out of a funk. However, there is also a darker side to scaffolding (Coninx, 2023). As recent research has begun to reveal, scaffolding can go awry and can play a variety of detrimental roles in our lives (e.g., Aagaard, 2021; Coninx, 2023; Krueger et al., 2019; Liao & Huebner, 2021; Slaby, 2016; Spurrett, 2024; Timms & Spurrett, 2023). Scaffolding can, in one way or another, contribute negatively to affective and cognitive dynamics, and come to harm us by, for example, diminishing, abolishing, or distorting cognitive and affective capacities, blunting emotional expression, reducing our ability to achieve our goals, or otherwise transforming cognitive and affective phenomena in ways that obstruct our desires or undermine our interests. For simplicity, I will refer to all of these as instances of “bad scaffolding”. Accordingly, the concept of scaffolding can be understood as in principle neutral, and can be utilized to examine both positive and negative consequences of relying on environmental resources to shape affectivity and cognition. Recognizing this opens up the possibility to use this theoretical device to analyze both beneficial and harmful cases of drug use.

Given that drugs, whether used under formal medical guidance or individually chosen, have the power to alter affectivity in ways that we value, granting us access to all sorts of emotional experiences and regulatory possibilities that may be otherwise out of reach, we can evaluate many effects of drug use as beneficial scaffolding. Nevertheless, despite the beneficial cases, it is clear that relying on drugs to manage our emotions and moods does not only or always benefit us. Cases of drug addiction make this point particularly evident. I have previously argued (Lavalée 2023) that under the influence of particular conditions, like high-stress environments, social isolation and socioeconomic precarity, some people become so dependent upon drug use to manage their emotional lives that this form of affective scaffolding ends up constraining agency through its monopoly over emotion regulation, and contributes to addiction. This then qualifies as one case of bad scaffolding (See also Spurrett, 2023, on cigarettes as hostile scaffolding). In this paper, I explore a different case of bad scaffolding that can result from psychoactive substance use, specifically, psychiatric drug use. Psychiatric drugs can play a crucial role in supporting mental health and may even be life-saving in some cases, but under certain conditions, this scaffolding can be harmful. The paper develops an account of what I will call *bad pharmaceutical scaffolding* by bringing the concept of scaffolding to bear on a much-debated controversy, namely, the expanding use of psychopharmaceuticals to treat an increasingly broad range of human discontents (e.g., Rose, 2006).

Many of us occupy social worlds – in the Global North, and increasingly the Global South – under the effects of what has been called the “psychiatrization of society” (Beeker et al., 2021, 2023, originally coined by Kecmanović, 1983). Psychiatrization refers to a complex social process through which more and more domains of human life come to be seen as “concerns for psychiatry” (Mills, 2015, 217), granting

psychiatry an expanding influence over a growing number of people's lives (Beeker et al., 2021, 2023; Mills, 2014). One key way that psychiatrization manifests is that behaviors, thoughts, and affective phenomena that were previously perceived as outside the domain of psychiatry come to be socially categorized or defined, and accordingly treated, as psychiatric problems.<sup>1</sup> This manifestation of psychiatrization is reflected in the dramatic growth in recent decades of psychopharmaceutical drug use in response to an expanding array of human concerns. The introduction of Prolonged Grief Disorder into the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), for example, is arguably an illustration of psychiatrization (Beeker et al. 2021, 5). Some bereavement processes are now claimed under the jurisdiction of psychiatric classification, and hence, become a legitimized target of psychiatric treatment, including psychopharmaceutical treatment. The argument developed in this paper is that under the effects of psychiatrization, some agents are influenced to select and habitually rely upon psychiatric drugs to try to manage emotional problems that are significantly caused, exacerbated, or sustained by social, material or structural conditions that are largely outside the domain of individual influence, and left unaddressed by the medication. In these cases, psychiatrization validates drug use in such a way that pharmaceutical scaffolding risks excluding or precluding other environmental supports and resources that would better address the agent's affective interests and needs.

The paper proceeds as follows. In section 2, I introduce the concept of affective scaffolding and present the case of psychoactive substances as affective scaffolds. Here I provide a brief overview of my earlier account of affective scaffolding in addiction, as an initial framework for thinking about how drugs as scaffolding can sometimes be harmful under the influence of particular external conditions, and as a comparison case for understanding the distinct kind of bad scaffolding that I will then argue can result from psychiatric drug use. In section 3, I demonstrate how psychiatrization processes influence people to interpret more and more of their emotional problems through the lens of psychiatry, and bias them toward selecting and relying upon pharmaceutical scaffolding as a strategy for managing these affective experiences. In section 4, I characterize bad pharmaceutical scaffolding and briefly discuss two applied cases where bad pharmaceutical scaffolding can emerge: the use of antidepressants to treat postpartum depression; and psychiatric drug treatment as a strategy for responding to the emotional consequences of poverty. Crucially, bad pharmaceutical scaffolding is not best construed as a failure of design or accidental effect of psychiatric drug use; under the influence of psychiatrization, bad pharmaceutical scaffolding can emerge even when psychiatric drugs are used for the very purposes for which they are designed, marketed and prescribed. In short, in societies in which more and more distress is viewed as a problem for psychiatry, psychiatric medications will naturally take an ever more salient role in our efforts to manage our emotions by means of affective scaffolding.<sup>2</sup>

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<sup>1</sup> See Lavalley & Gagné-Julien (2024) for discussion of the effects of psychiatrization on how we experience, understand, and respond to affective phenomena specifically.

<sup>2</sup> It is worth noting that, while this paper focuses on affective scaffolding, which is going to be particularly salient in cases of people taking medications like anxiolytics and antidepressants, a parallel argument could certainly be made in terms of cognitive scaffolding, considering how psychiatric drugs are used, for example, to scaffold attention, focus, memory and so on. Of course many of the experiences and conditions that individuals take psychiatric medications to address involve a significant mood or feeling component, so I take it that affectivity is worth paying attention to in its own right; however, the treatment of bad pharmaceutical scaffolding that I develop here is positioned to also cover harms of pharmaceutical use under the influence of psychiatrization that are not exclusively or primarily in the realm of affectivity.

## 2. Affective scaffolding and drugs

### 2.1. *Affective Scaffolding*

Situated approaches to cognition and affectivity explore, in various ways, how the dynamic interplay between agents and environmental entities contribute to shaping cognitive and affective phenomena. From a situated perspective, cognitive and affective states and capacities are conceived as dependent upon or even co-constituted by aspects of the world external to the individual's mind-brain-body (Coninx & Stephan, 2021; Stephan & Walter, 2020). These approaches can be contrasted with traditional internalist approaches that characterize cognitive and affective phenomena as realized exclusively “inside” the individual. Theories of affective scaffolding have recently emerged and are burgeoning within situated affectivity research, adopting the concept of scaffolding from its earlier articulation in the situated cognition literature (Saarinen, 2020; Stephan & Walter, 2020; Sterelny, 2010). Affective scaffolding describes the variety of ways that agents engage with, recruit or modify their environments to actively shape their emotions, moods, and other affective phenomena (e.g., Saarinen, 2020; Colombetti & Krueger, 2015; Coninx & Stephan, 2021; Fabry, 2023; Krueger et al., 2019; Maiese, 2016).<sup>3</sup>

We interact with and incorporate all sorts of environmental scaffolds. Scaffolds can be, for instance, material (e.g., tools, artifacts, physical spaces), abstract or representational (e.g., a song, a fictional narrative), social (e.g., interactions with non-human animals, other humans, or groups of people), sociotechnological (e.g., smartphone apps, video games, social media platforms), or, most relevant for present purposes, biochemical (e.g., food, drugs). Hence, affective scaffolding can take wide-ranging forms. We can wear a favorite outfit to feel more confident, use a daily meditation app to fortify feelings of calm and compassion, set mood lighting or music to amplify romantic feelings on a date, attend a weekly grief support group, post on social media in pursuit of feelings of validation, or call a friend when feeling lonely. Although affective scaffolding can involve a diversity of environmental entities, the involvement is of a particular kind. Scaffolding refers to a causal interaction between an environmental entity or resource and the agent whose affective states or capacities are changed by actively interacting with this scaffold (Fabry, 2023). As such, scaffolded affectivity depends in part on the characteristics of the scaffold itself; however, in scaffolding relations, as Coninx and Stephan (2021, 43) note, “the environmental entity needs to be more than a mere trigger.” The agent must actively engage with or structure the scaffold. Getting caught in an unexpected rainstorm might induce frustration or delight, depending on the situation, but here the affective response is induced by the environment accidentally, and the agent plays only a passive role. Scaffolded affectivity, then, denotes a relational dynamic, embodied by agent-scaffold interactions; the agent both actively engages with, and is acted upon by the environmental scaffold (Colombetti & Krueger, 2015; Coninx & Stephan, 2021).

While some scaffolds may be recruited arbitrarily, rarely, or perhaps only once, much of the scaffolding that we incorporate into our affective lives involves routine and repetition. We engage with other people, utilize material objects, modify the spaces we occupy, and so on, to influence our feelings in

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<sup>3</sup> As a clarificatory point, many of the issues I raise in this paper regarding scaffolding are also addressed in the niche construction literature; this paper is not concerned with which model (scaffolding, niche construction, or any other, for that matter), is *best* suited for analyzing the case of drug use to alter affectivity, so long as the relevant model emphasizes the dynamic interplay between agent and drug, and how this dynamic is influenced over time by the broader set of environmental conditions. See Coninx (2023) for useful background and discussion of the concept of niche construction.

habitual and ongoing ways, and we develop idiosyncratic patterns of scaffolding interactions, with varying frequency and stability. Accordingly, some forms of scaffolding come to play important, influential, and temporally extended roles in our affective lives. Colombetti and Krueger (2015) propose that the recurrent and habitual aspect of affective scaffolding can be examined by considering the level of *trust* that an agent has in any given scaffolding interaction (see also Sterelny 2010; Coninx & Stephan 2021). Trust, as a dimension of scaffolding, refers to an agent’s “perception of the reliability of a certain environmental resource and of the agent’s access to it” (Colombetti & Krueger 2015, 1160). We tend to rely more regularly and consistently on scaffolding that we trust – that we are confident is available to us and that we think will reliably alter our affective life in expected ways (Colombetti & Krueger 2015). Consequently, over time, highly trusted scaffolds can become increasingly *entrenched* in our habits of scaffolding, coming to play a more prominent and stable role in shaping our affective repertoires (Colombetti and Krueger 2015, 1169). And trust and entrenchment can be mutually reinforcing dimensions of scaffolding; the more entrenched a resource becomes in our habitual patterns of scaffolded activity, the more trustworthy it may be perceived to be (Lavalley 2023, 9).

In addition to identifying differing dimensions of scaffolding, we can analyze different timescales along which scaffolding unfolds (Coninx, 2023; Coninx & Stephan, 2021).<sup>4</sup> Consider two different temporal scales of scaffolding effects within an individual’s life. From a *synchronic* perspective, we can perceive how a scaffolding interaction in the here and now exerts influence on an agent’s occurrent affective condition. Think of a person who puts on their favorite album to lift their current mood, or someone who is angry and calls their best friend to vent. We can also take a more *diachronic* perspective, evaluating how a given form of scaffolding transforms affectivity and shapes affective dynamics and capacities over time, through an agent’s ongoing and repeated reliance upon it. Imagine how regularly attending a grief support group might play a role in shaping the character of a person’s grieving experience in a temporally extended way, for instance, shoring up feelings of ongoing connection with the person who has died, or, over time, cultivating abilities to process and navigate feelings of loss. One and the same scaffolding can, of course, transform affectivity synchronically and contribute to more cumulative diachronic effects. The grief group, for instance, can both support emotional experience and expression in real time during each session, while simultaneously having impacts on affective phenomena and capacities that accrue over months or years.

In many cases, a given form of scaffolding is best conceived as neither inherently beneficial or harmful (Coninx, 2023). One and the same scaffold can benefit an agent when relied on under some conditions, but under other conditions, be harmful. And the benefits and harms of scaffolding may unfold along one timescale, or there may be conflicts of benefit and harm, perceivable only when evaluated along different temporal scales (Coninx 2023). Consider, for example, Krueger and Osler’s (2019) account of how the use of Internet-enabled affective technologies, such as smartphones, as scaffolding can benefit us in manifold ways, but can also harm us over time through our overreliance upon them. They argue that in sociocultural contexts where the Internet occupies an ever expanding role in our lives, we can offload so

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<sup>4</sup> Fabry (2023, 1150) refers to this as the “causal-temporal aspect” of scaffolding, and distinguishes between an ontogenetic timescale and an occurrent timescale. Similarly, von Maur (2021) distinguishes between synchronic-local and diachronic-global perspectives for evaluating situated affectivity. And Coninx and Stephan (2021, 48; elaborated in Coninx 2023) develop additional distinctions, proposing that scaffolding can be analyzed not only from perspectives within an individual agent’s lifespan; we can also analyze how collective modifications of the environment effect (sub)populations across multiple generations, or even over thousands or millions of years.

much of our emotion regulation onto this one environmental resource that we become more vulnerable to emotional dysregulation when it is not readily available.

Recognizing that scaffolding effects emerge along different temporal scales and that beneficial and harmful scaffolding effects are contingent upon contextual factors allows for two interacting ideas to be underscored here. First, scaffolding can be harmful, but in many cases, perhaps typically, the harmfulness takes time to emerge, as a result of a certain temporally extended evolution of the relationship between the agent and the scaffold. Second, where scaffolding involves a harmful descent, the specific trajectory is determined not only by the agent and scaffold interplay itself, but by the way one's broader culturally structured environment influences the evolution of the dynamic interplay over time.

## 2.2. *Drugs as scaffolding*

Psychoactive drugs are commonly used for all sorts of purposes (Müller & Schumann, 2011). Research indicates that one reason many people use psychoactive drugs is to actively transform, alter, or regulate emotions and moods (e.g., Berking et al., 2011; Chester et al., 2016; Cooper et al., 1995; Garland et al., 2020; Hogarth, 2020; Kober, 2014; Koob et al., 2020; May et al., 2020; Verdejo-García et al., 2007). Drugs can have a wide range of effects on our affective states and capacities, varying from drug to drug and person to person. Drugs can be used to actively elevate mood and amplify feelings of confidence (e.g., stimulants, like cocaine or Adderall); inhibit social anxiety (e.g., alcohol, or prescribed anxiolytics); dampen painful emotions or enable relaxation (e.g., opioids, like heroin or morphine); generate awe, wonder, or feelings of spiritual connection (e.g., psychedelics); intensify feelings of love and empathy (e.g., ecstasy); lessen emotional volatility or blunt emotions (e.g., selective serotonin reuptake inhibitors, i.e., SSRIs); or relieve stress or boredom (e.g., cannabis). That is, drug consumption can be adopted as a form of affective scaffolding. Drug use as scaffolding designates a dynamic interaction between a chemical compound with specific pharmacological actions, and an agent who consumes it for their own affective purposes, in the context of their particular lifeworld.

While the appeal of a specific drug as an affective scaffold largely depends on how its consumption is perceived to address a person's idiosyncratic affective needs, interests and concerns by acting on their pre-existing affective condition,<sup>5</sup> it is also significantly informed by an agent's culturally structured environment. For example, which psychoactive substances are more readily available and socially approved in one's given cultural context or social milieu can influence what drugs an individual adopts for scaffolding, and the affective purposes they adopt this scaffolding for. Consider how the widely normalized use of alcohol within drinking cultures<sup>6</sup> can bias people toward using this drug and guide the sorts of affective purposes it is used for: for example, to enhance joy and excitement at celebrations, to bolster feelings of belonging or togetherness at sporting events, to unwind or temporarily escape worries after a stressful day, to subdue anxiety or enhance feelings of immersion in social settings, to feel "cool," to

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<sup>5</sup> This point is illustrated by Khantzian's influential self-medication hypothesis (SMH), which "considers the emotional and psychological dimensions of substance use disorders" (Suh et al., 2008). Khantzian (1985, 66) proposed that people with rage and aggression, for instance, are drawn to opiate drugs for their specific "muting action" on these emotions, where people struggling with depression or melancholy may be more drawn to cocaine use "because of its ability to relieve distress" and induce elation. In later work, Khantzian and colleagues studied the relation between participants' drug of choice and emotional states and found empirical support for these associations (Suh et al., 2008).

<sup>6</sup> In the United States, for example, a 2022 national survey found that 78.5% of people 12 or older reported drinking alcohol at some point in their life (SAMHSA, 2022).

facilitate uninhibited expression of emotion within interpersonal relationships, for young people to feel mature, for men to feel masculine, and so on.

While different drugs have different pharmacological action profiles and some are faster-acting than others, depending on features of the drug itself and also its delivery system (e.g., heroin is faster-acting when injected than inhaled or snorted) (see e.g., Grisel, 2019), drugs can be described as powerful and flexible scaffolds. Not only can drugs be recruited as emotion and mood changers for a diverse range of personally valued affective purposes, importantly, drugs can produce their effects in diverse external and emotional contexts. Drugs can significantly alter affective phenomena across a wide range of background variables, external circumstances, and pre-existing affective conditions, altering even the most extreme emotions and moods that may not be susceptible to the transformative actions of more subtle environmental scaffolding (at least in the case of some drugs, and depending on dosage) (Lavallee 2023). There are drugs that can, at least temporarily, alter even the most intense and painful affective states, and can enable desired affective outcomes even in bleak or distressing life circumstances. This feature of drugs as scaffolding is arguably reflected in the disproportionately high use of some drugs, including alcohol, benzodiazepines, cannabis and opioids by people coping with symptoms of psychiatric conditions, including extreme and distressing emotions and moods (Jacobsen et al., 2001; Khantzian, 1985; Lipari, 2018; Maté, 2009; for discussion see, e.g., Lavallee, 2023; Pickard, 2013).

Remember that the level of trust an agent has in a particular environmental scaffold influences their reliance upon it, contributing to repeated, habituated and entrenched patterns of interaction. If a drug is perceived by an agent to be an especially effective and flexible resource for shaping their affective life in ways they value, and especially if it is accessible in their social milieu or (sub)cultural context, it can accrue a high level of trust. Where a high level of trust develops, drug use can become entrenched within an agent's habits of scaffolding, resulting in this scaffolding coming to play a substantial, or even central, emotion regulation role in their life. I have previously argued (Lavallee 2023) that, in some cases, drugs can become such highly trusted and entrenched affective scaffolding in a person's life, used for more and more of their emotion regulation needs, that the person may begin to perceive the drug as indispensable to their capacity to emotionally regulate. This scaffolding dynamic can powerfully motivate ongoing drug use, hindering one's ability to reduce or abstain from its use, thus explaining one mechanism through which non-addictive drug use can escalate into addiction, and through which addiction can be sustained. While addictive scaffolding may still continue to play some beneficial synchronic emotion regulatory roles in a person's life, ongoing addiction tends to exacerbate emotional problems in the long run (e.g., depression, anxiety, emotional numbness). This constitutes a case of bad scaffolding; namely, addictive scaffolding.

Most people who use potentially addictive drugs never develop an addiction, however, and this holds true for drugs that are popularly construed as "highly addictive", such as heroin and cocaine (e.g. see, Alexander, 2010; Kalant, 2010; Lipari, 2018; Zinberg & Jacobsen, 1976; Zinberg et al., 1978). This suggests that the potency and flexibility of drugs as scaffolding alone cannot account for cases of addictive scaffolding. What makes some people vulnerable to developing an addictive scaffolding dynamic, as compared to the majority of people who can rely on drugs for scaffolding non-addictively? The influence of one's psychosocial and structural conditions plays a critical role in determining whether, over time, one's use of drugs as scaffolding becomes addictive (Lavallee 2023). As Hart (2017, 1) concludes, "regarding the relatively small percentage of individuals who do become addicted, co-occurring psychiatric disorders and socioeconomic factors account for a substantial proportion of these addictions." Factors such as mental

illness and histories of trauma (Jacobsen et al., 2001; Khantzian, 1985; Lipari, 2018; Maté, 2009), structural oppression (e.g., Bränström & Pachankis, 2018; Connolly & Gilchrist, 2020; de Leeuw et al., 2010), social disconnection (B. Alexander, 2018; B. K. Alexander, 2008), and economic precarity (Galea & Vlahov, 2002; Hogarth, 2022; Spooner & Hetherington, 2004) correlate highly with addiction. These are factors that produce disproportionate levels of distress in a person's life, which drug use may effectively reduce at least in the short-term (Dodes, 2009; Hogarth, 2022; Khantzian, 1985; Maté, 2009; Suh et al., 2008). Moreover, these are factors that can limit the availability of valuable alternative affective scaffolding resources; for example, material and social supports made accessible through secure and stable living and working conditions, disposable time and income for social and leisure activities, a robust interpersonal support network, access to adequate mental health care, and so on. Under the kinds of psychosocial and economic conditions that are known correlates of addiction, there is an increased risk that drug use as an initially beneficial strategy for synchronically managing affectivity will become entrenched as an addictive dynamic over time.

Addiction, then, presents one bad scaffolding trajectory that can result from drug use, the evolution of which is crucially informed by the influence of particular kinds of environmental conditions. Next, I will address a different case of drug use as scaffolding; namely, the use of psychiatric drugs, such as antidepressants, in response to affective phenomena interpreted as symptoms of psychiatric disturbance. To make my target of analysis clear, I address psychiatric drugs as an interesting and distinctive scaffolding category in light of their construction as *medication*. Psychiatric drugs *qua* medicine have a particular cultural profile, and their use is environmentally structured by a specific set of socio-institutional influences. The classification 'medication' carries positive social connotations and confers the kinds of cultural values associated with medicine. Medicine is, by definition, considered to be good for us, as the core notion of medicine is that it fixes, restores, or improves health – at least when used as intended. In everyday discourse, the use of medicine is associated with self-helping or self-improving behaviour, as something that allows us to exert control over our own internal states and thereby our health and wellbeing (Herzberg 2020). And the classification 'medicine' plays a role not only in social perceptions of drug use, but also in the ways that institutions, policies, laws, and markets promote and prohibit different kinds of psychoactive substance use.

It is important to note that the chemical properties and psychopharmacologic actions of different psychoactive substances do not neatly determine which drugs qualify as medicine. For example, as Cohen and colleagues (2001, 449) note, cocaine and Ritalin “have virtually identical, interchangeable physical and subjective effects in the short and long term on animals and humans who ingest them.” However, “they are classified in law, medicine, public policy, and lay knowledge as radically dissimilar substances” (Cohen et al. 2001, 449). Whether a particular drug is constructed as medicine is determined by a whole range of socio-institutional forces, and is historically and culturally dependent (Herzberg 2020; Hart 2013). Similarly, consider that some psychoactive substances, such as ketamine, are constructed as medicine, but only when used in psychiatric treatment, under the formal supervision of a clinician. The boundary is fuzzy and mutable between recreational or discretionary drug use and drug use aimed at treating or managing some condition; and likewise, between drug use that is self-selected without formal medical guidance and drug use mediated by the recommendation (and in some cases prescription, following diagnosis) of an expert.

I do not attempt to provide an account of how psychoactive drugs, including psychopharmaceuticals, can be multiply and complicatedly classified. Doing so is not necessary for the



purposes of the current analysis. Rather, where I have previously utilized scaffolding as a theoretical device to consider the case of potentially addictive drugs, in this paper, I take up the case of psychiatric drugs constructed as medicine.<sup>7</sup> The classification of psychiatric drugs as medication, and the moral connotations, value judgments and social practices that commonly accompany this classification, have a significant influence on people's use of these drugs, and on the evaluation of this use by the public, and within medical and legal domains (Herzberg 2020). Accordingly, while 'medication' as a category of psychoactive substances is constructed and changeable, nevertheless, this categorization has implications for developing a scaffolding model of beneficial and harmful psychopharmaceutical use. Recognizing this is crucial for demonstrating how the process of psychiatrization plays a part in conditioning bad pharmaceutical scaffolding. While different psychiatric drugs possess their own pharmacologic actions, have different indicated uses, transform affectivity in different ways, and may pose different potential benefits and harms, the class of "psychoactive medicines" generally share fundamental similarities in terms of how they are influenced by psychiatrization processes.

### 3. Psychiatrization and pharmaceutical scaffolding

#### 3.1. *Psychiatry and psychiatrization*

Psychiatry has gained immense cultural traction and social influence in recent decades in the Global North and increasingly globally (Beeker et al., 2021, 2023; Mills, 2014, 2015). Psychiatric institutions, concepts, vocabulary, classificatory systems, and diagnoses, have come to play an expanding role in shaping new domains of social life, impacting how we interpret and understand ourselves and each other, and contributing to the creation of powerful consumer markets for therapeutic goods designed to treat a growing range of human experiences (Beeker et al., 2021; Cova et al., 2023; Gambrell, 2014; Tseris, 2017). In this same period, there has been a marked rise in the use of psychopharmaceutical drugs (Cova et al., 2023; Rose, 2003; Tseris, 2017). Beeker and colleagues (2021) describe the social process that links these developments in psychiatry's growing influence as "the psychiatrization of society." They (2021, 3) define psychiatrization as "a complex process of interaction between individuals, society, and psychiatry through which psychiatric institutions, knowledge, and practices affect an increasing number of people, shape more and more areas of life, and further psychiatry's importance in society as a whole." As a complex process, psychiatrization is enabled by a diverse range of players or driving forces; among others, mental health institutions and their practices and services, the pharmaceutical industry and marketing guided by industry interests and incentives, government bodies and policy makers, as well as, "the needs and desires of patients, proto-patients, and consumers", i.e., the increasing number of people seeking out psychiatric diagnoses and treatments (Beeker et al. 2021, 5).

I will focus on two manifestations of psychiatrization: the growing influence of biomedical psychiatric interpretations over an expanding spectrum of human experience and behaviour, and the normalization and proliferation of psychopharmaceutical use as a response to affective phenomena deemed symptoms of psychiatric disturbance. These two aspects of psychiatrization are causally related

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<sup>7</sup> Note that some psychiatric drug use can lead to addictive scaffolding – there are psychiatric drugs that are widely considered to be addictive e.g., benzodiazepines. In parallel, not all "illicit" drugs are likely to enable addictive scaffolding. For example, lysergic acid diethylamide (LSD), produces intense changes in perception, sensation, and affect, but is not typically considered to have a high addictive potential.

insofar as (among other things) the biomedical interpretation of affective phenomena as psychiatric disturbances facilitates their designation as treatable by psychiatric medications (e.g., Beeker et al., 2021; Conrad & Slodden, 2013), and in turn, pharmaceutical industry marketing and investment have contributed to expanding the jurisdiction of psychiatry (e.g., Kaczmarek, 2022). I will introduce each of these aspects of psychiatrization and demonstrate how they work together to influence affective scaffolding in psychiatrized societies.

### ***3.2. Expanding influence of biomedical psychiatric interpretations***

Through the process of psychiatrization, more and more of our experiences of suffering and distress are interpreted as symptoms of underlying psychiatric disturbance (e.g., Brinkmann, 2016). Psychiatric terms are being applied to a continually broadening spectrum of human behaviour, and cognitive and affective phenomena. Consider how the DSM, widely considered the most influential nosological system in psychiatry (Horwitz, 2021), plays a part in this. As Gambrell (2014, 14) notes, the latest edition of the DSM (5th edition) “contains even more diagnostic categories, and the boundaries around many entries have been loosened, drawing more individuals into an ever widening net of alleged ‘mental illnesses’.” The incorporation of psychiatric language and concepts into more and more people’s lives is not, however, attributable solely to the DSM, or even to formal psychiatric institutions or practices alone. By looking through the lens of psychiatrization, we can explain the increasing “habitual interpretation of life events and people’s experiences through psychiatric terms” (Cova et al, 2023, 8) through an array of social practices and cultural institutions (Lavalée & Gagné-Julien, 2024). As Beeker and colleagues (2021, 4) point out, the psychiatrization process also involves “more subtle transformations, such as the infusion of psychiatric terminology into everyday language (e.g., trauma, paranoid) or the interpretation of life events and personal experiences through the lens of psychiatric concepts (e.g., burn-out, depression).” To this list, we could add the commonplace and colloquial use of terms like “anxious,” “obsessive,” “manic,” “narcissistic,” “delusional” to describe a growing array of experiences and behaviours.

The biomedical approach, which the DSM represents, is currently the most influential psychiatric paradigm, and “continues to dominate mental health policy, practice, and research” (LeFrançois et al., 2016). In broad terms, the biomedical approach emphasizes and prioritizes the contribution of underlying biological factors to mental illness, including to the affective experiences that are labeled symptoms of psychiatric disorders (Lavalée & Gagné-Julien, 2024). This approach views the phenomena conceived as mental illnesses or disorders as arising “from faulty mechanisms or processes of some sort, involving abnormal physiological or psychological events occurring within the individual” (Bracken et al., 2012, 430). And these underlying mechanisms or processes are taken to be context-independent, insofar as social and other environmental contributors to mental illness, while not necessarily dismissed or entirely ignored, “become secondary in importance” (Bracken et al., 2012, 430). Within this paradigm, psychiatric technological interventions – including psychopharmaceuticals – are approached as “discrete interventions that can be analysed and measured independent of context” (Bracken et al., 2012, 430). Within psychiatrized societies, the biomedical approach has had powerful uptake not only in clinical or research contexts, but in the public domain and in social discourse more generally where psychiatric language and interpretations proliferate. As Tseris (2017, 170) puts it, “biomedical descriptions remain firmly impressed upon everyday constructions of mental illness.”

A person need not have a direct clinical encounter or be officially labeled with a diagnosis in order to be personally impacted by the language and concepts of biomedical psychiatry, or to come to incorporate these hermeneutical resources into their interpretations of their own and other's emotional problems. Consider, for one example, the role that (social) media has come to play in proliferating biomedical psychiatric language and concepts (e.g., Barry, 2023; Chevalier, 2024; Klin & Lemish, 2008). The discussion of mental health, and the use of psychiatric terminology, has become prevalent in online spaces (e.g., Milton et al. 2023). For instance, consider the explosion of #adhd on TikTok, referring to the psychiatric label attention-deficit/hyperactivity disorder (ADHD) (Chevalier, 2024; Yeung et al., 2022). Under the influence of psychiatrization, biomedical psychiatric interpretations, acquired through a variety of avenues, gain more purchase, in more people's lives, and for a growing spectrum of extreme or unusual as well as quotidian affective phenomena (Lavalley & Gagné-Julien, 2024). Indeed, public attitudes reflect biomedical interpretations of distress and suffering that are reified through psychiatrization to encompass expanding areas of affective life (Pescosolido et al., 2010). Lay people are increasingly making use of neurobiological narratives to explain experiences of mental distress (e.g., Buchman et al., 2013; Davis, 2022; Deacon, 2013; Pescosolido et al., 2010). And as Pescosolido and colleagues (2010, 1324) suggest, “[p]ublic attitudes set the context in which individuals in the community respond to the onset of mental health problems, clinicians respond to individuals who come for treatment, and public policy is crafted.” In other words, the cultural influence of the biomedical psychiatric paradigm informs how we think about treatment, intervention, and response to suffering and distress.

### ***3.3. Normalization and proliferation of pharmaceutical use***

Arguably, the primary treatment tool within contemporary psychiatry, especially in response to what are labeled “serious mental illnesses”, is psychopharmaceutical drugs (Bracken et al. 2012, 432). The role that psychiatric drugs play in response to distress and suffering is not restricted to “serious mental illnesses,” however. In fact, psychopharmaceuticals are increasingly relied upon not only in response to diagnosed psychiatric disorders, but also in more contentious cases such as subthreshold symptoms of psychiatric conditions like depression, bereavement, and in cases of what has been termed cosmetic pharmacology – psychopharmaceuticals used to optimize oneself, simply “to feel more emotionally and functionally resilient” (Palk & Stein, 2020, 96). Davies, (2017, 189) refers to this growing reliance on psychiatric drugs as the “proliferation and normalisation of psychopharmaceutical consumption.” And Beeker and colleagues (2021) evaluate this as a manifestation of psychiatrization: “despite epidemiological research pointing to high, but relatively stable incidences and prevalences of mental disorders, there is clear evidence that more and more people are using in- or outpatient mental health services, regularly resulting in the prescription of psychotropic medication” (2). In the United States, for example, it is estimated that each year one in six adults take psychiatric drugs at some point (Beeker et al., 2023; Terlizzi & Zablotsky, 2020).

Marshall (2010) argues that the twenty-first century marks an era of the “pharmaceutical imagination” which is constituted by “an increasingly rigid and narrow definition of ‘healthy’ or ‘normal’ human experience; and a growing reliance on the use of pharmaceutical products to attempt to reach a state of perceived health or normality” (Tseris 2017, 169). The use of psychiatric drugs to treat an increasingly inclusive range of emotional problems deemed symptoms of mental illness or disorder is an evident example of the pharmaceutical imagination (Tseris 2017, 169). As Titchkosky and Aubrecht (2017, 312) articulate, “mental illness” has become “the primary way in which Western(ized) people are

encouraged to consider what is troubling themselves and others.” Given the cultural dominance of biomedical psychiatry, interpreting experiences of distress through the lens of mental illness, and using the labels and language of psychiatry, inclines a person toward understanding distress as the symptom of an underlying individual pathology. This understanding can in turn bias a person toward seeking out and adopting affective scaffolding strategies that promise to directly address the presumed “faulty mechanisms” or “abnormal physiological or psychological events occurring within the individual” (Bracken et al., 2012, p. 430). This is precisely what psychopharmaceuticals claim to do, and they are increasingly available and accessible for attempting the task. Some psychiatric drugs such as certain anxiolytics, like benzodiazepines, or stimulants, like methylphenidate (Ritalin) promise fast-acting solutions to emotional problems. Others like certain mood stabilisers, like lithium, or antidepressants, like the SSRIs (e.g., Prozac, Lexapro, or Paxil) are slower-acting, promising to reshape one’s affective condition, often through the suppression of moods and emotions, in a more temporally extended way. Whatever their particular properties, however, psychiatric drugs are designed, marketed, and prescribed as technologies that have the special power to transform one’s affective life by ‘directly’ intervening on the biological underpinnings of distress and suffering to change how we feel. Rose (2003) has introduced the concept of “neurochemical selves” to describe people who, under the effects of psychiatrization, come to “experience their own emotions as epiphenomena of their brain chemistry” (Becker et al. 2021, 3) that can be modified or reshaped by psychiatric drugs (Rose 2003).

The example of how the drug Paxil was marketed for social anxiety disorder and generalized anxiety disorder in the United States well-illustrates how expanding domains of psychiatric interpretations of affective phenomena can work together with the normalization and proliferation of psychiatric drug use to promote pharmaceutical scaffolding. In the construction of the DSM-IV, the label of “social phobia” taken up from the DSM-III was re-defined into “social anxiety disorder” (SAD) and “generalized anxiety disorder” (GAD) (Conrad & Slodden, 2013). As Becker and colleagues (2021,4) note, through this diagnostic revision, “[s]mall changes in wording expanded the reach of this previously rather rare diagnosis considerably” and “[t]his was embraced by the pharmaceutical company SmithKline Beecham’s as an opportunity to sell the SSRI-antidepressant Paxil, despite the market for depression having already reached saturation.” Through direct-to-consumer advertising of Paxil, SAD was publicized as a “widespread and highly debilitating condition” (Becker et al. 2021, 4) and Paxil as a remedy. These manifestations of psychiatrization collaboratively resulted in “a new epidemic of SAD with estimated point prevalences of up to 13,3% in the US-population on the one hand, and Paxil becoming one of the world’s best-selling drugs of all time on the other hand” (Becker et al. 2021, 4-5).

The language deliberately used in pharmaceutical drug advertising reflects the influence of the biomedical psychiatric paradigm in driving the pharmaceutical imagination. For instance, returning to the case of Paxil, a 2001 ad in *Newsweek* declared that “[if] you’re one of the 10 million people who live with excessive uncontrollable worry, anxiety, tension, irritability, restlessness and sleep disturbances for six months or more, you could be suffering from Generalized Anxiety Disorder. The good news is that it’s treatable. *Paxil*, the most prescribed medication of its kind for generalized anxiety, works to correct the chemical imbalance believed to cause the disorder. *Paxil* can help bring down your level of anxiety, even if you have been suffering for years” (Herzberg 2010, 2). Here, an underlying individual pathology (a “chemical imbalance” in this case) is appealed to in order to conceptualize the target of this psychopharmaceutical drug’s action, as treatment that has the special power to directly counteract experiences of excessive worry, anxiety, irritability, etc. The message is that suffering people can, through

pharmaceutical scaffolding, exert individual agency over their own distress to improve their affective quality of life. As GlaxoSmithKline, one of the largest pharmaceutical companies in the world, promises in their company's slogan, their pharmaceutical drugs help people "Do more, feel better, live longer."<sup>8</sup>

### 3.4. *Pharmaceutical scaffolding under psychiatrization*

Thus far, I have proposed that the combined effects of psychiatrization and the biomedical model encourage people to see a particular form of scaffolding – psychiatric drugs – as highly salient, biasing them toward selecting and adopting the tools of psychiatry (rather than some other) to cope with an expanding spectrum of emotional problems. Psychiatrization processes promote the perception of psychiatric drugs as highly trustworthy technologies for managing one's affective life. To reiterate, the level of trust that an agent has in any given scaffolding is informed by their perception of its availability, efficacy, and reliability, and we are more likely to develop habituated and entrenched patterns of reliance upon scaffolding that we perceive to be trustworthy (Colombetti & Krueger 2015). Through the workings of psychiatrization in coordination with the biomedical model, psychiatric drugs are constructed in the collective social imaginary as highly effective, reliable, socially approved and medically sanctioned resources for addressing a widening range of affective phenomena, construed as symptoms of underlying individual pathology.<sup>9</sup> And through the normalization and proliferation of psychiatric drugs as safe and licit medicines, psychiatrization contributes to the availability of this scaffolding resource. Within psychiatrized societies, psychiatric drug users' perception of the trustworthiness of psychopharmaceutical scaffolding is shaped, then, not only by their firsthand experiences with particular psychopharmaceuticals, but is magnified by the authority of the various institutions of medicine and their relations to commercial and other interests. Next, I articulate the conditions under which the influences of psychiatrization on affective scaffolding constitute bad pharmaceutical scaffolding.

## 4. Bad pharmaceutical scaffolding

Psychoactive substances are not inherently harmful affective scaffolds. Whether prescribed or individually chosen, psychoactive substances can be valuable, sometimes life-saving affective technologies, serving as beneficial scaffolding for some people, under some conditions. However, the influence of psychiatrization on affective scaffolding can enable *bad pharmaceutical scaffolding*. Bad pharmaceutical scaffolding emerges when an agent is influenced to select and rely upon pharmaceutical scaffolding in attempts to exert individual control over distress and suffering where 1) at least some of the key determinants of these

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<sup>8</sup> By encouraging individuals to seek out and request specific drug prescriptions, direct-to-consumer advertising could also be described as contributing to psychiatrization by eroding or undermining the boundary between drugs that are self-selected without formal medical guidance and drugs that require expert recommendation, thereby weakening the role of expertise in determining how and when these drugs are accessed. Thank you to an anonymous reviewer for raising this point.

<sup>9</sup> Psychiatrization processes promote trust in pharmaceutical scaffolding not only by amplifying the affective benefits of psychiatric drugs, which are conceptualized and promoted as 'therapeutic effects', but also by minimizing the adverse emotional effects that are evidenced in psychiatric drug use (e.g., sedation, dysphoria, emotional blunting), particularly long term use (e.g., Marazziti et al., 2019; Read & Williams, 2018), which are construed as unintended 'side effects,' excluded by definition from these drugs' characteristic actions. In fact, many psychiatric drug users encounter a "paucity of available information on the many potential harms and risks that may be associated with taking psychotropic medication" (Tseris 2017, 173; see also Young et al., 2015).

affective experiences are properties of the agent's environment, in contrast to, in a strict sense, properties internal to the person, and 2) pharmaceutical scaffolding obviates the need for or displaces alternative non-pharmaceutical options that would better serve the agent's affective needs and interests.

Psychiatrization encourages us to interpret emotional problems as symptoms of mental illness, attributable to underlying (often framed as neurobiological) pathology, thereby individualizing such problems (e.g., Cova et al., 2023; Mills, 2015). From this perspective, drug-based interventions seem to perfectly aim at the right treatment target. In light of this, we might say that psychiatrization itself aligns with cognitive internalism, treating affective and cognitive problems as “inside” the individual, and excluding the contribution of factors outside their mind-brain-body.<sup>10</sup> However, many of the extreme, distressing, and painful affective phenomena that are now conceptualized as psychiatric symptoms are crucially shaped by life events, social, interpersonal, material, and structural conditions, not only, or even primarily, by underlying neurobiological, physiological, or genetic factors. As Logan and Karter (2022, 4) put it, psychiatrization processes can “drain suffering of its political and social contents by converting it into an intra-individual problem.” When emotional distress, pain, disturbance or suffering that is fundamentally conditioned by one's environment is interpreted through narrow biomedical psychiatric narratives, important factors contributing to one's affective condition are obscured, including things like: high-stress, exhausting, boring or dehumanizing working conditions, unstable or insecure housing, painful life events, violence, loss, economic precarity or poverty, systemic oppression, social isolation or exclusion, incarceration, stigma, lack of a social support network, interpersonal abuse or dysfunction, lack of access to healthcare or other social services, and so on. When such factors are obscured, pharmaceutical scaffolding over-promises individual control over environmentally situated emotional problems, and consequently, the high level of trust placed in psychiatric drugs as scaffolding, influenced by psychiatrization, can be deemed unwarranted and detrimental. Moreover, in these kinds of cases, adopting pharmaceutical scaffolding can simultaneously mask a lack of, or simply displace, socially furnished non-pharmacological options that could more effectively transform one's affective condition by directly addressing the contributing environmental factors.

To illustrate bad pharmaceutical scaffolding, consider one example of how it might arise in the context of an individual's life under the influences of psychiatrization. Antidepressant consumption has been steadily rising for decades, and SSRIs are now among the most frequently prescribed drugs worldwide (Marazziti et al., 2019). The growing use of antidepressants has occurred alongside the increasing diagnosis of mental disorders that are deemed treatable with antidepressants (de Oliveira Costa et al., 2023),<sup>11</sup> including Major Depressive Disorder with Peripartum Onset (DSM-5), commonly referred to, in clinical and public contexts, as postpartum depression. Given the effects of psychiatrization on pharmaceutical scaffolding, narrow biomedical interpretations of postpartum depression may sometimes obscure crucial environmental contributions to a person's distress during pregnancy or the postpartum period. Consequently, in such cases, people who are pregnant or at postpartum may be encouraged to select and place an unwarranted degree of trust in antidepressant scaffolding in attempts to repair their affective condition. If this adoption of, and reliance upon, antidepressant scaffolding plays a part in masking a lack

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<sup>10</sup> I thank an anonymous reviewer for pointing out the possible framing of psychiatrization as aligning with cognitive internalism .

<sup>11</sup> The list of indicated uses for antidepressants now includes psychiatric conditions ranging from anxiety disorders, obsessive-compulsive disorder, panic disorder, to PTSD, as well as non-psychiatric medical conditions like chronic pain and chronic fatigue (Marazziti et al., 2019).

of, or displaces, other resources or environmental supports that would better address the person's depressive experience, then this constitutes a case of bad pharmaceutical scaffolding.

And in fact, research on the relationship between disordered sleep and experiences of depression during the perinatal period seems to offer one source of support for the proposal that bad pharmaceutical scaffolding can manifest in the context of postpartum depression (Solomonova et al., 2020). People who suffer disturbed sleep or poor sleep quality during pregnancy or postpartum are at an increased risk of developing delusional ideation and depressive symptoms in the perinatal period (Solomonova et al., 2020). Consider the kinds of factors in a person's environment that may undermine the possibility of undisturbed or high quality sleep during pregnancy or postpartum: social isolation or lacking a sufficient family or social network for support; having a partner who has to work long hours and cannot afford or will not take time off; experiencing income or housing insecurity; lacking sufficient access to healthcare and other social services; having a high-pressure job or inadequate parental leave from work; living with an abusive or unhelpful partner, and so on. If depressive symptoms are conditioned in the perinatal period by factors of one's social environment such as these, then treating depression with SSRIs may contribute to masking the lack of, or even displacing, alternative resources or options for structuring the environment that would better serve the emotional interests and needs of many individuals experiencing depression in the perinatal period.

The framework of bad pharmaceutical scaffolding can be useful for thinking about the kind of harm posed not only to individuals, but on a societal level, by the expanding consumption of psychiatric drugs under the effects of psychiatrization. For example, in the postpartum depression case, pharmaceutical scaffolding can act to conceal the ways that societies are inadequately set up to equitably support many people during pregnancy and postpartum. When critical environmental factors are obscured from the interpretation of a person's experience of distress or suffering, then their emotional problems can be conceptualized as resolvable "through a combination of personal effort and psychopharmacology" (Tseris 2017, 173), making suffering people responsible for repairing their own affective condition through medication. Pharmaceutical scaffolding, however, is a poor substitute for having real agency over changing the broader conditions of one's life that are causing or exacerbating emotional problems, or for having adequate, socially furnished scaffolding options. Under the influence of psychiatrization, pharmaceutical scaffolding, then, arguably not only facilitates the displacement of non-pharmacologic options from individuals' lives, but disincentivizes society to change the status quo regarding investment in the kinds of supports and resources that might better address the affective needs of many suffering people.

Put simply, we can think of bad pharmaceutical scaffolding as bolstering the treatment of social problems with individual medical solutions. Consider cases of diagnosing and medicating distress and suffering in the context of poverty. The connection between poverty and mental distress is well-established; there is a significant correlation between low socio-economic status and most categories of "mental disorder" (Mills 2015). Mills (2015, 216) points out that in some cases "poverty may well be so acutely or chronically distressing that it leads to 'symptoms' that might fit psychiatric diagnostic categories." And she poses the following questions: in such cases, "how useful is it to understand the distress [people living in poverty] speak of as constituting something called a 'mental illness' or disorder? Is this distress pathological and in need of psychiatric and/or pharmacological treatments ...?" or is it better construed as a response to "living in a harsh environment"? Mills (2015, 213, 218) argues that the growing use of biomedical psychiatric labels to interpret distress and suffering that is conditioned by poverty is an instance of psychiatrization that unfairly pushes people living in economic deprivation toward choosing and relying

upon psychiatric drugs to cope with the effects of poverty. She concludes that “seeking psychiatric diagnoses and taking potentially harmful medicines have come to be one of the remaining survival strategies for poor people in an ‘era of medicalized poverty’” (Mills 2015, 218). According to Mills’ analysis, psychiatrization does not only encourage individuals living in poverty to rely on inadequate scaffolding resources for managing their affective condition, this process plays a part in enabling and entrenching the very social and structural conditions that deprive these individuals of access to the kinds of lifeworld that would actually lessen their suffering and distress, and counteract the apparent necessity of psychiatric drugs.

## 5. Conclusion

This paper addressed a controversial issue associated with psychiatrization: the expanding use of psychiatric drugs. I proposed that the concept of scaffolding is one useful device for articulating certain dimensions of harm that psychiatric drug use can have on individuals and society. The concept of scaffolding, as I have adopted it, emphasizes the habitual and patterned ways that agents engage with and structure features of their environment for affective purposes, and how these dynamic interactions modify the relations between agents and constructed environments over time. I offered an account of how psychiatrization, in coordination with the biomedical model of psychiatry, influences affective scaffolding by biasing people toward selecting and relying upon psychiatric drugs in attempts to manage a growing range of affective phenomena. In cases where this pushes an individual to attempt to regulate environmentally situated distress or suffering through psychiatric drug use, such that pharmaceutical scaffolding comes to mask or displace other options or resources that would better address their affective needs, then this constitutes *bad pharmaceutical scaffolding*. Finally, using the examples of antidepressant treatment of postpartum depression and medication use in the context of poverty, I suggested that, on a societal level, bad pharmaceutical scaffolding articulates one avenue through which psychiatrization processes can “divert attention from the structural determinants of mental health and boost medical interventions which incite individual coping instead of encouraging long-term political solutions” (Beeker et al 2023, 1; see Davies 2017).

As a closing note, it is important to be cautious when theorizing the harms that can emerge from psychiatric drug use that we do not fall into criticizing or demonizing individuals who rely on these technologies, or deny the very real and critical benefits that drugs as scaffolding can have, whether prescribed or self-selected. As Herzberg (2010, 10) points out, emphasizing sociocultural and economic contributing factors to distress and suffering does not imply that the emotional pain of people labeled with ‘mental illnesses’, or the benefits and relief found by many in psychiatric drugs, “have simply been social constructions with no basis in reality.” Rather, the harmful scaffolding dynamic that I have identified highlights cases wherein, regardless of whatever relief may be found through pharmaceutical scaffolding, psychiatrization has pushed people into reliance on psychiatric drugs as a means of coping with affective responses to external conditions that are obscured by the pharmaceutical scaffolding. Understanding the harmful dynamics that can result from drug use as scaffolding, then, is not an argument against psychoactive substance use *per se*, or a claim that people do not really need this scaffolding and are simply depriving themselves of a better life by selecting and relying upon it. People consume psychoactive substances – those constructed as medicine and otherwise – because they serve valuable purposes, for example, responding to real suffering, emotional distress, disturbance or pain. I have argued that when



harmful scaffolding emerges from drug use, the problem is largely environmental: socio-institutional forces push people toward drugs as scaffolding in such a way that other therapeutic options or environmental supports are displaced, and broader social and structural problems that lead a person to rely on substance use as scaffolding are unaddressed.

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