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> *You must always be puzzled by mental illness. The thing I would dread most, if I became mentally ill, would be your adopting a common sense attitude; that you could take it for granted that I was deluded.* Ludwig Wittgenstein (Drury 1981:161)

Contemporary medical anthropology has peculiar problems. Like its cognate subfields, it is by necessity a scavenger of interpretive tools from diverse intellectual traditions. The art of producing an analytically adequate and intellectually honest piece of ethnography increasingly requires fluency in a plethora of historical, linguistic, philosophical, and economic theories and methodologies; medical anthropologists are, after all, anthropologists, and, as such, must contextualize their studies in a way that gives equal weight and dignity to the full range of human experience. Unlike many of their brethren in the sociocultural subfield, however, medical anthropologists face the awkward and seemingly omnipresent dilemma of having to vie with Western biomedicine for explanatory legitimacy at every turn, even when working alongside biomedical physicians toward similar goals, and even when themselves employing some of biomedicine's interpretive tools. Analyses of illness that dramatically depart from conventional etiological/epidemiological accounts are (at least outside of the pages of sympathetic periodicals such as *Medical Anthropology Quarterly*) commonly subject to a level of scrutiny, puzzlement, skepticism, and objection not faced by the initial, often flawed, biomedical accounts (Good 1997). Whether one interprets the explanatory hegemony of Western biomedicine as a historical outcome of colonial and economic forces, or as an inevitable outgrowth of Enlightenment rationalism, there can be no doubt that even our preference for the label "medical anthropology" over "anthropology of health and illness" constitutes "yet one more example of the powerful influence of M.D. medicine […] in the modern world" that unwittingly repackages and reproduces within it "the curative rather than preventative nature of health care in modern societies." (Baer et al. 2003:vii)

In this paper, I consider three propositions for a curricular tradition of what, following the nomenclature of our five-field discipline, could be termed 'psychiatric anthropology' (i.e. the anthropology of psychiatry). Each of these propositions strives to problematize medical anthropology's longstanding love-hate relationship – or, in the parlance of psychotherapy, its inferiority-superiority complex – with the diagnostic toolkit of Western biomedicine. Each additionally develops a distinct analytic framework within which their authors recommend that anthropological inquiries into psychiatric experience should be undertaken. Psychiatrist-turned-anthropologist Robert Levy recommends that anthropologists capitalize on the mainstream currency of biomedical vocabularies, entreating us to recontextualize our analytic objects and elucidate the subtle yet significant variability that exists within "pan-human" psychiatric categories with unmistakably biological etiologies – i.e. certain affective disorders, schizophrenic disorders, and "organic brain syndromes." (Levy 1992:214) By contrast, critical medical anthropologists Hans Baer, Merrill Singer, and Ida Susser (2003) advise us to look toward the capitalist world system for the processes by which psychological differences become pathologized, stigmatized, and reinterpreted as industrial handicaps. Finally, medical sociologist Nick Crossley (2004 and 2006) suggests that anthropologists take their cue from psychiatric survivor movements, and, rather than interminably focusing on the functionalist objectifications of biomedicine, explicate the logics upon which psychiatric subjects themselves deconstruct, resist, and subvert those objectifications. In interrogating the shortcomings of the above propositions, and with the hope of furnishing future researchers with a synthesis of their merits, I ultimately argue that an efficacious anthropology of psychiatry must adopt as its point of departure the candidly transformative objective of repoliticizing mental illnesses as historical rather than congenital events. Anthropologists must, in short, develop ethnographic, historiographic, and rhetorical strategies for destabilizing the biological with the biographic.

Not Pathology, but Pathogenicity

In his influential 1992 essay "A prologue to a psychiatric anthropology," Levy contends that a proper psychiatric anthropology would conceptualize Western psychiatry as one of multiple epistemological systems for making sense of psychological/behavioral difference, and would resist the temptation to view culture-specific forms of difference as mere variants of universal nosologies. While anthropologists wishing to make psychological dysfunction the organizing principle of their research may find it helpful to treat the simplified disease objects gathered in such compendia as the *Diagnostic and Statistical Manual of Mental Disorders* (hereafter "DSM") as starting points for their research, they should recognize that it is ultimately the **pathogenic contexts**[1] of these objects that are of etiological significance, and not the rote recitations of symptoms, laboratory findings, or even demographic patterns said to be associated with them. In order to shed light on the biographic emergence and experience of mental illness, anthropologists must ask

> whether there are specific aspects, clusters of aspects, or kinds of sociocultural environments that are significant for the production or prevention of some features of

[1] "Pathogenic" as in "creative (-**genic**) of pathology (**patho-**, i.e. social deviance)," not "infiltrated by (-**ic**) a disease-causing agent (**pathogen-**, i.e. foreign microbes)." The distinction between the two usages, both of which have some currency in the epidemiological literature, is obviously quite crucial when it comes to conceptualizations of mental illness.

> or kinds of personal disorders. This direction of inquiry would take us beyond the search for phenomena illustrating variations in frequency and quantity, form and course of disorders. (Levy 1992:216)

Moreover, in reinserting "pathogenic contexts" into etiological narratives, anthropologists should pay careful attention to regional histories, local processes of identity formation, and other kinds of social transactions paradigmatically excluded from biomedical narratives in order to distinguish **necessary** etiological agents from **sufficient** ones. While certain congenital factors may precondition an individual's susceptibility to, for example, schizophrenia, the cultural factors that activate the disorder will in most cases determine whether or not an individual ultimately develops the condition – as corroborated by numerous studies on identical twins (Levy 1992:215-216). The crucial danger in confusing necessity with sufficiency is not simply that it encourages a reduction to the genetic, or that it trivializes the role of sociocultural environs, but that it "manipulates its model of disorder so that those people who have the 'necessary factor' but do not have the disease may be said to have the 'latent' disease" (Levy 1992:219). To conflate genotype with phenotype is to dehumanize *a priori*; a society that places too much faith in the logic of biological predisposition may soon find itself confronted with a multitude of legal controversies and unpleasant eugenicist questions.

While many of Levy's observations are no longer particularly novel, he does advance several provocative questions that would-be psychiatric anthropologists continue to find fruitful. How might local understandings of culpability and responsibility elucidate local rates of suicide and self-destructive behaviors, as well as the logic behind particular instances of suicide ideation and self-contempt (Levy 1992:218)? Is it significant that the notions of **incompetence** (e.g. communication disorders, social phobias) and **over-competence** (e.g. obsessive-compulsive disorder, anorexia nervosa) have both been leveraged toward the legitimization of new DSM categories?

The Historical Materialist Intervention

This latter question is taken up by Baer et al. in *Medical Anthropology and the World System*, wherein they outline the neo-Marxian tenets of critical medical anthropology (hereafter "CMA") and conceptualize mental illnesses as pan-societal maladies with roots in the global capitalist system. Whether defined upon the criteria of incompetence or over-competence, labels of mental disorder achieve their legitimacy from debilitations in patients' daily functionality, industrial efficiency, and/or occupational performance. Baer et al. (2003:4-5) argue that the concept of health is intelligible only in the context of a system of production, and distinguish between "functional health" (optimal capacity to carry out productive work that contributes to profit-making, and a normative requirement of social life under capitalism) and "experiential health" (access to material and nonmaterial resources that permit freedom from illness and alienation). Within this framework, mental illness is interpreted as a mechanism for expressing dissent from – and signaling the untenability of – existing sociocultural arrangements as well as "certain core values, metaphors, beliefs, and attitudes […] such as self-reliance, rugged individualism, independence, pragmatism, empiricism, atomism, militarism, profit-making, emotional minimalism, and a mechanistic concept of the body and its repair" (Baer et al. 2003:6, 12-14; Martin 2006[1992]). This is not to

say that all mentally ill individuals are *ipso facto* opponents of free market economics, only that the rising diagnostic rates and worsening prognostic trends of major mental disorders in capitalist societies – especially clinical depression, addictions, stress disorders, and anxiety disorders (Jadhav 2000; Kirmayer 2002:305-309; Young 2004; Capps 1999) – are indicative of, to use Levy's coinage, the existence of an empirically constituted pathogenic context whose determinants must be traced back to material relations of power and the ideologies that legitimate them.

Anthropologists of psychiatry who wish to take a CMA approach to their subject matter should thus begin with historiographic inquiries into the confluence of material circumstances that has allowed biomedical psychiatry to achieve its hegemony in the West; such inquiries will help reveal the historical particularity of certain mental illnesses and illuminate their social etiologies. Private sponsors and governmental agencies in the United States (e.g. the Carnegie and Rockefeller foundations), for instance, have traditionally provided funding only to medical schools and research institutes that heavily emphasize germ theories of disease, and that lend legitimacy to adverse industrial conditions by focusing attention on "discrete, external agents rather than on social structural or environmental factors" (Baer et al. 2003:13; Herman 1996). The interests of biomedical professionals and the emerging capitalist class were thus reciprocally serviceable, as the former would receive financial patronage from the latter, and, in return, the latter would be both inoculated from proletarian criticism and provisioned with a healthier workforce that would contribute to economic productivity. As a result,

> [a]lthough a patient may be experiencing job-related stress that may manifest itself in various diffuse symptoms, the physician may prescribe a sedative to calm the patient or help him or her cope with an onerous work environment rather than challenging the power of an employer or supervisor over employees. (Baer et al. 2003:15)

It is evident that the above relationship flourishes today in the therapeutic practices of what Foucauldian scholar Nikolas Rose (1998 and 2001) has influentially termed the "psy" disciplines. Psychiatrists will prescribe drugs – encouraged by the "constant extension of pathological terminology to cover new conditions and behaviors," which is itself partly driven by "the profit to be made from discovering new diseases in need of treatment," (Baer et al. 2003:14) – psychologists will accentuate the role of such things as individual personality and attitude, and psychotherapists will dwell on dysfunctional familial relationships, but none will generally encourage a view of psychic distress as something systemically nourished by forms of structural violence. Baer et al.'s argument is, in this regard, trenchant and quite refreshing, but nonetheless emblematic of a kind of economic determinism that, in many ways, undermines the authors' humanitarian objectives. By insisting on a "historical materialist epidemiology" that construes the economy as the engine of all social activity and thus the prime mover of not only psychological distress, but the concretization of distress into objective illness categories, Baer et al. (2003:54) yoke two independent phenomena together: 1) the deprivation and alienation of disprivileged demographics (workers, women, aboriginals, sexual minorities, the homeless, etc) and 2) the experience of psychological distress, which is **not** restricted to the aforementioned disprivileged demographics, even if there is some evidence of stratification in diagnostic rates. What are we to make of the clinically depressed multimillionaire, or the bulimic Fulbright scholar? If indeed Baer et al. insist on the neo-Marxian contention that socio-economic inequality and unequal accessibility of resources are the primary determinants of mental illness, then the very fact that mental illness transcends class lines, albeit unevenly, would

seem to immunize proponents of biological reductionism to a good deal of criticism.

Difference or Dissidence?

In his pioneering work on anti-psychiatric social movements, Crossley (2004 and 2006) accordingly critiques CMA for falling into the same trap as the biomedical authorities it claims to critique; that is, the imposition of *a priori* categories upon individuals, and the consequent identification of coercion, dominance, and subordination, where there is, in fact, consent, resistance, and negotiation. The classical Marxist stances popular within CMA, wherein social inequality and class stratification are posited as logical precursors to the "systemic" and "institutional" oppression of individuals within medical systems, Crossley (2004:163) argues, are too rigidly "macrocosmic" and fail to capture the "dynamic, conflictual, pluralized and fluid nature of the world of mental health, past and present." Anthropologists, whose careers have historically been built on the enterprise of classifying disprivileged Others, have an obligation to honor the fact that, in today's world, those Others can speak for themselves, and do not need to loft the banner of *prima facie* marginality in order to resist, frustrate, and deconstruct the disciplinary projects to which they are subject.

Crossley develops this assertion by examining the political tactics of psychiatric survivor movements through several notions developed by Pierre Bourdieu: that of 'symbolic violence,' the processes by which social difference is construed as nature-given, and those who are different are enjoined to self-regulate and self-censor; that of the 'habitus,' the learned dispositions that are anchored in individuals' daily practices so as to achieve a commonsensical texture; and that of the 'illusio,' whereby actors who struggle for expertise, authority, and rights within an established paradigm must already believe in the rules of the game in order to even participate in that struggle. Within this theoretical framework, Crossley examines how members of European psychiatric survivor organizations as the Campaign Against Psychiatric Oppression (CAPO), the Mental Patients Union (MPU), and the European Network for Alternatives to Psychiatry (ENAP) have corralled discursive and semiotic resources to combat their depiction in the popular media and biomedical discourse as weak, irrational, and cognitively deficient, while at the same time strategically accepting those very images when pushing for policy reform.

The salient point, as Crossley sees it, is that the biomedical (and, indeed, popular) portrayal of psychiatric survivors as irrational and vulnerable constitutes a recalcitrant form of symbolic violence, wherein survivors are unremittingly confronted with both overt and covert allegations of "being mentally ill," and must live in an environment wherein the equation of difference with deficiency is everywhere encoded. The rhetorical strategies by which survivors reconfigure themselves as "**not** being mentally ill" should therefore not be interpreted by scholars **only** as political activism, but also as a deep phenomenological opposition to the cognitive and behavioral self-policing that has been socialized into these individuals since birth (Crossley 2004:162). Such forms of opposition will have consequences for their habitus, and thus for the personal, professional, and philosophical choices they make in their lives generally.

Diagnosed schizophrenics in the British Hearing Voices Network (HVN), Crossley (2004:171-173) observes, have collectively reinterpreted their auditory hallucinations as a boon rather than an impediment to their everyday functionality. The existence of the organization, which provides resources for impoverished schizophrenics and lobbies for expanded patient rights, is thus enabled only by the collective harnessing of a reclaimed habitus unique to, but shared amongst, a larger community of schizophrenics who can neither be monolithically classified by class, gender, or any other singular demographic label. The alliance is sustained on the basis of psychological difference alone; rather than arguing that their 'difference' is a social construct with roots in systemic inequalities, members deploy a kind of strategic essentialism that challenges the **pathologization** and **stigmatization** of intrinsic difference without refuting the **validity** of difference as an organizing principle. CMA analysts who focus exclusively on structural violence while ignoring the role of symbolic violence are thus failing to honor the phenomenological realities of mental illness, omitting a crucial dimension of its ontogeny, and neglecting to credit survivors for their political versatility.

Confronting the Tyranny of the Category

Slightly under two decades ago, Nancy Scheper-Hughes forewarned against a burgeoning malaise that she discerned among medical anthropologists, whose "once-holistic" roots had seemingly been cast aside in favor of increasingly esoteric divisions. Medical anthropology, she lamented,

> seems to have departed from its roots as a bridging discipline between the fragmented human sciences […] biology and culture, history (writ large) and ethnology have seceded from the union and now "liberated" each is free to pursue its own form of reductionism. (Scheper-Hughes 1992: 221)

Without necessarily echoing her alarm, it is perhaps worthwhile to consider her criticism. The uniqueness of our discipline, its utility, and often its professional allure resides in its epistemological and methodological diversity. Anthropologists are linguists, literary theorists, forensic investigators, ecologists, biographers, biologists, cartographers, and sometimes novelists; it is this versatility that permits us to level critiques at other scholars – sociologists, development theorists, legal scholars – on their own terms without having to feign fluency in their vernacular. Our challenge now is twofold: to sharpen our interdisciplinary literacy with biomedicine and its cognates, but in a critical rather than deferential manner; and, in so doing, to elucidate the emergent, rather than immanent, character of illness experiences.

What lessons should we learn, therefore, from the theorizations of Levy, Baer et al., and Crossley, and how might we fruitfully synthesize them? The key to this exercise, I think, resides in a holistic credo of restoring historical depth and geographic breadth to the subjects of our theorizations, and in so doing reauthorizing those subjects to speak for themselves and be received with due gravity. As Jackson (2003:185) has eloquently observed, "It is not actually the case that the sick do not speak; rather, when they speak they are seen as making no sense, because the illness has taken charge and has the floor." In aspiring to disquiet the overly consonant logics of DSM psychiatry and render suspect its reductionist instruments, it is imperative that we devise techniques that specifically permit the **evidentiary value** of anthropological investigations (discourse analysis, participant observation, oral history elicitation, and so on) to be legible outside the boundaries of our discipline, and, in so doing, open

up the floor to those whose lives are most impacted by expert discourses (Capps 1999:86; Gabriel 2004). While the theoretical frameworks advanced in the works analyzed above may be founded on quite distinct epistemic premises and political priorities, I think it would therefore be reasonable to extract from them four fundamental methodological criteria that a robust anthropology of psychiatry must be equipped to meet:

- An adequate means of distinguishing **proximate** and **ultimate** causes of specific mental illnesses.[2]
- An explicit aim of recontextualizing, repoliticizing, and rehistoricizing mental health issues through elucidations of pathogenic conditions.
- Methods for critiquing the specific ways in which hegemonic texts (e.g. the DSM, clinical scripts, standardized questionnaires) systematically delegitimize and obscure social etiologies.
- Methods for reinserting alternative etiological narratives into mainstream medical conversations and, ultimately, into lay discourse.

It is often a contentious enterprise to advance, let alone advocate, first principles of social scientific investigation at a time when anthropologists have justly come to view prescriptive projects with considerable *prima facie* suspicion.[3] Yet the shared ethical imperatives of medical science and medical anthropology surely enjoin us to do a little more than merely 'no harm.' In order to expose and unpack what Michael Lambek (2004:9, 13) rightly terms the facile "encyclopedic projects," "easy attributions of accountability," and "linear inevitabilities" of MD medicine, anthropologists of psychiatry must ultimately be literate in the language of biomedical science and trained in the use of its heuristics – not only to be able to communicate with doctors within their own frame of reference, but to be able to recognize subtle errors in biomedical reasoning when they occur and to understand how those errors are methodologically produced. "Neither scientific expertise nor bureaucratic or legalistic rationalization will find in irony a happy bedfellow," observes Lambek (2004:2). And indeed, anthropologists who seek to honor their informants' narratives and confute clinical meta-narratives may find it useful to illuminate the perils of overliteralization: to explain why it is that those who are sick and suffering will so often thumb their noses at those who presume to offer help; to highlight the tragicomedy in the seemingly bottomless capacity of highly educated MDs and PhDs to overlook simple things like the anaesthetizing comforts to be found in a bottle or at the edge of a razor blade, or why a person might choose to act out of anguish rather than economic rationalism.

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[2] Despite the differences in the terminology used by each author – "**microdepressogenic**" versus "**macrodepressogenic**" (Levy 1992:215); "**microparasitic**" versus "**macroparasitic**" (Baer et al. 2003:6-7); "**microcosmic**" versus "**macrocosmic**" (Crossley 2004:163) – it is clear that all three are referring to a distinction between such things as the cognitive mechanisms that incur a dysphoric experience, and the broader social conditions that both motivate the dysphoria and sustain its chronicity.

Observers must, however, be careful not to apply these categories too rigidly. While it might be said that a patient's serotonin deficiency is the 'proximate' cause of her depression, while her immediate family environment and occupational stresses are the 'ultimate' causes, it might also be said that the latter are **also** 'proximate' causes, and it is economic recession and the difficulties of reconciling Old World filial piety with New World lifestyle imperatives that are the 'ultimate' causes (and so on).

[3] See Haslam (2003) for another recent synthesis of social scientific approaches to mental illness. While Haslam, a cognitive psychologist, excludes considerations of *both* structural violence and symbolic violence from his proposed framework, his insights concerning the uneasy coexistence of medicalizing (blame-absolving) and moralizing (agency-restoring) discourses in medical sociology are quite timely.

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Résumé/Abstract

Dans cet article, j'évalue les avantages et les désavantages théoriques de trois modèles d'analyse de la maladie mentale (Levy 1992; Baer, Singer, and Susser 2003; Crossley 2004), qui remettent en question les tendances réductionnistes et essentialistes de la biomédecine occidentale, dans l'espoir de fournir aux chercheurs une synthèse des mérites de ces tendances et de les avertir de leurs faiblesses. Je soutiens qu'une anthropologie saine de la psychiatrie doit restituer les dimensions historique, politique et symbolique des expériences psychiatriques localisées dans toute leur profondeur. Face au capital culturel dont jouit la biomédecine, nous pouvons et nous devons profiter de la polyvalence de nos propres méthodologies (ethnographiques, historiques et rhétoriques) afin de déstabiliser le biologique par le biais du biographique.

Mots clés : Anthropologie de psychiatrie, biomédicine, anthropologie médicale critique, pluralisme théorique, mouvements sociaux

In this paper, I evaluate the theoretical assets and liabilities of three proposed frameworks for researching mental illness (Levy 1992; Baer, Singer, and Susser 2003; Crossley 2004), all of which share a commitment to challenging reductionist and essentialist trends in Western biomedicine. With the hope of both furnishing future researchers with a synthesis of their merits and forewarning against their demerits, I argue that a sound anthropology of psychiatry must strive to restore historical, political economic, and symbolic depth to localized psychiatric experiences. Rather than forever remaining in thrall to the cultural capital of biomedicine, we can and ought to capitalize on the versatility of our own methodologies (ethnographic, historiographic, and rhetorical alike) in order to destabilize the biological with the biographic.

Keywords: Anthropology of psychiatry, biomedicine, critical medical anthropology, theoretical pluralism, social movements

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