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The bad expert

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Abstract

We focus on two cases in which participants narrate and perform a new culture of expertise by constructing a bad expert, a reviled or dangerous figure of scientific credibility gone wrong. We show that a key mechanism in the construction of expertise cultures is the use of antithesis performances, which are performances of scientific and professional credibility that rely on telling stories about a scientific enemy or ostracized Other. By performing the antithesis of the bad expert, actors help generate turning points in expertise, allowing new cultures of expertise to emerge. Our two case studies are: (1) feminist therapeutic expertise related to domestic violence, and (2) the revival of psychedelic medicine. In explicating these cases, we link the jurisdictional model of expertise (from the sociology of professions) with the network model of expertise (from science and technology studies): Cultural factors such as scientific narratives and embodied performances link together expert domains and forge new boundaries around expert practice.

Keywords

expertise, culture, knowledge, boundaries

Scholars of expertise have been interested in how cultures of knowledge and expertise emerge (Bourdieu, 1991; Hilgartner, 2000; Knorr-Cetina, 1999), how expert boundaries are enacted and transformed (Abbott, 2004 [1988]; Gieryn, 1999; Starr, 2008 [1982]) and how expertise changes when actors create new networks (Collins and Evans, 2007a; Epstein, 1996; Eyal, 2013a; Eyal et al., 2010). While there are many cultural mechanisms through which expertise may be transformed, we focus on 'the bad expert' as a particular set of narratives and performances that transforms expertise. One important way in which actors produce new cultures of expertise is by narrating cautionary tales and constructing 'bad' forms of expertise embodied by failed or dangerous experts. We

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call these narratives and their ritualized enactments *antithesis performances*. Antithesis performances construct a bad expert – an Other, a noncredible insider-turned-outsider – through telling stories that congeal new boundaries and ethical hierarchies around the non-credible figure, while still drawing on the existing tools of an expertise network. As such, these performances are in line with what Hilgartner (2000: 6) refers to as scientific 'dramas'. Participants tell stories about bad expert figures and perform in opposite ways to create a pivot point for their emerging expertise culture. Antithesis performances are an important addition to the literature on expertise because they expose a performative, cultural mechanism of transformation that is transportable across types of cases.

In this way, antithesis performances help explain how scientific fields reinvent themselves in response to crises or challenges, such that existing techniques and tools remain useful and in play, while the cultural practices and narratives of expertise change. Think, for example, of the revival of midwifery, in which many practical techniques remain relatively consistent across historical eras, but the culture of professionalism amongst midwives changes to accommodate new patient interest in alternative medicine (Cant et al., 2011). Or consider transformations in how the gynecological exam is taught in medical schools: The Pap smear and the speculum are still used, but the culture of expertise has become more 'patient-centered' in response to feminist challenges (Underman, 2011). In both cases, a bad expert figure emerges – the authoritative, masculine physician who does not understand women's bodies – as a key mechanism in transforming a culture of expertise. The shared goals, narratives, and ethics of expertise change dramatically, while existing technical practices are imported and merely tweaked.

The bad expert also responds to a tension in the literature on expertise. Classic work in medical sociology and the sociology of professions focuses on boundaries, domains and distinctions of status. However, some recent shifts in the study of expertise move away from expertise as attributed toward a focus on its performative and relational aspects. In the latter approach, expertise is something that people *do*, not something they have. The bad expert is helpful here because they are used to connect expert projects (network model) while also constructing boundaries of credibility around what stakeholders do (jurisdictional model). In other words, attending to the bad expert as a performative cultural symbol unites the *constrictive* study of expert boundaries with the study of expertise as *expansive*. Our approach is therefore uninterested in whether expertise is *really* held by stakeholders. We depart from realist approaches to expertise that emphasize the 'substantive' acquisition of know-how that allows experts to act in the world (Collins and Evans, 2007b: 3). Instead, we explore performative *claims* to expertise.

In what follows, we develop the concept of the bad expert and explain how performing their antithesis generates transformations in the narratives, performances and shared goals surrounding expertise. The bad expert is a figure used to construct an 'outside' to an expert domain: they are not themselves expelled from the category of expert, since they still have technical expertise, but they have 'gone wrong'. We use two case studies of politicized expertise to provide empirical support for the development of this concept. For each case, we ask: how are cultural resources picked up and made to enact transformations in expertise? We show how stakeholders call an existing culture of expertise into question, using bad expert stories and performances to create a turning point in expertise. In so doing, they generate a new culture of expertise, complete with new stories and

performances of expert credibility, thereby extending expertise into new, adjacent arenas. Participants change but do not radically transform existing tools to accommodate the new expertise culture. Expert tools are extended in response to the sustained, public performance of a bad expert (network model). Stories and public performances of credibility transform expertise and new boundaries are established (jurisdictional model). Overall, we demonstrate that narratives of the 'bad expert' and antithesis performances of their Other-ness emerge as critical resources in establishing new cultural forms and practices surrounding expertise. Thus, expertise is constituted by the cultural resources that actors mobilize to generate differences.

Literature review

Experts and expertise

Who counts as an expert, and why? What conditions make possible the creation of new systems of expertise, and what makes them legitimate? How is credibility enacted and embodied? Some scholars view expertise as an acquired social status while others approach expertise as a practical accomplishment (Craciun, 2018). In this first perspective, from the sociology of professions, expertise is viewed as a property of groups who struggle to gain authority. Research emphasizes the socially and historically contingent process by which such authority is acquired and contested, and the rewards that come with securing it (Freidson, 1970; Larson, 1977; Parsons, 1951; Starr, 2008 [1982]). Central to this work is the study of jurisdictions, the who and what of boundaries between expert and nonexpert domains (Abbott, 2004 [1988]). Scholars have considered how particular kinds of expertise become more credible through boundary-work, a process of discursively parceling out 'science' from 'nonscience'. (Gieryn, 1999). For example, Starr (2008 [1982]) traces the jurisdictional battles that contributed to the rise of medical dominance in the early 20th century – a feat accomplished through standardizing medical education, establishing professional organizations, and distinguishing physicians from 'quacks'. These boundary-drawing practices brought significant social and cultural authority to the medical profession, granting physicians power over definitions of health and illness *and* adjacent health professions.

In contrast to this work on the circumscription of expert realms, Eyal's (Eyal, 2013a; Eyal et al., 2010) work on the precipitous rise of the autism epidemic offers a theory of expertise as coordination and networked social action. Eyal (2013a) has called for replacing the sociology of professions with a sociology of expertise. Building on the assertion that expertise is *practice*, Eyal (2013a) conceptualizes expertise as networks that 'link together objects, actors, techniques, devices, and institutional and spatial arrangements' (p. 864). The focus here is on connections rather than jurisdictions; on actors who make claims to expertise, rather than just professionals; expertise as practice rather than technical skill (Knorr-Cetina, 1999); what experts and would-be experts *do*, rather than the organizational forms that serve as arbiters of status. Scholarship in the sociology and anthropology of medicine, as well as science and technology studies, focuses on the interactional and performative dimensions of expert work – for instance, the carefully crafted performances that allow for expertise to take shape through gestures and clothing

(Carr, 2010; Hilgartner, 2000; Matoesian, 2008) or how actors learn jargon to distinguish their own knowledge from that of laypeople (Jacobs-Huey, 2003). These shifts in the study of expertise have allowed scholars to understand expertise as relational, and they require attention to the structural conditions that make a new form of expertise possible or prevent it from coalescing.

In part, linking the study of social movements (such as parent autism activism (Eyal et al., 2010)) to the study of expert systems (such as biomedicine) has allowed these new insights around expertise to emerge. Attention to the co-production of social movements and scientific fields illuminates the role of frames, narratives, coalitions and performances that characterize knowledge production (Frickel and Gross, 2005). The involvement of lay people in the production and use of scientific knowledge (Brown et al., 2004; Hess, 2009; Morello-Frosch et al., 2006), the activism of scientists (Frickel, 2004; Moore, 1996), and the role of social inequalities in shaping intra-scientific expertise (Azocar and Ferree, 2015) have all encouraged scholars to unpack stories of scientific credibility. Further, attending to the interpenetration of professional expertise and politics has allowed scholars to highlight transformation and change in expertise. For example, Whooley (2019) analyzes how the field of psychiatry continuously manages its own ignorance by reinventing its styles and objects of expertise – often in response to political crises or challenges. Psychiatrists, he argues, tell and retell stories about their own object of knowledge, retooling expert claims, in order to manage credibility struggles. Linking political movements and expertise has therefore encouraged scholarly attention to hybridity (Epstein, 1996), expert 'workarounds' (Whooley, 2010), and collaboration (Eyal et al., 2010).

Despite this attention to expertise as fluid and connective, however, expertise necessarily requires the study of boundaries and legitimacy – the very term 'expert' or 'expertise' suggests a hierarchy, or at least something or someone that is *not* expert, outside the realm of authority and professionalism (Cucullu, 2003). Some difference is cleaved, a distinction produced. Boundaries and hierarchies inhere in the very concept of expertise and its institutional forms (Collins and Evans, 2002). A robust account of expertise, then, demands attention to fluidity, transformation and networks *as well as* boundaries. We suggest that attending to the cultural aspects of expertise, especially narratives and embodied performances, can help account for the multiplicity and complexity of expertise, its connections *and* its jurisdictions.

Culture(s) of science

With the understanding of expertise as relational has come a focus on practice and enactment (Epstein, 2008). Following insights around the 'doing' of expertise, we are working toward a robust account of the cultures of expertise, the ways in which expertise is narrated and performed by participants. After all, scientific credibility requires the use of powerful cultural resources to establish, distinguish or link together authority projects (Hilgartner, 2000). We therefore position the emerging scholarship on performing expertise alongside the literature on scientific cultures. In so doing, we theorize expertise as embedded in and produced by epistemic communities characterized by particular cultural forms. Studying expertise cultures requires attention to the narrative and performative resources that scientists deploy to erect boundaries, make connections and repurpose tools.

By 'cultures', we mean the narratives, performances and shared goals of professionalized participants that are structured around claims to credibility and authority. For example, Knorr-Cetina (1999) uses the language of 'epistemic cultures' to ask questions about expertise as a cultural form and practice, rather than a technical assemblage and professional venture. She defines epistemic cultures as 'machineries of knowing composed of practices' (p. 10), which we can study through patterns of expert 'doing'. Shifting away from science as knowledge domains and credentials, Knorr-Cetina approaches knowledge as that which scientists *enact*. Further, epistemic cultures are *situated*, such that knowledge has to be 'created and warranted' in a set of structural and institutional conditions (Knorr-Cetina, 2005: 67).

If culture is a set of resources that can be assembled for particular aims in particular settings (Swidler, 1986), we ask how expertise is made and remade through telling and performing stories about good and bad science, good and bad politics and good and bad scientists. Such credibility struggles shape expertise cultures – particularly actors' narratives and performances – and have a causal impact on the trajectory of an expert domain and its interlocutors (Gieryn, 1999; Shapin, 1995).

In fact, scholars have long argued that studying science requires attending to cultural logics and practices – storytelling, narrative-building and embodied performances – as well as the holes, slippages and failures therein (Haraway, 1997; Harding, 2008; Keller, 1992; Knorr-Cetina, 1999; Kuhn, 2012 [1962]). As Law (2002) argues, telling stories about the world helps to perform the world. Science brings itself into being at least partially by naming and telling stories about itself (Herzig, 2004). For example, Aviles (2015) shows how cancer scientists situate their work in stories of brilliant 'originators', ancestor scientists who act as cultural symbols to help stakeholders reinterpret the history of their field, thereby allowing them to tell coherent stories about their work in the present. Narratives are central to the 'doing' of science. Scientists constitute science in part by telling stories about themselves as committed and objective witnesses to truth (Herzig, 2005). But this does not mean that stories have to be positive or aspirational in order to be effective. Recent scholarship has shown, for example, that science is not only pushed forward by 'positive' knowledge projects, but also through 'non-knowledge', gaps at the center of fields, and negative storytelling (Decoteau and Sweet, 2016; Decoteau and Underman, 2015; Frickel et al., 2010; Kempner et al., 2011).

Storytelling is therefore a critical feature of knowledge communities, though its role in social movements has been more clearly elucidated than its role in scientific knowledge production. For example, Polletta's (1998) work on storytelling in collective action shows that stories of redemption, chosen people and setbacks are motivating for movements. These narratives may eventually become part of what makes someone appear as an 'expert' (Polletta, 1998). In the case of science, narratives about progress, evidence and credibility are critical, though they are not often treated as important for understanding expertise. Craciun (2018), for example, critiques scholars of expertise for dismissing the subjective elements of expertise, for studying emotions as sources of bias rather than as productive features of expert toolkits.

Attention to narratives and their performative character calls attention to multiple aspects of expertise. Expertise is emotionally laden, collaboratively produced and its enactments sometimes slip (Craciun, 2018; Kempner et al., 2011; Underman et al., 2017).

The cultural constituents of expertise may compel particular distributions of 'scientific self-concept' (Frickel and Gross, 2005). Narratives and performances also take place in settings: the logics and habits embedded in particular institutions are therefore critical to constructing expertise (Knorr-Cetina, 1999). Finally, uncertainty is always part of expertise – whether boundaries are uncertain (Eyal, 2013a), performances are ambivalent (Barker, 2009; Panofsky, 2014; Whooley, 2010), or uncertainty is deployed strategically (Carr, 2010). In order to pull these contributions together, we generate the concept of the bad expert, elaborating on the narrative, performative and 'negative' aspects of expertise, while highlighting its networked *and* boundaried nature.

Through two case studies, we show how transformations in expertise may be generated through the construction of a bad expert and the performance of opposition to that reviled figure. The central effort of this paper is to theorize expertise by focusing on a figure to which various ideas about scientific progress, politics and ethics become attached. According to Haraway (1997), scientific figures are 'performative images that can be inhabited' (p. 11) – thus, analyzing a figure in an expertise culture allows us to map practices and narratives specific to an expert domain, revealing patterns of knowledge and power (Haraway, 1997: 23). Further, the bad expert is used to construct an 'outside' to an emerging expert domain, but an expert gone wrong. The bad expert is therefore a *technical insider* despite being a *cultural outsider*.

The primary mechanism of transformation in both of our cases is antithesis performances, or public performances of the bad expert's opposite that work toward shifting expertise. Each of our cases documents cultural transformations in expertise through the following indicators of comparison: (1) an existing form of expertise that is in crisis or undergoing a public challenge, (2) the construction of a bad expert figure, (3) antithesis performances of the bad expert's opposite, (4) changes to tools and institutions, and (5) a transformed form of expertise. We compare and contrast across these factors in order to develop a more general understanding of how stakeholders construct bad expert figures and mobilize performances of his opposite in order to transform expertise, thereby transforming and extending expertise into new and adjacent arenas of practice.

While both of our empirical cases demonstrate actors' use of the bad expert figure to enact transformations in expertise, the cases importantly differ. For example, in the first empirical case, actors transform the institutional space in which expertise is enacted: from the male psychotherapist's office to the feminist, non-profit organization. This institutional shift is critical because it allows feminists to appropriate and make changes to psychotherapeutic tools, generating a new kind of therapy. In the second case, the institution in which actors are embedded remains the same. Actors transform expertise by telling stories about the bad expert and performing his[1] opposite, but they remain part of clinical research infrastructures. Our cases therefore highlight distinct institutional scenes in which the bad expert figure can be mobilized to great effect. Thus, knowledge environments and structural contexts shape the ways in which cultural resources like the bad expert are picked up and enacted by actors to do different kinds of transformative work.

Analytical strategy

The authors develop these arguments from extensive qualitative, historical data. Sweet's analysis draws from a larger interview and archival project about the medicalization of

domestic violence. The analysis presented here uses data only from the archival research, which includes original documents from US-based feminist anti-violence activism spanning the late 1960s through the 2000s.[2] Sweet used four archives to generate this analysis, drawing from activist newsletters and personal letters, meeting minutes from activist and professional meetings and federal and state funding documents. This archival material therefore reflects activists' own assembled archive as they built their expert domain throughout the 1970s to 1990s. Sweet coded and wrote memos about all archival materials. Following the knowledge that activists developed through these decades of mobilization allows Sweet to analyze the construction of a new domain of expertise as it developed *over and against* adjacent fields such as psychotherapy and social work.

Giffort's analysis is based on a qualitative project about nonknowledge concerning psychedelic medicine. The analysis presented here uses 40 semi-structured interviews with researchers and mental health professionals involved with clinical psychedelic drug research, as well as over 60 hours of observations at psychedelic science lectures and conferences. In addition, the analysis draws from archival data, including published psychedelic research, news and magazine articles about psychedelic science, organization reports and newsletters. All data were analyzed using situational analysis (Clarke, 2005). Giffort uses these multiple sources of data to trace the unfolding of this expert domain, locating shifts in knowledge and practices against the backdrop of larger transformations in biomedicine, drug development and drug policy.

The battering psychotherapist: Transforming domestic violence expertise

Histories of the feminist anti-violence movement typically focus on activists' relationship to criminal and legal systems (Bumiller, 2008; Richie, 2012). This makes sense, because criminal and legal advocacy have long been central to feminist anti-rape and domestic violence work. However, this focus on legal systems ignores the key mechanism through which feminists transformed their movement into an expert, professionalized field: by setting themselves up in opposition to psychiatry and psychology. By telling stories about the reviled figure of the 'battering psychotherapist' – the masculine, authoritative, Freudian psychiatrist who labeled battered women masochists – feminists secured legitimacy and forged their own (relatively autonomous) culture of therapeutic expertise. By constructing the psychotherapist as a 'bad expert' and pivoting their work away, feminist actors *created* feminist counseling – drawing from the technical tools of psychotherapy, without importing the authoritative, masculine culture of psy-expertise. In other words, feminists invented and mobilized the psychotherapist as 'bad expert' so that they could use psychological tools in their work while rejecting the culture of psychiatry. Feminists generated a new form of expertise by creating a masculinist enemy figure from whom it was necessary to turn away, bringing the tools of psychotherapy into new institutional spaces.

Antithesis performances

While some early (1970s) feminist anti-violence movement materials focus on 'bad' figures like police officers, the majority of the personal stories, pamphlets and academic

work published during this time focus on the problem of psychotherapists. Occasionally, the psychotherapist emerges in these materials as an even more detestable figure than the batterer himself. This figure emerged so prominently because one of the central myths that feminists sought to disrupt about battered women during the 1970s was that they were 'masochists', a favorite theory of Freudian psychiatrists. Constructing the male psychotherapist as a batterer himself – or *as dangerous* as a batterer – feminists generated story after story about the evils of putting abused women in the hands of male psychotherapists.

In Betsy Warrior's classic 1975 article, 'Battered lives', she calls psychiatrists 'mind-butchers' and argues that the central aim of the women's movement is to contradict theories of masochism and save battered women from psychiatric institutions (Warrior, 1975: 18). It wasn't just that psychotherapy was a largely male profession, but also that it wielded too much cultural and institutional authority. This type of authority was detached and cold, representing a quintessential scientific masculinity that feminists rejected. Articles and pamphlets about sexist psychotherapists and misogynistic marriage counselors were shared throughout the emerging network of domestic violence shelters and coalitions during the 1970s, and the male psychotherapist soon became the central reviled figure of the movement.

Two early battered women's movement meetings in 1977 showcase how telling personal stories helped generate this bad expert figure. In New York, the meeting drew a crowd of 500 and included a panel of battered women who spoke about their experiences with marriage counselors and psychotherapists. These meetings are some of the first identifiable antithesis performances against the figure of the battering psychotherapist. Participants identified the bad expert, told stories about his cruelty, and performed his opposite: a non-hierarchically organized room of women sharing personal stories. Feminists rebuked existing institutions (psychiatry) and existing actors (psychotherapists) through these antithesis performances, ultimately transforming the expert culture surrounding domestic violence.

A report from the New York meeting summarizes one woman's story: 'When she was seven months pregnant and being beaten, she called the marriage counselor. He told her to go home and tell her husband that she would no longer tolerate the beatings. Her husband continued to beat her' (American Friends Committee, 1977: 2). These types of stories – in which therapists were cast as dangerous authorities who put women's lives in danger – were published in feminist pamphlets throughout the 1970s. At a similar meeting in Michigan, one of the first women to speak stated, 'I was in group therapy at the time, and I had a therapist who told me I was a masochist … A male doctor who treated the broken nose and concussion said that I should try to be a good wife' (Michigan Women's Commission, 1977: 3). Stories focused largely on harmful interactions with male authority figures, especially doctors and psychotherapists. These pamphlets circulated amidst the growing anti-violence movement and helped early feminists organize a narrative about their work. Psychotherapists came to represent many of the problems of patriarchy that feminists sought to redress on a larger scale, especially the dismissal of women's stories from the authoritative seat of clinical expertise.

For example, the first directory of domestic violence organizations, published in 1976, begins with the following story: 'When I said that I was so afraid of my husband because he had tried to strangle me the night before, the therapist answered: "But ma'am,

do you ever think how terrible it is for your husband that you're so afraid of him?"' (Warrior, 1976: 2). The directory then lists dozens of feminist anti-violence organizations, documenting for the first time a network of new shelters and drop-in centers, establishing this emerging field as the *antithesis* of masculine psychotherapy. This network of shelters, premised on ideals of mutual support, was forged to oppose the model of the individualized, clinical encounter. Narrating the male psychotherapist as a battering husband figure, a bad expert with too much authority, thus became critical to establishing a 'secret' shelter network. Here, constructing the bad expert operates as boundary work, enacting a turning point. A new culture of expertise is generated *and* a new institutional scene emerges, justified through antithesis performances.

In fact, one of the most lasting ways that feminists made their own expertise distinct from masculine psychotherapy was through their representations of place (see Figure 1 and 2). Many women's shelters were founded in dilapidated Victorian houses and were modeled after private homes. Feminists capitalized on the image of shelters as caring, feminine spaces in order to construct their own culture of expertise *against* cold, masculine therapy.

Complete with houseplants, windows, trees, and front walkways, these ubiquitous images of domestic violence shelters suggest sanctuary and charm, rather than detached, clinical expertise. Feminist therapy, activists seemed to be saying, is safe and feels like home, whereas traditional psychotherapy will inevitably replicate the harms of the battering relationship. Elaine Hilberman, a feminist psychiatrist, wrote in 1980 that while psychotherapists cared about domestic violence only when it was thought to represent an 'intrapsychic liability on the part of the victim' (Hilberman, 1980: 1336), domestic

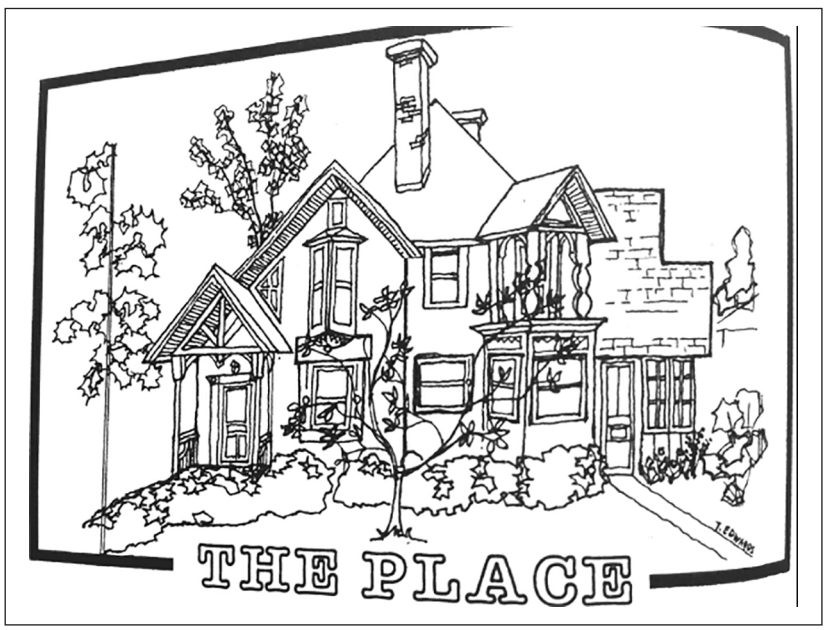

Figure 1. Elgin, Illinois Community Crisis Center Shelter Manual (n.d.).

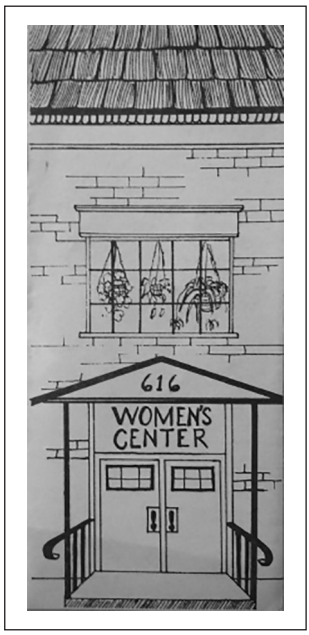

Figure 2. Pittsburgh Women's Center Pamphlet (n.d.).

violence shelters are 'therapeutic experiences' where women are cared for instead of 'treated'. Feminist actors were not experts because of status (degrees or elite training), but because they had 'experiences' as feminine subjects and were part of a community of activists. These images are themselves antithesis performances, making feminist care and community central to this new form of expertise.

Indeed, it was *only* personal or activist-generated experience that could supply expertise in this rerouted network, since the cold, authoritative persona of the psychotherapist had been so thoroughly trounced. An Illinois Coalition Against Domestic Violence (1981) pamphlet from 1981 reads: 'Instead of therapists to analyze women's problems, we wanted women who believed in each woman's abilities.' The category of 'experience' became central to the expert culture that feminists developed, as they mobilized women's personal stories into a new kind of authority that was a clear foil to the therapist-as-expert model. As Craciun (2018) demonstrates, tacit knowledge and 'insight' are often locally valued over standards and 'objectivity', but scholars do not typically read these *as* expertise, even though they establish credibility. In this way, 'experience' as a woman, stories about the psychotherapist as bad expert, the creation of new institutional spaces, and public representations of shelters as sanctuaries made up a set of antithesis performances that ushered in new expert logics and practices.

Tools and institutions

Constructing the male psychotherapist as bad expert allowed feminists to enact boundaries that would establish the culture, ethics and politics of their work as distinct from

masculine psychotherapy while nonetheless drawing on clinical tools. For example, in their presentations to the US Commission on Civil Rights (1982), feminists characterized existing mental health approaches for abuse as 'rudimentary'. Freudian therapists, they argued, blamed women for their own victimization and sought to 'keep families together' rather than to keep women safe. Alongside this critique, however, feminists offered undeniably therapeutic interventions to the Commission, insisting that feminist therapists and social workers were *experts* who could offer 'group therapy' as an evidence-based tool for battered women. In fact, every suggestion to the Commission was about group counseling or individual therapy – but not conducted by a 'traditional' psychotherapist. Thus, feminists began performing their new, 'good' expertise, characterized by supportive listening, conducted by volunteers, social workers and semi-clinical professionals. Feminist counseling did not reinvent psychotherapy; rather, it aimed to dismantle the authoritative culture of psychotherapy while drawing from its techniques.

In fact, the technical interventions feminists offered did not diverge dramatically from clinical psychotherapy. Groupwork and individual talk therapy were the primary modalities of care offered in domestic violence agencies. Making the battering psychotherapist into the problem, rather than the tools themselves, allowed feminists to salvage the existing therapeutic model while remaking the expert culture of therapy. Instead of rejecting psychotherapeutic *approaches*, then, feminists imported clinical practices – that is, narrating one's experiences to an expert – while wrenching these practices away from the psychotherapist himself. Social work publications associated with the anti-violence movement included titles such as 'Integration of feminist and groupwork theories', specifically intended to take therapeutic work out of psychotherapists' hands and into feminists' (Gilin and Begleiter, 1979). Consider Figure 3 below, an image from a domestic violence agency pamphlet, which depicts a group counseling session. The image deliberately disrupts the one-sided relationality characteristic of Freudian therapy. Feminists imagined their work as collaborative and non-clinical – they then built a new model for support groups precisely by positioning their work *against* psychotherapy.

The antithesis performance exemplified by this image was effective in pivoting domestic violence expertise away from a bad, dangerous figure, while simultaneously constituting feminist counseling as a 'better' form of expertise. Antithesis performances rerouted tools away from male psychotherapists and toward feminist domestic violence agencies. For example, the work of a feminist counseling collective was described in an academic journal in 1980 and the article specifies that the group was made up of a Chicano activist group, nurses, the local alcoholism task force, grant writers, a women's center and formerly battered women (Ahrens, 1980: 1). This statement of diversity demonstrates the key labor of antithesis performances: Feminists explicitly rejected the figure of the male psychotherapist and in so doing allowed for the importation of therapeutic tools into feminist spaces, assigning expertise to a newly eclectic array of stakeholders in a cooperative arrangement. These new stakeholders were not only politically active, but rejected the masculine culture of therapeutic authority. Assembling this new form of expertise, then, required accounting for who the players were and the type of culture they embodied – one of cooperation, political engagement and non-hierarchical listening. Some of the new feminist experts were in fact clinicians with traditional credentials, but they performed expertise differently, committing themselves to a new culture of politicized therapy.

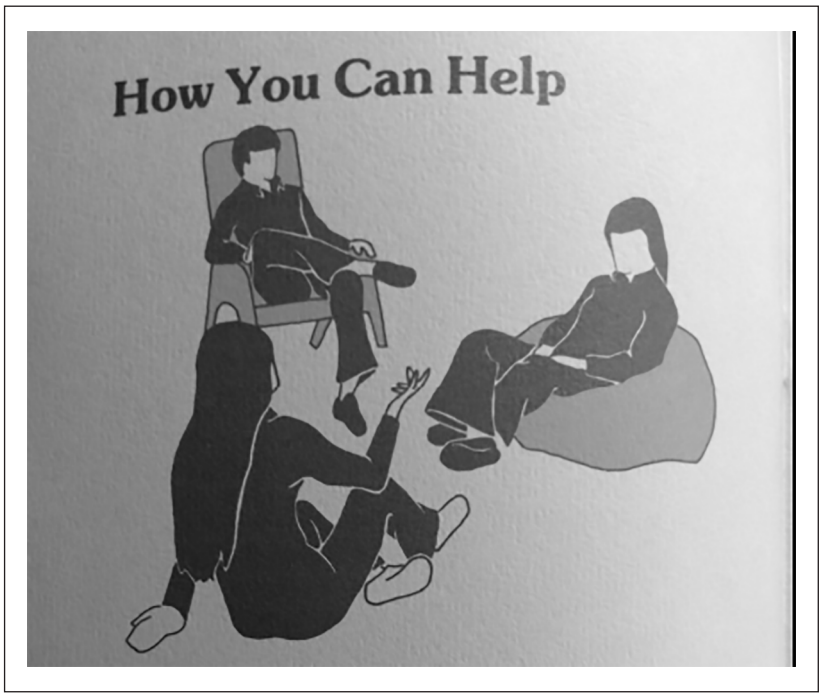

Figure 3. Assault Center Pamphlet (n.d.).

In fact, feminist models were typically not called 'counseling' or 'therapy' at all, but 'empowerment': 'Empowerment counseling is not psychotherapy. Most battered women are in crisis; they are not mentally ill. Our organizations do not treat battered women. If women request mental health services for themselves or their children, we refer them to trusted agencies or individuals within the community' (Pennsylvania Coalition Against Domestic Violence [PCADV], 1985). Narrating the psychotherapist as 'bad expert' allowed feminists to construct their work as a good kind of expertise that 'trusts women' and is based in 'the community'. In order to argue that feminist approaches were the 'right tools for the job' (Clarke and Fujimura, 1992), however, activists had to continually engage in antithesis performances. They brought their performances into new political contexts throughout the 1980s, publishing attacks on the American Psychiatric Association's revised *Diagnostic and Statistical Manual* and protesting at their annual meetings. In this sense, feminists changed – but did not radically transform – therapeutic tools to fit their new expertise culture, embedded firmly in the institutional setting of the domestic violence agency.

Expertise transformed

In the case of domestic violence, then, antithesis performances replaced the dangerous, authoritative expertise culture – symbolized by the battering psychotherapist – with a

new culture of expertise premised on feminist philosophies of care. By performing expertise in this way, activists extended psychotherapeutic expertise into the new space of the domestic violence agency *and* changed psychotherapeutic tools to make them 'feminist'. Further, activists rejected male psychotherapists' hierarchical performance of expertise, replacing it with a feminist ethics of care. These transformations were effective precisely because feminists mobilized cultural narratives and performances of the bad expert. In this way, feminists created new boundaries around their work while making changes to existing tools. Those tools would be used in new institutional spaces, extending therapeutic expertise into a novel arena.

Constructions of the male psychotherapist as 'bad expert' were effective such that feminists have been the major 'winners' of federal and state funds for domestic violence services since the late 1970s. Funding – alongside the standardization of feminist counseling models in domestic violence agencies – is what made the new network 'stable' (Eyal, 2013a). Feminists successfully pushed their antithesis performances into the realm of the state, convincing funding authorities that domestic violence dollars should be routed to their organizations. Despite this autonomy and stability, domestic violence workers today still construct the psychotherapist as a kind of bad expert, even though feminists long ago defeated masochism as a legitimate category (Sweet, 2015). Thus, the domestic violence field is still characterized in part by its antithesis performances, suggesting the staying power of the bad expert as a critical figure in professionals' narratives of credible expertise.

In this case, performing the bad expert also shifted the *gender* of expertise (Azocar and Ferree, 2015). Cultural logics associated with scientific masculinity – authority, distance, detached rationality – were attached to the bad expert figure, allowing actors to pivot toward a new culture of expertise that reflected the aims of second-wave feminism. Changing the expertise culture therefore also marshalled resources away from male-dominated psychotherapy toward the female-dominated field of domestic violence services. The gender of the actors was therefore transformed. The case of domestic violence also shows, then, that the standpoint of social actors and their political and institutional contexts matter enormously for the operations of the bad expert figure. Understanding how new forms of expertise are assembled requires attending to the cultural logics of the good/bad figures generated by situated actors.

The specter of Timothy Leary: Reassembling expertise in the psychedelic renaissance

In an op-ed piece published in the *Lancet*, psychiatrist Ben Sessa (2015) invited readers to 'turn on and tune in to evidence-based psychedelic research'. After a decades-long dry spell, psychedelic drugs are making a comeback in medical circles, with several research teams conducting federally-approved clinical studies to find out if psychedelic-assisted therapies can treat a range of psychiatric conditions. Most of this research replicates studies conducted during the so-called 'first wave' of psychedelic science, a period spanning the late-1940s to mid-1970s. Sessa's call referenced Timothy Leary's most quotable slogan: 'turn on, tune in, drop out'. Leary was a clinical psychologist who launched a series of controversial experiments with psilocybin, the psychoactive ingredient in

'magic mushrooms', at Harvard University in 1960. During these experiments, he used his living room as a makeshift laboratory where friends, artists and intellectuals were given psilocybin to learn more about the drug's subjective effects (Leary et al., 1963). Leary later took the drug with prison inmates to find out if psilocybin-assisted group therapy reduced recidivism (Leary and Metzner, 1968). His colleagues at Harvard charged that his methodological approach failed to follow emerging standards, and administrators chastised him for regaling students about the spiritual virtues of psilocybin and its psychedelic relatives. After getting the boot from Harvard in 1963, Leary morphed into a psychedelic salesman, encouraging young people to 'turn on' with consciousness-altering drugs. Leary's storied transformation from professor to pied piper dominates the modern history of psychedelic drugs; it also shapes how psychedelic researchers talk about the history of their field.

Constructions of Leary as the bad expert are generative of contemporary psychedelic researchers' antithesis performances. In psychedelic research circles, investigators invoke Leary as the bad expert in multiple ways as they confront numerous, overlapping legitimacy crises in the 'psychedelic renaissance', including conflicts between science and spirituality, subjective experience and objective knowledge, and the mainstream and counterculture (Giffort, 2020). Today's researchers construct Leary as methodologically 'bad' for refusing to follow the professionalized standards of clinical research: the randomized controlled trial, or RCT. Contemporary researchers actively adopt these methodological standards as part of their antithesis performances. However, they also draw from Leary's techniques for administering the psychedelic experience. Consequently, while contemporary researchers tell stories about Leary to generate a more credible kind of expertise in the current institutional setting, slippages in their performances create a hybrid expertise that merges biomedical expertise with the expertise of the bad expert.

Antithesis performances

'We want to be anti-Leary', announced psychiatrist Charles Grob to a reporter for the *New York Times Magazine* (Slater, 2012). The article was part of a cover story that spotlighted Grob's 2011 controlled study of psilocybin therapy for cancer anxiety. Grob's declaration reflects a common trope in the psychedelic renaissance: distancing from Leary, who researchers believe polluted the legitimacy of psychedelic science through his transgressive methodological practices. Today's researchers hope to transform their expert domain by performing a new, 'better' kind of expertise – one prominent researcher put it: 'We're serious, sober scientists' (Slater, 2012). Although most first wave researchers failed to adhere to RCT models, Leary is the focal figure of their stories, shorthand for the bad expert who failed to make the psychedelic drug experience intelligible through standard models. In contrast, contemporary researchers' antithesis performances are designed around aligning psychedelic therapy research with the *sine qua non* of clinical drug research: the RCT.

Psychedelic science was set into motion after Swiss chemist Albert Hofmann synthesized LSD in 1938 and discovered the drug's psychoactive effects five years later. Sandoz Pharmaceuticals distributed the drug under the trade name Delysid to interested investigators at no cost. Some investigators used LSD to induce temporary psychoses in healthy subjects to uncover the biological causes of mental illness while others used the drug

alongside psychotherapy to alleviate patient's psychological symptoms. Researchers practicing what has been dubbed 'psychedelic psychotherapy' hypothesized that a single, high dose LSD session could produce an ego-shattering trip that would spark behavior change in patients. Researchers using this model reported astounding success rates, particularly for treating alcohol dependency (Chwelos et al., 1959; Jensen and Ramsay, 1963). Most studies in the first wave of psychedelic therapy, however, lacked adequate controls, random assignment, blinded raters, objective measures and consistent follow-up, causing members of the medical profession to question the results coming out of these studies. Indeed, LSD entered the medical scene in the midst of larger shifts in the culture of psychopharmacology and clinical medicine towards RCTs as the new 'Gold Standard' of clinical experimentation (Marks, 2000). Several research teams – many without previous psychedelic research experience – set up their own LSD studies with controlled procedures to see if they could replicate the positive findings of earlier uncontrolled experiments, but their studies failed to demonstrate LSD's efficacy for treating alcohol dependency (Hollister et al., 1969; Kurland et al., 1967; Ludwig et al., 1970; Oram, 2018; Smart and Storm, 1964). This methodological dilemma was left unresolved in the first wave and reappears in the revival.

Looking back on the first wave, contemporary researchers, who were trained in RCT methodologies, wince at earlier investigators' research designs. Jeremy (a pseudonym, as for other interview subjects below) describes how many first wavers had a 'relaxed approach to psychedelics', explaining that 'Leary is the best example. The controls just weren't in place. They didn't exist. But they weren't in place for any investigator. Medicine was just like that back then. You can't really blame them for carrying out psychiatry like that because all the other psychiatrists were doing that. I think Leary is the best example.' Similarly, Eric describes how:

> The research that went on back then ….I mean, from what I've read about Leary, a lot of [drug] sessions were very unstructured, so that's one of the differences now. We are using different research methods that are much more highly controlled to produce more valid statistics. Recent methodologies are much more sophisticated than they were back then; we stress control groups, identify patient characteristics – you know, exclusion and inclusion criteria. It's just more controlled than it was back in the 50s and 60s.

Like Jeremy and Eric, many contemporary researchers construct Leary as *the* bad expert even though many acknowledge that his practices were actually characteristic of the expertise culture of early research.

Researchers pivot away from Leary by drawing on the existing practices and tools of biomedical expertise to make the psychedelic experience into something that can be controlled, observed and measured. For example, Jeremey explains how 'there's been problems in the past with clinicians who have crossed boundaries – I'm thinking of someone like Timothy Leary', adding that:

> I want people to adopt psychedelics [as medicines] not because I say they are great, and I had a really good time and got off my head so you could, too. I want to be using medical data. I want to say we designed a study where we gave twenty people this drug, twenty people that drug, that we tested them under conditions and measured this and that. We looked at their brains under a scanner. This is all pretty boring scientific data, but it's how science is done.

Jeremy contrasts Leary's predilection for making provocative claims without adequate empirical support with his own sober scientist expertise, which assiduously follows standard biomedical protocols with all its attention to hypotheses, controls and cold, hard data – the stuff of objective, scientific knowledge. Here, we see an example of boundary-work, as researchers like Jeremy distance themselves from Leary, rebuking his methodological approach while taking up a different performance that they hope will transform their expertise culture.

Their performance of methodological rigor is heavily shaped by the current institutional context. The Food and Drug Administration's (FDA) standard of efficacy, for example, explicitly requires that evidence for treatment efficacy come from 'adequate and well-controlled clinical investigations', which has come to be understood as RCTs wherever possible. Consequently, contemporary researchers' expertise culture favors RCTs not necessarily because they believe the model is ethically superior but because the institutional environment demands it. Eric, for example, describes how Leary 'said that we can't use these methods, but the people who won this argument are the people who said that we have to use RCTs and checklists'. As a result, Aaron argues that sticking to the 'science game' is crucial because doing otherwise is 'going to prevent me from being able to do the work that I'm doing, to look at these therapeutic applications, which if things continue to look safe and efficacious, may lead to FDA approval'. Today's researchers engage in boundary work to distance from the bad expert who rejected RCT methods and engage in performances that align with this model to bring psychedelic research into the space of biomedicine and the federal agencies that regulate their work.

A good example of this antithesis performance comes from a pair of clinical studies at New York University and Johns Hopkins University, where investigators examined whether psilocybin-assisted therapy decreased psychological distress in patients with a cancer diagnosis. Both studies employed standard typical clinical trial procedures, including standardized measures and checklists to evaluate treatment outcomes. Investigators regularly monitored subjects' blood pressure and heart rate during the drug sessions. Seven hours after given the drug, participants completed a battery of questionnaires designed to assess the subjective effects of the drug. Months after the drug session, researchers gathered additional outcome measures to determine whether participants experienced persisting changes in their attitudes and behaviors. Using rating scales allowed researchers to quantify results, making the subjective aspects of the experience amenable to objective methodologies. These researchers, therefore, pivot away from the bad expert through their willingness to incorporate standard biomedical models into their clinical trials, from blinding procedures to selecting placebos. Indeed, the Hopkins team's lead investigator, Roland Griffiths, is regularly heralded by today's researchers as the prototypical sober scientist, or as one of his colleagues told Giffort, he is 'as far from Tim Leary as possible'.

In 2016, results from both studies were published in the same issue of *Journal of Psychopharmacology*. Although the specifics of the experiments varied – the Hopkins group, for example, used high and low doses of psilocybin across the two drug sessions, while NYU used the B-vitamin niacin as an active placebo – the findings were similar: a majority of participants reported a significant decrease in their anxiety and depression symptoms (Griffiths et al., 2016; Ross et al., 2016). Nearly a dozen editorials from top

researchers in the fields of psychiatry, addiction and palliative care appeared alongside the two articles. While the commentators identified similar methodological shortcomings in both studies, including concerns about blinding procedures and generalizability, they acknowledged that these problems plague all studies of antidepressant and anxiolytic drug therapies. Most editorials agreed that the pair of studies demonstrates the potential value of psychedelic therapy for psychiatry and encouraged additional controlled experiments (Goodwin, 2016; Lieberman and Shalev, 2016; Summergrad, 2016).

A particular kind of performance underpins the expertise culture embedded in the sober scientist, one who follows the rules and expectations for conventional scientific methods. At the same time that researchers push away from the bad expert, however, they are also pulled toward him, as they actively reconfigure his tools to bring biomedical expertise into the space of psychedelic therapy.

Tools and institutions

Like their predecessors, today's researchers argue that making psychedelics therapeutically effective requires attention to 'set and setting', shorthand for how psychological and social factors shape the drug experience. Although many first wave researchers hypothesized that an optimal 'set and setting' catalyzed therapeutic drug experiences, the phrase is typically attributed to Leary, who condensed this hypothesis into a pithy catchphrase. First-wave studies were designed to enhance set and setting, such as creating a comfortable space for the drug sessions, having experienced guides present to help subjects push through challenging movements and offering integration sessions afterwards to help subjects process the experience. Many first-wave researchers were critical of the move towards the RCT and of its advocates' insistence on controlling for non-drug factors (Fadiman, 1967; MacLean and Wilby, 1967). RCT controls conflicted with first-wave researchers' expertise culture, of which set and setting formed the backbone. Today's researchers are hoping to make a descendant of that culture work by extending the idea of set and setting into a biomedical network of expertise. They accomplish this by sharing stories about the bad expert, a figure who is generative of their antithesis performances, allowing researchers to shed some elements of the past expertise culture.

Set and setting remain key for the effectiveness of contemporary psychedelic therapy, with one team writing in the *Journal of Psychopharmacology* that the 'therapeutic action of psychedelics is *fundamentally reliant on context*', adding that 'neglect of context could render a psychedelic experience not only clinically ineffective but also potentially harmful' (Carhart-Harris et al., 2018). Another researcher criticized early attempts at controlled LSD research: 'They didn't understand set and setting in the beginning. Patients would be injected with LSD, put in restraints, and somebody would come back hours later. They were put in very drab clinical environments' (Morin, 2014). Like Leary and other first wavers, contemporary researchers design clinical trials with set and setting in mind.

Take, for example, the NYU and Hopkins studies described in the previous section. While part of their research design aligned with current methodological mandates, other parts drew heavily on the bad expert's tools. Careful attention was paid to set and setting in both studies. For example, participants met with study monitors several times before their first drug session, to build rapport with the therapists who would be present during

their drug sessions, as well as to outline the range of possible effects of the drug so that the participant has some idea of what might happen. The drug sessions took place in living-room-like settings (Figure 4). The rooms were decorated with wall hangings and fresh flowers. Table lamps were placed next to the bed, replacing harsh, overhead fluorescent lights. When participants began their session, study monitors invited participants to put on eye shades and lie on a couch while listening to music piping through headphones. Participants were encouraged to 'let go' and focus on their inner experiences.

By optimizing set and setting, researchers hoped to facilitate positive experiences. Many participants reported that the psilocybin experience allowed them to ponder existential questions about the meaning of life and death, leading to insights that helped loosen the grip of fear that had been dictating their moods and behaviors. These results lingered for months after the studies ended. On top of that, over half of the participants in the NYU study reported that the psilocybin experience was one of the most meaningful of their entire lives – at the level of getting married or having a child (Ross et al., 2016). These findings are reminiscent of one of Leary's uncontrolled studies over four decades earlier in which an overwhelmingly majority of participants rated their psilocybin experience as 'very pleasant', changing their lives 'for the better' (Leary et al., 1963). Both the NYU and Hopkins teams found that the rapid and sustained mood and behavior changes correlated with participants' reports of a psilocybin-induced mystical experience (see Giffort, 2020, for more on tensions between science and spirituality in the psychedelic renaissance) – ones the investigators believe were facilitated not by the drug

Figure 4. The living room-like space for clinical studies on the therapeutic effects of psychedelic drugs at Johns Hopkins University. Photograph taken on February 7, 2008 by Matthew W. Johnson and emailed to the owners of Erowid.org by request. Copyright CC BY-SA 3.0, via Wikimedia Commons (http://commons.wikimedia.org/w/index.php?curid=17820236).

itself but by creating a favorable set and setting. Contemporary researchers' antithesis performances, therefore, extend the practices of the previous expertise culture into the current network of biomedical expertise.

Today's researchers pivot away from the bad expert while tweaking old tools to fit with the current institutional milieu, and so far, mental health professionals outside of their expert domain have supported this tinkering approach. For example, former president of the American Psychiatric Association (APA), Paul Summergrad, praised the investigators for their preparation of the participants prior to the drug session, while Jeffrey Liberman, another past APA president, encouraged future investigations on how the setting impacts the effectiveness of psilocybin therapy (Lieberman and Shalev, 2016; Summergrad, 2016) – in fact, a team of psychedelic researchers at Imperial College London is currently using controlled methods to test the set and setting hypothesis (Carhart-Harris et al., 2018). Guy Goodwin (2016), a past-president of the European College of neuropsychopharmacology, similarly highlighted how shaping the setting influenced participants' attitudinal and behavioral changes. But he also had a word of warning about today's psychedelic therapy revival. Explicitly referencing Leary, Goodwin (2016: 1202) reminded readers that these studies 'raise[] the caution that the investigation of hallucinogens as treatments may be endangered by grandiose descriptions of their effects and unquestioning acceptance of their value. Timothy Leary was a research psychologist before he decided the whole world should "turn on, tune in, and drop out"; it is best if some steps are not retraced.' Today's researchers hope that their antithesis performances will effectively exorcize the ghost of Leary, and his notorious transition into a deviant scientist constantly compels them to do so.

Expertise transformed

In the case of psychedelic science, contemporary researchers move away from the bad expert (in the sense that they tell 'bad' stories about Leary and use conventional biomedical methods to study psychedelic drugs) at the same time that they draw on his tools and practices (in this case, set and setting). By reconfiguring the tools of the bad expert to fit with an institutional environment that demands RCT methods, researchers are crafting an expertise that draws on features of the existing network of biomedical expertise while merging elements from their previous expertise culture. Rather than tossing out the bad expert completely, there is a co-mingling of conventional biomedical expertise and the expertise of the bad expert. Researchers retain set and setting as part of the previous expertise culture but mobilize this tool in a way that takes into account the methodological tools that grant legitimacy, thereby allowing researchers to reject the bad expert at the same time that they extend his practices into new spaces. The problem with psychedelic science becomes a problem of the bad expert and how he used these methodological tools, as opposed to a problem with the tools themselves.

Discussion: On the bad expert

The concept of the bad expert demonstrates the key role that cultural narratives and performances play in establishing new expert connections and forging new expert boundaries:

arenas of expertise are assembled and reassembled in part through cultural labor. The lasting power of bad expert narratives and antithesis performances are tied to place, history and institutions, suggesting that cultures of expertise are dependent on symbolic and material resources. By introducing the concept of the bad expert, we argue for merging jurisdictional and network models of expertise toward an understanding how cultural resources are mobilized in expertise transformations. Highlighting the cultural aspects of expertise is one way to demonstrate how social actors simultaneously enact boundaries and establish connections when they perform new expertise cultures into being. Specifically, in both empirical cases, new boundaries are established around credibility performances and field narratives, while tools from previous expert domains are extended into new domains.

The bad expert also reveals that expertise is relational and historically embedded. On the surface, the cases presented here might seem like classic examples of boundary work – that is, actors distinguish between who is and is not an expert. In both cases, however, the bad expert is still an expert, as opposed to being expelled entirely from the bounds of science. In the case of psychedelic science, researchers continue to construct Leary as the bad expert even as their expert work mimics his tools and knowledge. Today's researchers characterize Leary as getting 'tired of science' or refusing to 'play the science game', but do not place him completely outside of their domain. Discounting Leary as an expert – even if he is constructed as a bad one – would put their own reemerging expert domain at risk. The bad expert remains useful, both for directing and uniting scientists' antithesis performances and for retaining his tools. This contribution speaks to literature on hybridity and 'spaces between fields' (Eyal, 2013b), illustrating the porousness and instability of expert boundaries. Indeed, both empirical cases highlight how expertise itself may be transformed and thereby extended – through stories and performances – into new, adjacent domains of professional practice. The study of expertise requires a relational approach that understands the 'inside' of a field to be shaped in part by what is expelled from its boundaries, but in an ongoing, re-constitutive way. The bad expert figure therefore highlights the performative nature of knowledge itself.

Further, expertise must be historicized as part of a larger political and institutional context in order to understand its cultural transformations. Institutions are important to each of the empirical stories. In the anti-violence movement case, institutions were transformed as part of antithesis performances. Feminists performed a new culture of expertise into being by placing therapeutic expertise in the new institutional setting of domestic violence agencies. In psychedelic research, key institutions have remained similar: The first and second waves of research were both conducted in the clinical, academic arena. Thus, while both cases highlight transformations in expert performances, the cases diverge on the question of institutional transformation. In fact, the bad expert figure is mobilized effectively *with or without* institutional shifts, though those institutional shifts matter enormously for the type of expertise that is generated. Despite our focus on storytelling and performance, both cases involve important structural shifts (the development of RCTs, second-wave feminism) of which those cultural factors are a key part.

Finally, the bad expert – or how cultural figures are mobilized to *do things* related to credibility, knowledge and professions – could be used to explicate other cases. In the case of autism science, for example, Andrew Wakefield, who erroneously linked autism

to vaccines and was later stripped of his medical license, could be theorized as a kind of bad expert figure against whom mainstream autism science reacts (see Decoteau and Daniel, 2020).[3] Bad expert figures need not be so public or controversial, however. Bad experts could be constructed by a local group of stakeholders to enact small-scale transformations, in or outside science. Further, it is not the case that all enrollments of the bad expert will be 'successful', as they have been in our cases – plots may indeed unfold 'unpredictably' (Hilgartner, 2000: 7), revealing the limits of cultural transformations in expertise. In either case, the bad expert showcases the power of theorizing expertise as a set of cultural performances and narratives that can be mobilized by interested actors.

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Notes

1. In both of our cases, the bad expert is a male figure whose masculinity is central to his 'badness'. Bad experts need not necessarily be gender-specific, but masculinity and femininity are important cultural resources that may be mobilized to construct 'better' expertise projects (Azocar and Ferree, 2015).
2. Archives accessed: National Coalition Against Domestic Violence (Denver, CO), Harvard Schlesinger Library on the History of Women in America (Cambridge, MA), Illinois Coalition Against Domestic Violence Archives at DePaul University (Chicago, IL), and Smith College Violence Against Women Archives (Northampton, MA).
3. Though in this case, Wakefield is more firmly rejected from the boundaries of legitimate science than the previous bad expert figures were – that is, losing his license.

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