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The Domains of Psychiatric Practice: From Centre to Periphery

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Institutional Expansion

Despite the great attention western countries pay to the mind and human consciousness in philosophy and the arts, disturbances of mental health remain not only neglected but also deeply stigmatizing across our societies. Viewed through a global lens, this marginalization is only amplified further still... mental health is a neglected aspect of human well-being, which is intimately connected with many other conditions of global health importance.

—Excerpt from Editorial, “Launching a new movement for mental health” by Richard Horton, Editor, *The Lancet* (September 2007)

The Lancet Series for Mental Health, launched late last year, aims to raise the global profile of mental health problems and to urge international partners to join the “broad new social movement” to strengthen mental health (Horton 2007). Psychiatry itself is barely mentioned in the series, but the leaders of this movement are psychiatrists concerned with transforming psychiatric practice into an easily employed set of tools that will increase psychiatry’s cross-cultural applicability and relevance to non-clinical institutions. Part of the globalization of health technologies, this movement is nevertheless not based on a straightforward exportation of “Western models” of psychiatry to “non-Western” settings. While North American and Western European traditions dominate, the movement is best characterized as an attempt to converge diverse psychiatric traditions into a relatively unified and institutionally coherent system of values, representations and practices. How this movement will gain or lose ground, and be modified in the process, will be largely dependant on how it is embraced by key institutions and actors within national and regional contexts.

The attempt to create a cohesive global movement for mental health is an example *par excellence* of a possible new chapter in the institutional expansion of psychiatric expertise. The broadening of psychiatric practice to new domains is certainly not a new phenomenon. Since the mid-nineteenth century, psychiatrists in Western Europe and North America began the slow process of creating an institutionally and symbolically self-contained domain of expert practice, one that would assuage internal factions, command respect from colleagues in other areas of biomedicine and help psychiatry advocate for policy attention and public funds (Ellenberger 1970; Porter and Micale 1994; Rosenberg 2007). As psychiatry has become professionalized, the purview of psychiatric practice has widened, infiltrating into a number of non-clinical institutions, such as prisons, the criminal justice system, the work place, the military, immigration law, socio-political movements and formal education (e.g. Scull 1989; Jones 1999).

The papers in this volume aim to contribute to what is now a sizable anthropological literature on diverse aspects of psychiatry’s expanding processes. Following the seminal

works of Michel Foucault, anthropologists and historians working in an array of countries have demonstrated how a significant consequence of this diffusion process—of what is effectively the medicalization of non-medical institutions and of everyday life—has been a shifting definition of that which is considered “pathological,” and so, of that which falls legitimately under psychiatry’s domain (e.g. Castel et al. 1982; Birman and Costa 1994; Barret 1995; Young 1995; Sadowsky 1997; Ehrenberg 1998; Rose 1998). This expansion means that psychiatric practice has become increasingly important not only for defining and treating mental illness, but also for the creation and management of modern identities and of modern society itself (Foucault 1973 (1963), 1977, 1981, 1988 (1965)).

Focusing on these themes, the six articles in this series provide confirmation of the relevance of these theoretical undercurrents, particularly as they relate to the way psychiatric knowledge interacts with other bodies of knowledge from a range of socio-institutional realms outside biomedicine. Kilshaw, for example, traces the infiltration of psychiatry into the UK military, as well as the way military ethos provides a platform for its modification. Béhague’s paper shows how the connections being forged between psychiatry, community mental health and school-based initiatives, while full of opportunities for empowering youth, paradoxically depoliticizes some disadvantaged young men by implicitly encouraging them to seek the “therapeutic” effects of strict military training and discipline. Kitanaka demonstrates how psychiatrists in Japan are both contributing to the transformation of “suicide of resolve” into a form of suicide explicitly linked to depression, and openly confronting the far-reaching implications of the pathologization of suicide and free will. And Saris, in emphasizing psychiatry’s absence, demonstrates how multi-institutional discourses surrounding poverty and inequities in Ireland negate psychiatry’s relevance for the problem of drug addiction.

Importantly, both Velpy and Leibing add a refreshing perspective to understanding the multi-institutional nature of psychiatry. Focusing not simply on newly created disease categories, but on the medicalization of non-scientific concepts—“personhood” and “patient subjectivity,” respectively—these authors tackle the difficult task of unpacking how medicalization infiltrates into the core of societal values. Velpy’s work in a community mental health centre in France, for example, demonstrates how the notion of the patient’s “subjective experience” has been thoroughly medicalized and is now considered a core component of the collective therapeutic endeavor. Although the patient perspective is treated by practitioners to be a distinct entity emerging from the patient’s mind, in practice, the co-production of the patient’s “illness narrative” by both psychiatrist and patient constitutes a therapeutic goal aiming to imbue the patient with rationality. Leibing’s historiography, in turn, shows that the emergence of “personhood” as a concept is a reflection of a particular socio-historical moment in the science and biomedical practice of Alzheimer’s. A globally salient and culturally specific concept, personhood has enabled certain health practitioners to defend humanist values against the supposed threat of biomedicine’s reductionistic tendencies.

The papers in this series do not simply demonstrate psychiatry’s powerful expansion, however. They also capture psychiatry at a tension-filled cross-roads, one in which psychiatry is showing considerable ambivalence towards maintaining itself as an institutionally coherent and hyper-specialized body of knowledge and practices. On the one hand, to preserve its status, psychiatry must persist with the continual recreation and reestablishment of itself as a distinctive body of expert knowledge, a movement that can be seen as a continuation of its history. Unification and assumptions of universality have been and continue to be central to psychiatry’s authoritative power. Objects of medical attention—prototypically, the diagnostic category—have come to be defined through a core set of ahistorical and acultural characteristics (Foucault 1973 (1963)). A well-known example of

this phenomenon was the biomedical “revolution” in US psychiatry of the 1970s and 1980s, culminating with the marginalization of psychodynamic approaches and the creation of a symptom-based categorical system of disease classification embodied in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (Kleinman 1988; Hale Jr 1995; Gaines 1992b; Good 1996; Mayes and Horwitz 2005). This has given psychiatry a more concrete, reproducible and distinctly pharmacological and geneticized character, thereby also facilitating its infiltration into (and modification of) national psychiatric entities across the globe (Lock 1987; Gaines 1992a, b; Luhmann 2000; Lakoff 2006; Lee and Kleinman 2007).

At the same time, over the past 50 or so years, psychiatric institutions have sought to become more socially accepted and less stigmatized, more central to everyday life and in dialogue with other institutions. The shift to a more mainstream and de-specialized form of psychiatric practice is somewhat antithetical to the historical processes that established psychiatry as an expert field of professional practice within medicine. The US de-institutionalization and community-based mental health movements of the 1960s, for example, gave prominence to less specialized practices relating to mental health prevention and the incorporation of the social determinants of mental disorders in psychiatric initiatives (Dain 1994). The biomedicalization of psychiatric practice and the rapid infiltration of pharmaceutical regimes since the 1970s, while based on a highly specialized body of knowledge, has also meant significant increases in interventions for less severe disorders, such as mild depression, now experienced by “average” citizens (Healy 1997). Throughout the 1980s and 1990s, mental health advocates have pushed to make psychiatric expertise more central to international public health practice, and thus, less individualized and more population-based (WHO 2001). Psychiatrists committed to population health have called attention to high prevalence rates of “common mental disorders” and their role in determining an array of physical and social ailments in developing countries (Patel 2007). These changes have also given increased visibility to social critiques of cross-cultural psychiatry, creating an imperative for psychiatry to adopt a more radically relativistic and sensitive understanding of “cultural contexts” (Littlewood 1990; Dejarlais et al. 1996; Kirmayer 2006).

Reflecting on the ramifications of larger global developments such as these, papers in this series show that the mainstreaming of psychiatry is diluting the core institutional processes through which psychiatry originally came to hold power. To gain wider societal acceptance, psychiatry must show considerable flexibility. In Japan, for example, Kitanaka’s work demonstrates the new subtle powers of persuasion that psychiatry must adopt to be accepted as a natural and internalized form of personal transformation. Béhague’s paper highlights the “watering down” of psychodynamic principles in Brazil to suit a new politicizing form of public sector psychiatric work—work that is carried out in shantytown clinics and schools for youth. In turn, Leibing’s work, on the emergence of “personhood” in psychiatric discourse surrounding Alzheimer’s shows how the ethos to which psychiatry must adapt itself is at times more conceptual and broad-based in nature, more “commonsensical.” Crucial to the emergence of the personhood concept in psychiatric knowledge has been the strengthening of a stark duality between a “flat” biomedical intervention and a “deep” one provided by other professionals, precisely those that emphasize the notion of “personhood.”

The expansion of psychiatry now clearly depends not only on bringing individuals to the asylum or clinic, or on redefining pathologies to gain greater command over specific subgroups or other institutions. Psychiatry must also look outwards and adapt to working in new institutional terrains and subpopulations. While continuing to develop a specialized and scientific body of expertise, it must also recreate and redefine concepts to fit with local cultural codes, with everyday concerns and with diverse epidemiological realities.

Institutional Disruptions

In studying psychiatry at a cross-roads, these papers underscore the importance of arguments put forth by Atwood Gaines regarding the immense diversity that exists in the ethnopsychiatries of professional communities within North America and Western Europe alone. As Gaines' seminal book demonstrates, even professional psychiatric communities that share similar historical roots evolve into distinct institutional and symbolic forms (Gaines 1992a, b). Moreover, these are not harmonious historical creations. At the same time that multi-institutional expansion affords psychiatry a wider landscape in which to develop, it also leads to inter-institutional tensions and analytical upheaval (Kleinman 1978; Gaines 1992a, b). It is through such upheaval, in turn, that psychiatry's fundamental assumptions are disrupted and unsettled, and that we, as ethnographers, are given the opportunity to directly observe the process of societal and institutional change.

In exploring diverse historical disruptions, we are confronted with the limitations of the theoretical premises that oriented the anthropology of psychiatry during earlier phases of psychiatry's history. Focusing on how the relationship between psychiatry and other institutions effects change at various levels—societal, representational, symbolic, emotive—papers in this series flag the need to nuance what have become rather standardized “Foucauldian” understandings of the hegemonic power of medicalization. As Rose has argued, such understandings typify biomedical practices as flowing primarily in one direction—that of gaining greater hegemonic power and of subsuming subjectivity through both explicit domination and subtle persuasion (Rose 2007). This linear view of medicalization posits power and meaning in opposition to one another, the biomedical system in contrast to the individual's subjectivity (Jenkins 2004; Biehl et al. 2007). Structured by this polarity, we often read that biomedicine silences local resistance and denies “cultural context,” and we are implicitly taught that it is the duty of the social researcher to unveil the underlying (and often more righteous) experiences of biomedicine's subjects.

Authors in this series empirically scrutinize this polarity, and show that much of psychiatry today gains ground not through a triumphant colonizing of new domains. The widening of psychiatric practice is not ever-increasing or institutionally pre-determined, nor is the unifying endeavor of medicalization ever wholly complete. Rather, while certain aspects of medicalization are indeed highly authoritative, others are intensely malleable, creating pathways for personal and social transformations that need not inevitably fall prey to the dominating mechanisms of power.

At the core of this malleability is the production of authoritative practices that are not so neatly imbedded in biologizing the social or existential. Intra-institutional upheaval and cross-fertilization muddles the biological-social polarity. In Japan, for example, Kitanaka shows us that the growing medicalization of suicide has not necessarily meant side-lining the cultural ethos of “suicide of resolve,” nor straightforward biological reductionism. Outside the therapeutic encounter, psychiatrists often demonstrate considerable respect for Japanese psychiatry's own distinctive cultural heritage, together with genuine interest in understanding the existential depths of the mind. To effectively tame suicide ideation, however, they also recognize the importance of resisting their patients' compelling arguments against medicalization. Therefore, psychiatrists emphasize the biological treatment of depression and are intentionally “reductionistic,” but not because they cannot see beyond the pathology or do not appreciate the existential will to die. Rather, when faced with the ease with which engaging in matters of the will can be used to justify suicide, they respectfully leave questions of intentionality aside.

Whether biologization takes on reductionistic qualities or not is clearly a result of the way professionalizing trajectories are made meaningful in time and space. In the UK, for example, Kilshaw argues that the psychiatrization of Gulf War Syndrome in the UK implies not a process of biologization but of psychologization, one that veterans equate with feminization and the generalized view that the syndrome is not “real,” or “just in the mind.” These portrayals are adamantly rejected by Gulf War patients, who insist on a biological explanation to their condition, claiming that it originates from exposure to chemical toxins. Even when veterans acknowledge the existence of psychological symptoms such as anxiety, they attribute these not to the trauma of war, but to the stress of the medical establishment’s persistent denial of the physical legitimacy of their illness.

The malleability of the medicalization process also means that the establishment of authority is a punctuated process. At one extreme of the exercise of power is negation, the refutation of psychiatric authority. Notwithstanding the many examples of outright resistance to psychiatric knowledge found throughout the papers, two papers significantly demonstrate psychiatry’s truncated attempts to harmonize itself with wider societal concerns and new socio-institutional processes. Saris’ work, for example, analyses the negation of psychiatric influence over drug-addiction in Ireland, despite the fact that, in many regards and in many other settings, drug addiction represents a phenomenon which readily lends itself to biologically inclined psychiatric practices. As he shows, the localization of treatment within a system of methadone maintenance therapy controlled by the general practitioner rather than the psychiatrist has come to serve a variety of compelling non-clinical interests—particularly those relating to public welfare policy and the governance of poverty and inequalities. For the time being in Ireland, these interests are proving much more powerful than the persuasions of psychiatry, no matter how locally it is constituted. Kilshaw’s work, in turn, demonstrates a different type of negation, one in which the symbolic powers generated within psychiatric debates in the US are contributing to the derailing of what might have otherwise been a logical progression towards the medicalization of Gulf War Syndrome in the UK. The social and cultural associations now tied to Post-Traumatic Stress Disorder (PTSD) in the US—specifically that it legitimates patients’ search for legal compensation—have contributed to Gulf War veteran’s avid stance that Gulf-War syndrome is not PTSD. To ascribe to a view of Gulf War Syndrome that is akin to PTSD would mean to willingly ascribe to a “victimized” status and thus, to contradict the masculinity and robustness of the UK military culture. The specificity of the UK scenario then, means that veterans are currently being persuaded by their military identity more than a need to ascribe to a medicalized condition.

The papers also show that the punctuated forces that limit psychiatry’s power are not always imbedded in the explicitly articulated positions of popular-patient responses or psychiatry’s critics. Rather, as both Kitanaka and Béhague demonstrate, disruptive and limiting forces can also result from dilemmas played out within psychiatry. This is particularly true in settings where psychiatric practice is heterogeneous and where multiple forms of psychiatric practice come into contact with other institutions. Examples in papers by both these authors demonstrate the creation of a wider social climate that enables some psychiatrists to openly grapple with conflicting, polarizing forces in society, sometimes within a single therapeutic encounter. Rather than resolve these conflicts by jumping to either side of the polarized fence, or indeed, straddling the fence, some of the professionals these authors came to know found responses that did neither. As such, they both defy polarized categorization and attenuate established forms of power.

Limitations on psychiatric authority can also be unintentional products of wider societal developments. Saris’ work on the negation of psychiatric power does not attribute resistant power to any one group, individual or discourse. Rather, he sketches a historicizing map of

how diverse discourses and sets of practices around the social recognition of the heroin user have engendered psychiatry's "institutional hesitancy" to see heroin addiction as a market for its services. Béhague, in turn, shows that although the therapeutic encounter shapes some young men's view of military training as a self-perceived opportunity for psychological transformation, it does not do so deterministically. Such consequences are unintended, indeed opposite developments to the therapists' politicizing aims, and result, rather, from the institutional, political and economic conditions through which psychiatric knowledge and interventions are imparted.

Finally, the series underscores that conflict and upheaval can be productive therapeutic processes that need not reify a unidirectional form of psychiatric power. As psychiatry accommodates itself to new institutional arrangements, new practices emerge, along with new opportunities for individual agency. Velpry, for example, shows that the co-production of the "patient's view" in the French therapeutic encounter is a negotiated and conflict-ridden process. Although not in any way a direct representation of subjectivity, the production of patient illness narratives in the clinic nevertheless functions as a resource for patients to garner status, legitimacy and freedom of action. In Brazil, Béhague also focuses on the potential for new conflict-ridden psychiatric forms to empower both therapists and patients to use psychiatric knowledge as a tool for wider moral and socio-political struggles. For many young men, the school therapist, seen to be a member of the upper class, represents a contentious and conflict-inducing figure. However, this very feature renders the therapeutic encounter an initially productive counterpoint through which youth begin to work through their difficulties with inequities and social injustice. Psychiatry is therefore partially achieving its politicizing goals precisely because it lends itself to the social reproduction of class-based conflict.

The Anthropological Endeavor

To a large extent, a proper empirical exploration of medicalization has been constrained by the difficulty of fully embracing the notion that medical knowledge and practices are ever-changing products of history (Lock and Gordon 1988; Lock 1993; Young 1995). In breaking the mechanisms of this premise down further, Allan Young has argued that global scientific discourse—a non-localized and global template based on scientifically produced knowledge—is in a dialectical relationship with clinical ideologies, or local systems of knowledge that are embedded in a particular institutionalized hierarchy of practices (Young 1993). This creates a constant tension between global concepts and institutional practices, as well as the forces that unpack these concepts and institutional practices. The science of depression and drug addiction, for example, together with evidence-based standards promoted for use in the clinical encounter, come into conflict with what it actually means to be depressed in Japan, or a drug addict in Ireland, or a "problem student" referred to a school psychiatrist in Brazil. Such a theoretical premise is analytically inspirational, but difficult to articulate in all its ethnographic detail. To do so, we must first learn to critically reflect on both biomedicine and our own disciplinary heritage. Thanks to Young, epistemologies in medical anthropology have been carefully scrutinized, and we are now keenly aware of the ways anthropology has often been circumscribed by biomedical knowledge systems and their assumptions about rationality (Young 1981).

However, one lingering and persistent rationalistic bent is found in standard portrayals of medicalization's mechanisms of power, as noted above (Lock 2001). The roots of these assumptions can be traced to wider changes in anthropology throughout the latter part of the 20th century, which turned to the study of individual subjectivity, in part, to counter the deep-seated consequence of 19th century armchair anthropology and its contributions to evolutionary science and post-colonial exploitation (Stocking Jr 1992; Fox and Gingrich

2002). The move from over-generalizing and broad-brush comparisons to intense localized fieldwork and a detailed consideration of “subjective experience” represented an indispensable shift in the way ethnography was used in anthropology. However, recent scholarship has sometimes tilted the balance so heavily in this direction that what we now often produce are highly individualized accounts of personal experience, driven by the desire to give members of local communities (usually subordinated groups) a “legitimate voice” (Butt 2002; Littlewood 2003; Biehl et al. 2007). Through this, we risk (re)creating an unsatisfactory separation between subjectivity, or “lived experience,” and the social and institutional structures that allegedly shape subjectivity (Frohlich et al. 2001).

The contemporary ramifications of these historical roots have influenced theoretical frameworks not only in anthropology but in the social and medical sciences as well, as is well exemplified in the papers by Leibing and Velpry. Both authors carefully outline the historicity of two concepts—“personhood” and “the patient’s perspective”—that as anthropologists we often take for granted. Leibing shows that ardent critiques against the “neurological determinism” of biomedical approaches to Alzheimer’s have made recourse to the notion of “personhood,” giving the dualistic concept—biological reductionism versus “deep personhood”—considerable social currency both within and outside of medical communities. As Leibing cautions, when a dualistic concept is at the crux of a cultural phenomenon, anthropologists’ own analytical use of the concept and of the polarity by which it is characterized runs into slippery ground.

Like Leibing, Velpry also uses her research to bring epistemological questions to the attention of anthropologists. She shows that there is now a strong moral imperative in anthropology to take the patient’s perspective into account, to the extent that some works in medical anthropology can be characterized as a type of advocacy that aims to empower patients. To be swayed by this moral-political imperative is problematic, she contends, not in and of itself, but because it has a tendency to obscure analytical clarity. Velpry claims that many anthropological treatments of the patient’s “subjective experience,” while in no way assuming such an entity is stable and rational, as is the case in some mental health practices, fail to thoroughly define and historicize the concept, both theoretically and empirically.

Rationalistic understandings of medicalization also impact on anthropology’s empirical practices. The focus on subjectivity has sometimes been erroneously understood to mean the study of individual experiences and locally formulated meaning-systems (Biehl et al. 2007). This has supported the disproportionate use of particular methodological techniques, most notably, the interview. While interviewing is useful for eliciting compelling first person narratives, the near-sole use of interviews feeds into theoretically simplistic understandings of subjectivity. In order to adopt an empirically sound approach that is less biased towards limited understanding of subjectivity, it is worth reconsidering the merits of a more holistic ethnographic approach based on participant-observation, informal and formal interviewing, broad-based survey work (be this qualitative or quantitative), comparative analysis and archival research. Such ethnographies are better poised to avoid polarizing subject from structure. More importantly, history is not relegated to a background section. History, rather, becomes a fundamental way of accounting for the differential patterning of psychiatric knowledge systems, without losing sight of the subject as both a product and agent of history (Dreyfus and Rabinow 1982; Sanjek 1990; Jodelet 1991; Guess 1999). Saris’ paper, for example, in focusing not on the space that psychiatry occupies, but on the various forces and discourses that intersect to unwittingly disallow any breadth of psychiatric work, demonstrates particular prowess in coherently combining data collected from various sources. Indeed, to adequately represent negation, his research focuses only partially on first-hand accounts from drug addicts, and rather, is a medley of discourse analysis,

historical research and thick description of Ireland's national policy environment, placed within a discerning comparative framework.

The excessive use of interviewing, together with individualizing understandings of subjectivity, can also lend itself to an unbalanced focus on societal polemics. It is easier to conduct interviews, write and analyze, within a framework that privileges polarized debates and provides visible contrast. To do so neatly frames the fieldwork and analysis, and anchors writing. However, the degree to which we emphasize cultural polarities in our ethnographies should reflect empirical realities, rather than analytical ease or a theoretical predilection for a trope of contrasts (Fernandez 1991). As Ian Hacking has shown, cultural polarities are one of four central and socially variable "vectors," or forces, that account for the historical appearance of a particular mental disorder (Hacking 1998). The importance of historically-specific cultural polarities in bolstering the power of medicalization over a meaningful constellation of symptoms is further evidenced in Leibing's work on Alzheimer's and the imaginary of "personhood." Similarly, as noted above, several papers in this series demonstrate that the collapse of the biological-social polarity within certain segments of psychiatric practice is historically and socially contingent.

Questions regarding psychiatry's diverse mechanisms of power and the relative salience of cultural polarizations in establishing that power should be resolved through empirical means, rather than philosophical exercise or semantic refinement. That is precisely what this series of articles, as a whole, begins to accomplish. It flags the specific social and institutional conditions through which certain types of psychiatric practices become authoritative, while others do not. It is only by giving additional attention to the systematic question of how medicalization garners its power, rather than letting our theoretical inspirations color our orientations a priori, that key questions regarding the emergence of diverse epistemic systems and practices in psychiatry can be answered. It is also only by recovering the methodological medley of the ethnographic endeavor that we can properly investigate the societal and institutional production of pathology.

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