**The International Critical Psychiatry Network** **(ICPN)**



**Critical Psychiatry and Anthropology Workshop**

**Berkeley, May 2013**

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**DEPARTMENT OF ANTHROPOLOGY**

**UNIVERSITY OF CALIFORNIA, BERKELEY**

**Critical Psychiatry Conference, Friday, May 17, 2013**

**Sponsored by: UC Berkeley Program in Medical Anthropology**

**(Critical Studies in Medicine, Science and the Body)**

**Co–Sponsor: School of Social Work**

**DRAFT SUMMARY of Conference Proceedings**

**Notes by Susan Miller (PhD candidate, UCSF)**

Panel I. Critical Psychiatry – Utopias and Dystopias

Panel II. The Madhouse and the Prison – Criminalization of Madness, Sadness, and Addiction

Panel III. The Political Economy of Madness and Recovery

Panel IV. Trauma and the Experience of Madness

**Opening**

[Welcome and Intro by Nancy Scheper-Hughes explaining how this conference came about, and the goal of opening a dialogue among a select group of critical psychiatrists, critical medical and psychiatric anthropologists, medical ethno-psychiatrists, critically engaged psychiatric social work and social service providers, and psychiatric survivor/service users.] The meaning of “critical” and of theoretical critique will vary but what we all share is a strong sense of dismay at the failures of the “dominant psychiatric paradigm” to respond adequately and humanely to human \anguish without reifying psychological, emotional and cognitive differences and reducing them to diagnoses and drug regimes. We will open with brief presentations from two critical psychiatry networks, one from Ireland and the UK, the second from Italy and based on the movement and practices based on the visionary work and theoretical writings of Franco

Basaglia. One goal is to produce a short position paper to be distributed at the APA meeting this weekend. In lieu of read papers we have opted for brief presentations and conversations.

**Panel I. Critical Psychiatry – Utopias and Dystopias (9:00am – 12:00pm)**

Pat Bracken (Ireland) Roberto Mezzina (Italy) Hugh Middleton (UK) Sami Timimi (UK)

Christopher Zubiate (Psynergy) Robert Okin (UCSF)

**Pat Bracken:** [He discusses an article that was published in the *British Journal of Psychiatry* in Dec 2012. This was partially the inspiration for this workshop.]

1. The paper was co-authored by 29 psychiatrists from the UK and Ireland with the goal of bringing a sense of cohesion to the critical psychiatry position. The history of critical thought within psychiatry has been largely based on the contribution of committed individuals working on their own to critique the

establishment. In the English-speaking world the Critical Psychiatry Network has been an exception to this. It

is a group of psychiatrists that has worked together for nearly 14 years and built up a strong and coherent critique of the status quo. [Pat Bracken pointed to the Italian experience of Trieste and what can be achieved by people working together.]

2. Our analysis hinges on the Foucauldian insight that, for good or bad, psychiatry is very much a modernist project: it represents an attempt to bring a scientific and technological imagination to bear on the messy

world of madness and distress. Through this, mental health problems ‘show up’ as technical difficulties to be classified, mapped, modelled and, ultimately, ordered through treatments and other forms of intervention that can be tested and compared.

3. Psychiatry is that process whereby madness is extracted from a spiritual idiom and inserted into a medical one. We are no longer afflicted by demons but instead become victims of faulty genes, faulty neurotransmitters or faulty cognitions. This is proudly put forward as an achievement in itself. It is understood as inherently progressive and anyone questioning it is regarded as a heretic, backward-looking, etc.

4. We argue that in the currently dominant paradigm, non-technological aspects of mental health and mental health care are not ignored but they are firmly rendered of secondary importance. In the current regime, academic priority is afforded to nosological issues, the search to identify causal factors (using a causal logic) either biological or psychological and the effort to frame all mental health care in within the language and logic of EBM. The non-technological aspects of mental health – values, meanings and relationships – are simply pushed to the margins. They attract little attention in terms of research, publications, service priorities, training, etc.

5. There are philosophical, sociological and ethical objections to this paradigm, but in the *BJPsych* paper, we focus on the empirical arguments. We point out that there is overwhelming evidence that these non- technological aspects are, in fact, the most important.

Towards a post-technological psychiatry

6. If our analysis is correct and the non-technological issues are the most important, are the things we have to grapple with, the question arises: can we imagine a medical practice that is not technological? What sort of science should we use?

7. This is where we seek collaboration with social science and humanities academics. We need help to think about a discourse that is centred on qualitative research and non-positivistic, non-causal accounts of the dynamics of mental health.

8. In terms of non-positivistic forms of research, social anthropology has led the way. Your work is qualitative at its core, very much focused on the nature of ‘meaning’ and open to questions of power and the politics of representation unmatched by other academic disciplines.

**Hugh Middleton:** [Offers a few basic facts about critical psychiatry as a movement:] It’s relatively new, it’s deliberately psychiatrists only; communication is through an open email system that has fostered discussion/debate. People know one another and can and do meet a couple of times a year and are able to stimulate conferences/gatherings. We had a gathering of 60 or so UK psychiatrists a couple of weeks ago to

begin to solidify thinking. It’s organized/politically viable and has a website and entry in Wikipedia. It’s a developing discourse. This is in a world where there are other organized discourses. [Reads statement by US Surgeon General David Satcher, suggests that we talk about how/why this statement was made:] “Mental disorders are characterized by abnormalities in cognition… These mental functions are all mediated by the brain. It is in fact a core tenet of mental science that …all our subjective lives….reflect the …functions of the brain…”

**Sami Timimi:** [Speaks about the broad cultural contexts in which we operate and trying to understand how change might come about. Before discussing this he mentions how a number of people in the Critical Psychiatry Network have found themselves being accused of clinical incompetence and have been scrutinized.] Usually it’s because a psychiatrist is trying to go down a non-diagnostic path or is looked at suspiciously because they’re not prescribing as much as others. The Critical Psychiatry Network has been invaluable at times like this and made a difference in 2 ways: it has provided a forum with mutual support (and there something about having psychiatrists in the network mattered – others had been through similar things); it’s an academically active group, quite a few have written articles published in leading peer reviewed journals – so they have an established body of opinion. Because articles are published in mainstream medical journals it becomes harder for others to say that what you’re doing is outside the bounds of medical practice.

In connection with this and the *British Journal of Psychiatry* paper, I’m increasingly confident about the empirical position, which is that the technological paradigm can’t be a primary paradigm to understand the types of suffering we see in the consulting room. I’m confident for a number of reasons including that the rebuttals I get tend to be ideological, and people struggle to argue on the basis of evidence – which makes me think they’ve got the evidence right. I hope that reading cultures might help think about why the existing paradigm dominates and continues to do so despite the poor evidential basis.

One important issue is commodification – how the economic system organizes sets of values. In neoliberal cultures, most things can be turned into a commodity. Because we’re ruled by values of what makes money/ a profit, certain ways of thinking about mental distress are much easier to commodify. It makes me think of how the diet industry grew to exploit the problem of obesity, thereby contributing to commodifying appearance, health and body image. There is suffering, alienation, distress all around – but something about commodification turns problems into privatized ones helps obscure how they might connect to the broader context. If suffering happens within an individual and there might be technical fixes then a market for this can grow. A diagnosis grows an industry…assessments, treatments, care pathways, professionals, pharmaceuticals, etc. Because this fits the value system of a neoliberal economy, how is there a way in?

Regardless of all the current concerns about medicalization and “over”-diagnosis that have been discussed in medical journals and publicized for the past couple of decades, the relentless rise of the decontextualized, biomedical model for understanding our fears, worries and distresses seems impossible to slow down, let alone stop. Our collective paper in December’s *British Journal of Psychiatry* is an attempt to review the evidential basis (or lack of it) supporting the current paradigm and appeal for our profession to move on to a paradigm more in keeping with the evidence base. However, we are not the first and won’t be the last to make this sort of argument. The evidence is there but is not influencing key bodies. We need to understand why this is and how, pragmatically, we can wield influence without compromising our position too far, thus

making it easy to usurp and incorporate a watered down version that has little meaningful impact. Challenges include the ease with which diagnostic medical model thinking can be commodified and thus enter the neo-

liberal economy with profit, branding, and established market dynamics. Vested interests not only include (most obviously) the pharmaceutical companies who understand the profit potential in marketing “distress as disease,” but also vested interests of professional groups and more recently the exploitation of “consumers” through processes of ‘labels as identity’ (for example promoted by celebrities). All this has made viewing emotional distress and ‘unreasonable’ behaviour as within the realms of more ordinary understandings that connects with real life experiences, more difficult to achieve. One approach is that of developing alternative “brands,” but the danger is that marketing for brand survival means that inevitably there is some degree of blindness to pitfalls and disconnection from problems that real patients experience, in order to serve the marketing needs of the brand.

Then there is the problem of the globalization of this industry. There are probably better indigenous models because members of many other groups and cultures are more connected to each other than we are and being trained to be in the leading neo-liberal countries. The recent Grand Challenges to Global Mental Health launched in 2011 by the US National Institute of Mental Health is a good example of this and shows all the hallmarks of a colonial project that seeks to export a Western view of mental health/illness. In its emphasis on medical model based diagnoses and lack of attention to distress being mediated by culturally derived systems of meaning and being connected to real life challenges (such as poverty, exploitation, violence, community dislocation etc.), it exports a system of values embedded within the “disease” narrative. We need more sociologically and anthropologically informed work to help us get a more culturally rich or culture-near understanding of how those deemed “mentally ill” by Western psychiatric systems understand and respond (and are responded to) to their predicaments, particularly given the frequent finding that levels of mental

distress and dissatisfaction are often lower in the developing world and outcomes, including for severe mental illness a lot better than in the West. This will help develop more locally informed and relevant services in the diverse communities found in different societies across the world.

So how can we respond to these challenges and how can a critical psychiatry and anthropology help inform us about useful strategies that can help promote services that speak to evidence and real life contexts rather than be slaves to the market. Do we need to think about what we do in a branded way? What are the consequences of doing that? Will we find ourselves sucked in?

**Christopher Zubiate:** [He does work for profit, he notes by way of introduction. He wants to talk about stereotypes.] Some of the questions I get are how do I make money, why do I work with “those people,” why don’t I work in academia? There will be 1772 new hospital beds in California next year. There will be

931 employees to incarcerate people who will be called “patient-inmates.” What does it mean when you hyphenate a person? Are they 50/50? 60/40? I work at the intersection of practice and policy; I’m experienced working in a backward, politically minded organization, with authors of the Surgeon General’s report. I work with people who provide the most face time with clients (workers lower in the medical hierarchy) because they’re the ones most likely to screw up or get it right. Because no one has told them about the clinical gaze, about evidence-based practice. …

About stereotypes vs. what we need to do to “help me to become a true human being.” At the very core of what we try to do as healers there is anguish. There is social responsibility, healers – but what we mostly do doesn’t work. And that’s why I do what I do for profit – because early on I was taught that what I was doing is to advance my social class. So that‘s my stereotype. Early in my work I learned that whether we were trying to focus on a work force that was culturally competent or create dialogue for a promising practice, at the center of this was what was called what’s important. We wrote about values-based, evidence-based

practice – the main idea was that if we don’t define what we value others will define it for us. My goal is to translate research to practice as quickly as possible. The framing of the research questions has to come from the field and from the people it affects. My fundamental frustration is that after returning from Trieste in

2005 after passage of the California Mental Health Services Act, what I’ve seen is more people working in mental health services and fewer people coming to the table to talk about what’s happening. I’m a capitalist and haven’t received any money for transformation of services; instead, more people are being locked up, having rights taken from them. I know that what’s happening is wrong, I want academia to help make it right, and I wonder why it isn’t just illegal.

[He closes with a story.] One of my workers said, “Wouldn’t it be great if we just didn’t pay for what doesn’t work?” I think that ultimately a capitalist system pays for things that have values – if we’re paying for things that don’t work and are violent, we must value those things.

**Robert Okin:** [Notes he has worked all his life in public service.] It seems like the basis of what’s being said is how to fundamentally change the way we look at people suffering mental distress. How do we get society to view them as like ourselves rather than as the others? How to create that change seems overwhelming. More concretely, how can we adopt the Trieste model and the conceptions underlying it, how do we adapt it to a society like the US that is more complex, diverse, rigid, less socially responsible, with a very thin social safety net, with laws that make it very difficult for people with mental distress to be assured

of their freedoms, with a political and economic system that creates and criminalizes poverty and homelessness. With a conception of rights that’s much narrower than that in Italy, with much looser family structure, more anomie, less sense of social responsibility, with subcultures that create and protect child neglect and abuse. We represent a feeder system for people who become “mentally ill.” A few years ago we invited Roberto Mezzina to San Francisco to consult in how to think about clients we were seeing at San Francisco General Hospital – how to think about them through the lens of Trieste model. Instead of speeches and conceptual discussions only, we looked at several clients, each for about an hour – what do we do to

bring these conceptions to life? It was enlightening and humbling when we tried to figure out within this context how we work with these clients within the economics and power relations of the structure. How do we adapt this model? Do we have to change society, or can we do it in more modest ways? It would be helpful if we figure out not just what structures we need to dismantle, but which we need to build to create opportunities to treat people more holistically and humanely. This practice is supported by systems. It’s very difficult to isolate individual practice from the social and economic structures surrounding it.

It’s useful to compare the institutionalization experience in Trieste with the experience in the US. It’s hugely different and points to what we need to do differently. In Trieste the whole idea of the institution was challenged, the whole idea of mental distress was challenged. In the US, the idea of the asylum has never been challenged. It’s just been moved from mental hospitals to different institutions – primarily the criminal justice system. I think it hasn’t been changed because the fundamental notions of mental distress haven’t been changed. I don’t think it’s possible to change one without the other. It’s cheaper to abandon people; a

deeper analysis would probably show it probably isn’t cheaper – but from the point of view of the legislature, it seems to be cheaper. Finally I would say that unfortunately complexity is always more important than simplicity – it’s always going to be more expensive to help someone out of the complexity of their emotional distress than to consider as our goals treating a bunch of systems, pushing complexity and relationships to the side.

**Roberto Mezzina:** [Notes that Trieste is historically a world leader and model for institutional change.]

There was a critical approach to psychiatry “in the practice,” rooted in an anti-institutional thinking. They were driven by practical issues as “responding to needs” – and developed an alternative to the psychiatric hospital, and now in Italy there are no psychiatric hospitals at all for more than 15 years so far. At first Franco Basaglia applied phenomenology to treatment, but he suddenly realized it was impossible to meet the person within the institution. So we need to start to recognize challenges to psychiatry from philosophy and

elsewhere – e.g., Foucault, Goffman, Deleuze and Guattari – and from others working in the institution – e.g., David Cooper, Tosquelles, Maxwell Jones. Psychiatry as a knowledge was conceived historically in a dialectic process with its institutions. Hence we have to understand mental illness as an historical

construction, a byproduct of knowledge created by psychiatry. So our thinking was that after dismantling the institution we would see changes in mental illness, and in suffering itself.

Basaglia wrote, “In order to deal with illness we must encounter it outside of any institution…” but does

there really exist an outside? So our utopia was to find out if there was a change in the phenomenology based on reciprocal change in relationship between observer and observed. Coming to the idea that meaning- making was a way through illness – so gaining power through empowerment. The expropriation of meaning

is behind psychiatry. Meaning can become an intersubjective project. If we focus not on speaking to mental illness but on the relationship with mental illness we should look at the whole system’s change.

We’re in a difficult field where we can find a lot of contradictions, professionalism vs. all-stakeholder, hospital vs. integrated/decentralized services, budgeting based on individual discrete and standard services vs. personalized integrated budget, institution vs. community. So there are a number of questions that can be opened about how the mental health system is separated from or integrated with general mental health systems. We think we have to move toward a global network to get a critical mass of observation and evidence based on practical shifts: e.g., from total institution to organizations based on relationships which can conceive of a different way, from Taylorist services to overall comprehensive services where the individual is seen as the unity. These are not performances but projects for life – changes from services provided, measured in terms of outcomes, to options and opportunities that a person can catch, from formal rights guaranteed by legislation to social rights based on notions of citizenship based on inclusion.

How can we describe new outcomes in terms of how people experience this? Having services where people can walk in, no selection, patients have not just a voice in their own care plan but in services’ life. We’re definitely interested in developing research and practical evidence and network; I sent an email to participants to build this approach, a more radical approach to complexity in research. Probably this idea of the paradigm shift is more naïve, but at least we can now envision a paradigm clash with the medical model. We must look at the real world rather than abstract models; epidemiology should be based on a person (as citizen), not a paradigm of disease. There should be study for a career and network and response to needs, participatory research that places all stakeholders as actors – we should combine these efforts and create a new movement. It’s not enough to move from old institutions to new ones.

**Panel I Discussion**

**Nancy Scheper-Hughes:** We have to create a way to ensure that every paper has a response. We’ll begin with Pat Bracken and open up a discussion around the table. Many of you have already read Pat, Hugh and Sami’s published critique. One of the embarrassing things about the response to that paper is that a well-

known medical anthropologist responded rather critically. I wonder if that might be a way to open up.

**Sue Estroff**: Objection – I don’t think that’s fair to tag the rest of the discipline [because of that response].

**Nancy Scheper-Hughes:** I do think that we need to look at our own field – not everyone is a critical psychiatric thinker. What Arthur Kleinman was saying is we need global mental health… the response has been to mobilize to get the rest of the world access to drugs, the model that neuroscience is good and we have to go with it…

**Pat Bracken:** When our paper was published, the journal invited Arthur Kleinman to do an editorial linked

to the paper. In his editorial, it’s odd – there are 2 parts: he starts with a very sharp attack on the status quo in academic psychiatry and on domination of biological model in academe, but then the part about where it should be going seems rather naïve – that we should support the global health movement, that we should support psychiatry, with all of its baggage.

**Sami Timimi:** If I may, he [Kleinman] was predicting academic psychiatry was going to be extinct in 20 years’ time because they’re coming up with nothing useful to clinical practice. On the global health bit, I read what he wrote – he was making comparisons with public health and epidemiology and was thinking that in looking at global mental health we have a way of engaging with meaning and cultures, but the examples he gave are of movements that we in the critical psychiatry movement are very critical of – these are movements supported by a number of organizations. There’s this whole thing of MH gaps – trying to get middle and low income countries to scale up services – but they have an idea of what that means using mainstream diagnoses. They talk about the importance of culture but the models are very mainstream, Western.

**Anne Lovell:** I was thinking about Sami’s point about commodification as a leveler that extracts what is quantifiable and thus commodifiable in mental health / mental distress, and relegates it to private spaces, making it difficult to connect the dots (e.g. between poverty, power relations, suffering, souls) or see the commonalities in different situations. An important part of Basaglia legacy is a global (in the sense of holistic) perspective that allows us to understand how the institution has to be fought against at many levels

and at many sites. This critical perspective should lead us to avoid replacing “the poverty of the asylum” with poverty in the community, as Franca Basaglia said (and we can replace “poverty” with “institution,” “power over patients,” etc.). But today that requires us to pierce the neoliberal veil that works against understanding connections. Kleinman, possibly because of Harvard’s position, isn’t part of that conversation. Sami also mentioned Kleinman’s advocacy of global mental health. One of the problems for critical thinkers/practitioners regarding GMH is that the leaders in the GMH movement are to a great extent from the very parts of the world that are being targeted with the Western model – even if some of those leaders are trained in the West. We have to be careful about how we talk about (and against) exporting the Western mental health model, because the issues are complex – on the ground, they’re not always about exporting

wholesale a global model from the West. There’s a little hubris in how we’re talking about ourselves. We are focused on UK, Italy and North America, but we need to be more reflexive about what we’re doing and more knowledgeable about elsewhere.

**Hugh Middleton:** I was going to say something similar. We’ve acknowledged a sociology *of* medicine but there is sociology *in* medicine. My sense is Kleinman was advocating the latter – not interested in deconstructing. We want to deconstruct what we mean by mental health.

**Sue Estroff:** This is peer support. This is what peers say they get from support. Who owns psychiatry? Is it medicine anymore? Why would you have to go to medical school to be a psychiatrist? Why not get a degree in psychopharmacology? I think positioning our whole conversation within medicine needs to be questioned because through some fault of our own, the practice of medicine within psychiatry doesn’t exist, aside from prescribing drugs. I want to question that relationship and the ascendance of the neuropsychiatric. Neuropsych residencies are growing in number. This is on the horizon. What is it? Is it medicine? Why should it be?

**Andrew Phelps:** What I’m hearing goes back to Erasmus … I think that what I have to say has some positive quality as a statement of being, I do think that it’s not as simple as getting the movement up. There is the problem of sectarian dynamics, there are processes of control inside of this process. We organized a national movement of client survivors – not consumers – which included the main activists involved 10 years ago. We held together trying to face this dynamic and now we’re here because we need to network, because we need

to get through the hard part, which is, aside from the neuropsychiatric business, social accountability and distress – and those go beyond getting our team together.

**Steven Segal:** I’m having a déjà vu experience. In 1973, a few years after I came to Berkeley, we developed a Doctor of Mental Health (DMH) degree. It was taken through the state legislature and approved. We recruited for 10 years individuals who wanted to become a DMH. Following Lawrence Kubie’s notion that one didn’t have to be a psychiatrist to do mental health care, the DMH required two years of basic science on the Berkeley campus, followed by a residency with psychiatrists at UCSF. DMH students in the residency functioned as psychiatric residents with prescription privileges. They were a fantastic group of people. Unfortunately the Calfornia Medical Association was able to get their DMH licenses revoked. The program was ended and the DMH graduates were given a consolation prize of being a clinical psychologist, without prescribing privileges. So went the DMH degree. When you’re talking about power structures – we talking about medicine. Even in Trieste, medicine rules a very paternalistic system.

To carry forward my déjà vu, the mental health field is now discovering “social integration.” In 1978 I published my first book: a study of a probability sample of all individuals who left state mental hospitals to live in residential care facilities in California. We interviewed 427 people, in 211 facilities in 157 census tracts in the state. We measured social integration and followed these folks for 13 years to look at what facilitated or hindered their reintegration into the community. Individuals residing in such facilities were

beginning to be thought of as consumers of services –i.e., they received SSI and in effect were purchasing board and care with their stipends. Unfortunately, they often had little choice in their residence as they were “placed.” I wrote a chapter on consumers as commodities. Providing funds to people unable to control the use of the funds made them more of a commodity –traded in the newly developed residential care business, the consumer. The creation of funding streams enabling the provision of services to patients shapes the field. Pharma drives community care. What we need to do is commodify social necessity as opposed to medical necessity.

We can treat people in supportive housing for less money than putting them on the street, yet we continue to put them on the street. We need a financing scheme for long-term chronic care that values social integration. The focus of psychiatry on the brain is a specification problem in that it eliminates critical aspects that need to be considered to understand the realities of people with mental illness face in securing and maintaining a socially integrated lifestyle in favor of support technical innovations with few social links.

**Orla O’Donovan:** I’d like to comment on the political challenge that Pat Bracken mentioned of critical movement and user movement – how can the revolts from above and below meet? And there’s another challenge related to other user movements because they are playing a huge role – we can see diffusion of biomedical science from the US to Europe. Many user movements involve people who see themselves as fighting for a diagnosis, for recognition of their patienthood. Some see critical psychiatry as their enemy and furthering their suffering.

**Hugh Middleton:** Now clearly it’s essential to hear those voices. Nobody’s going to get it right the first time. Yet we know from the clinic that there are a whole variety of people going to a psychiatrist – we have to hear as many of those as we can rather than assuming that we know. That relationship with the user movement is an important resource.

**Sami Timimi:** Two quick things. It’s a complicated thing about why psychiatry or mental health has come under the rubric of medicine: there are historical reasons and it’s a legitimate question. I think of it the other way around – I’ve tended to think we’re upside down in the way we think about position of psychiatry in to medicine. We’ve supported the McDonaldization of medicine, whereas in fact what we bring to medicine,

we should have the skills to help the rest of medicine to understand – most primary care doctors’ consultation involve people’s experience of suffering. These are the sorts of things to do with health care. This should be where critical psych sits at the confluence of several discourses. We’ve been shooting ourselves in the foot

for many years. It’s happening without us, and that’s ridiculous. I think in my lifetime it’s not likely to happen. We have to work with trying to reform the systems as they are professionally, and maybe that will change the balance. On the second point, that’s an important issue – what you’re talking about is, there are some functions attached to diagnosis. If you think about, within our neoliberal culture, how you have your suffering recognized, if the system you live within, if someone giving you a diagnosis is a validation. We shouldn’t be surprised people are seeking diagnosis. That is the language by which suffering is recognized. The second thing diagnosis is meant to fulfill, there is the hope that diagnosis has led to understanding and created an opening for something to get better. And when people find this not getting them anywhere – that’s where the diagnosis doesn’t work. A lot of users come in with that expectation and then years later find their

lives have not been transformed.

**Stefania Pandolfo:** What does it mean in your clinical practice, in the encounter with madness, what does it mean to “abolish the diagnosis”?

**Roberto Beneduce:** Please, don’t consider psychiatry and its practices and use of diagnosis in a “monolithic” sense. There are many uses of psychiatric diagnosis, in many cases very “pragmatic.” Critical psychiatry – all revolutionary changes we realized in Italy in asylum and psychiatric institutions, as well as in daily clinical work, started from a deep questioning of suffering. Psychiatrists were *available* to be

questioned by suffering and its multiple languages. Critical psychiatry has to start again from this questioning. In global mental health programs this questioning sometimes seems to be avoided, or forgotten.

I think critical psychiatry cannot forget this necessity to deeply and continuously question our knowledge and what the sufferers ask. This is an open, endless process, an uncertain theory of the human condition and its fractures that psychological and psychiatric anthropology can contribute to write and to interpellate. To make this possible, I think we have to imagine how it is possible to avoid what I call the *bureaucratization of clinical work*. Unfortunately, psychiatry continuously risks falling into this trap.

**Anne Lovell:** Anthropology has contributed a lot to showing how psychiatrists work with prototypes and workarounds in making diagnoses. There’s a myth about monolithic ways in which even the DSM gets used in clinical practice. Who is really compelled to use it in a literal way? The lower-level staff. And I agree that many people seek diagnoses. Patients and people who want to be patients do. The experience we’ve had in France is interesting because French psychiatry sees the individual as a suffering subject before seeing the individual as a diagnosis. But what has fascinated me in working with French user groups, psychiatrists and anthropologists on issues of diagnosis is the extent to which some user leaders want the diagnosis and it’s not

(or not just) political, it’s existential. We have to acknowledge what is happening when someone says, “Don’t tell me schizophrenia might be taken out of DSM or ICD.” Some users oppose doing away with diagnoses.

In France, because they are afraid of losing access to care and disability entitlements, but also because they need to feel that someone understands what is going on with them. The only visible user groups who want out of psychiatric diagnostic systems are transsexuals, and the French Ministry of Health has taken the position that transsexualism must be de-psychiatrized. A last point about diagnoses: we tend to forget that DSM III developed as a product through which psychiatry could legitimize itself as a branch of medicine. That’s the whole history of modern psychiatry: there are no biomarkers, but by DSM III two psychiatrists could supposedly see the same thing and can give you the same diagnosis. DSM V represents the same stakes, but expanded because of tendencies towards an RDoC (Research Domain Criteria) model that dreams of de- constructing the old diagnoses on the basis of new science.

**Sharon Clausen:** A clarification. The [NIMH] is abandoning the DSM. Thank you.

**Pat Bracken**: They’ve been stating that for some time that this is a new position, and it’s not.

**Roberto Beneduce:** No, it’s worse than before.

**Pat Bracken:** Just to point out that some of this discussion we have already responded to in letters about our article. One was from a group of psychologists in Liverpool saying actually psychology could do all this

stuff and we’ve responded. There’s a very interesting letter that we’ll have a response to this month – what you’ve said about psychiatry you could say about all of medicine. If you could get the notion of embodiment we’d have a richer practice of medicine. In some ways some of the discourse so far, I’m very interested in

the notion of the work of culture, what cultural systems are there to deal with suffering. How do we deal with loss of a child, the suffering that comes with being there. How do we make sense of that, tolerate it, endure it? That’s what cultural systems give us. And in some ways psychiatry is the secular society’s response to it. They say yes, there is a diagnosis. And just as Marx criticized religions so too there are mythologies in psychiatry, there’s displacement. We have to, as doctors, only help people make sense, and sometimes that does involve discussion about diagnosis, but to do that in an open way, a deconstructed way. It’s not my job to say you don’t have schizophrenia but to give intellectual tools to the patient to think about what might be going on in their lives. In a wider sense we do have as a society to think about how we make sense of suffering in a world where we don’t have religious frameworks to give us that. That pushes us toward things like creative arts, community, other responses. Where do we see our priorities for money? Yes, neuroscience matters, but shouldn’t we be spending more money on creative arts to make sense of suffering?

**Angela Garcia:** So much of this has been about networks. In addition to prioritizing conversations in psychiatry, there should be conversations outside of psychiatry. In Mexico I imagine a place for psychiatry outside of psychiatry. Logically, in California our huge undocumented population is suffering – why aren’t more psychiatrists writing op eds, a more visible part of the immigration reform movement?

**Sue Estroff:** If we’re talking about revolutions, I don’t want us to assume it’s inevitable that what we’re talking about has to be part of medicine. Everyone has talked about how medicine gets in the way – all I’m asking is that we turn it on its head and not assume the baggage of medicine must distort attending to both suffering and to creating relationships with people with schizophrenia or other psychoses. Yes, it’s the holy grail, but a lot of the problems we’re talking about adhere to the place of medicine as the border patrol for deserving and undeserving in terms of who gets recognized or not. I’m asking us to critically look at psychiatry’s being engulfed by medicine.

**Roberto Mezzina:** A few words about disability. There are very few people who claim a diagnosis in our context; few people claim this as a right and I think this is positive and reflects on system change in Italy. Disability is a word used in the US for achieving sectorial rights. I think this is a trap for the whole process of recovery and emancipation which was for us one of the most important aims. Something similar is

happening. The MH gap program covering the gap between need for care and existing services is now focusing on mixing up organic problems with non-organic problems for economic reasons. This is because a lot of people still in institutions in developing countries are people with neurological disabilities and the only way to achieve more attention is to put things together. I should be careful about the idea of disability as being used and the emerging definition of infirmity. Similar to this is assuming the medical model into mental health services. If this remains located in the hospital, in the medical model, it doesn’t make any sense. I think it’s important to claim for the alliance between psychiatry and user movements what the objectives are – for what are we doing this.

**Nancy Scheper-Hughes:** Former NYC Commissioner of Mental Health, Mike Hogan, who spoke at the Stanford Public Psychiatry Meeting in April, was very concerned that there will be some conflicts with the application of the ACA (the Affordable Care Act – ObamaCare) based on the principle of the integration of mental health systems into basic health care (on the basis of equity). The problem is that depression is not like diabetes. His concern was that the integration of large numbers of previously uninsured persons with psychological problems and needs might be directed into general health care clinics where the doctors may not have much experience or knowledge of the specificities and complexities and may lead to drug- diagnosing. Another issue concerns the need for critical thinking from within the survivor/user/patient’s rights movement. There are many different approaches within the community. Some patients’ rights demands can be unpredictable – to take an example from a different field of medicine, I’ve been studying

organs trafficking. It’s driven by patients’ rights. They’re the ones who will go to any country and argue that the right to a purchased kidney is a symbol of global medical citizenship. We have to constantly use critical consciousness – otherwise we’re all dangerous to each other.

**Sharon Clausen:** [Notes that there aren’t enough people who are patients at the table.] Do you know my language? I have one question: MH clients talk about what it means to be crazy. What words to you use? What is that, that you call crazy?

**Andrew Phelps:** My official diagnosis is schizoaffective with depressive features. I don’t want that diagnosis. What I want is real science. As a student at UC Berkeley, I wanted to get a PhD in math because I wanted to have a reasonable relationship with society instead of being a diagnostic object. I have a PhD in dynamic systems; I understand dynamics from a mathematical framework, a perspective with which others here are not fully familiar. … Many people have to make this a dialog.

**Sharon Clausen:** [Encourages rearranging the seating so that everyone is included, rather than having presenters at a table at one end and everyone else observing rather than participating.]

**Sue Estroff:** I think it’s ironic and troubling that we’re stuck recreating what we’re trying to address. I’m very uncomfortable about who gets to speak and who doesn’t. It’s hypocritical to talk about power structures

without addressing what goes on here in a way that works for all of us. We have a variety of understandings about what we’re doing and whose doing it. And if we can come to some consensus.

**Robert Okin:** I also have felt increasingly uncomfortable. I understand there’s a contradiction. …

**Sue Estroff:** We can’t reproduce what we’re being critical of.

**\*\*\* Break to move tables and arrange chairs in circle to create a more democratic space. There’s also brief discussion, I believe, about how to organize talk and some disagreement re: whether to highlight panelists or allow more group discussion.\*\*\***

**Hugh Middleton:** [Points to Nazi propaganda poster that reads “You are sharing the load. A disabled individual costs about (?) Reichsmarks by the time they’re 50 years old.”]

**Young man:** I don’t mean to flatten the distinction between psychiatry and critical psychiatry – how are we talking about the category of suffering in psychiatry and critical psych? We’re concerned about stereotyping, but we’re sure there are some people suffering. 2 points: We’re using that word cross-culturally and then we’re understanding the way people understand it differently, as if that word has some cultural significance, as if we have the same concerns.

**Roberto Beneduce:** I would like just to clarify: When I used the expression “politics of diagnosis,” or “strategic, pragmatic use” of it, I was thinking to the multiplicity of practices made by psychiatrists, patients and “users,” their families, and so on. In many cases these uses reveal “tactical,” so I think we need many models to think about a so complicated field. I was and I am very interested in questioning the role of culture in suffering, professional labeling of it (“diagnosis”), and healing/therapeutic strategies. I think we are now involved in a wide movement for good use of these concepts. On the other part, any “scientific” category is *always* culturally constructed and socially/historically related – this is just a truism. We have “culture” in the DSM and other diagnostic manuals, beyond the paragraph on Culture Bound Syndromes or the few lines on the need to consider the role of culture before making a diagnosis of Personality Disorder… And, of course, we will continue to have it even when it remains concealed by algorithms, formalization or other forms of objectivation. But now I would like to add another short consideration. There is no therapy without an effort of naming the illness, of suggesting the source of suffering, and this naming process often takes the form of “diagnosis.” On the other part, this doesn’t mean that there is a relation between psychiatric diagnosis and therapy. On the contrary, we can state that this relation is weak and uncertain (or absent and arbitrary…). We can say that diagnosis and therapy are deeply embedded and – paradoxically – autonomous. Even in the traditional healing or therapeutic rituals there is a naming procedure, a diagnosis *of* (a dialogue *with*)

suffering. And even in these cases the act of naming the suffering accompanies or anticipates therapy. Finally, all naming/diagnosis is a *political act*, everywhere. And while it names and shows, on the other transforms and occults.

**Sami Timimi:** In my own clinical practice I have to encounter diagnosis in several different ways. We see patients who haven’t been diagnosed before, (or sometimes?) diagnosis doesn’t seem to happen. In other conversations people have been diagnosed and that’s how they’re cultured into suffering. I think it’s important to develop a campaign against diagnosis because we want to take these discussions into the public arena. In a capitalist culture one way is to stop buying this stuff…how do you engage in change in a culture where money is king?

**Christopher Zubiate:** [Wants to talk about asylum.] You said in conversation: unless we talk about emotional distress, we don’t get to the core of the issue. How did you come up with the idea of addressing emotional distress and abolishing the institution?

**Robert Okin:** [Responds very briefly.]

**Christopher Zubiate:** For me that’s at the core of healing. It shouldn’t be this difficult.

**Sue Estroff:** This issue of getting back to the ground level. In this country the primary relationships that most people have diagnoses are with people who don’t have MDs, MSWs, nursing degrees. Those are the relationships that endure. And we neglect the pluses and minuses of that when we talk about systems because we don’t have enough people who want to do those jobs. Someone who wants to be in practice has to account for every 15 minutes. And it has to be written up and translated into gobbledygook. The work of being with and being in relationship is something we don’t talk very much about. What I hear is, I’m angry, I’m angry at being misread, misunderstood, not seen, not recognized.

**Sharon Clausen:** What is the content of craziness?

**Sue Estroff:** To me it’s what I just said, that there’s a kind of angry anguish, a kind of monumental being aloneness, having different thoughts that may or may not connect and may baffle you, and being either too visible or invisible.

**Sharon Clausen:** Let me tell you what the clients say. What is crazy? It’s magic, it’s spiritual, it’s intuitiveness, it’s predicting future, it’s empathy, it’s caring, it’s needing to have the truth and having a problem of not being told the truth. And it’s where the beauty path idea comes from. Mental illness is filled with marvelous, wonderful, delightful surprises if you ever get a chance at them.

**Antonio Maone:** When I entered the department this morning I saw the two big wooden statues of primitive art in the hall, and suddenly I was reminded of a recent article of Heinz Katschnig, past president of the World Psychiatric Association, entitled “Are psychiatrists an endangered species?” And I wondered if the next meeting could take place in a Paleoanthropology Institute!… About diagnosis and power… [continues in Italian, and Stefania Pandolfo translates:] There’s a problem in the very complex relationship of families with psychiatry, the problem with the technological approach: it’s requested by families because behind the diagnosis there’s the possibility, the hope for treatment. The problem is there’s this fixation of roles and the family. As a consequence the family has the tendency to delegate the solution to the psychiatric services.

The implicit assumption is that the family would have no competence, no knowledge. But the fact is that on the other side of this, the psychiatrist also does not have competence and in the large majority of cases will not be able to solve the problem. So this creates a false conflict, and it’s a serious one because it can last your whole life. And instead if we think that it is the relationships as we said this morning, that are the heart of the possibility of transformation. So this means that already at the outset – the rules of the game are laid such that we’re missing the possibility of accessing this enormous amount of resources that have to do with the possibility of transformation of resources. So that the problem for psychiatry or the challenge is to give up this power or to renounce this power to access the other level of resources that could be therapeutic. And the problem is that giving up at the same time delegitimizes the role of the psychiatrist. And also his social and even economic power. And so this is a huge question and problem for the future of this conversation.

**Steven Segal:** I think there are two issues here. One is diagnosis. The DSM is largely a political document used so policymakers can decide who’s worthy of special privilege due to disability. The ever-expanding nature of the DSM is to some extent an expanding business opportunity for the mental health establishment and a legitimate attempt to help those excluded from the allocation of services. Medicine holds a special place in this society with respect to being the arbiter of who gets such privilege. By adding social necessity to the list of issues justifying disability privilege, other competing concerns come into play in determining where resources ought to go. The second issue is the relationship of diagnosis to suffering – and not only suffering but mental illness. It is being so depressed that you think you’re an ant, or you’re going after your neighbor with a baseball bat because you believe this person has been plotting against you and you’re so concerned they’re threatening your life. We all suffer, we have our ups and downs, but it’s when those downs go so far down there can be no reasonable justification that we have an illness. In many contexts we come across those who find a delight in their experience, and those who are truly really at wit’s end and functionally so disabled by the condition that they are doing themselves in, their loved ones in, and their futures in.

**Joshua Moses:** We’re leaving out one large group of people, religious leaders, which trump all mental health services. When in distress most Americans go to clergy. Psychiatrists haven’t yet ousted clergy.

**Robert Okin:** I was asking the question, why was it so difficult to adapt the Trieste model? It went from

soup to nuts – the first thing was that we had to give the person a diagnosis and we had to document necessity for treatment that was medical. The requirement for treatment is medical necessity, not social necessity, not suffering. So right off the bat, before we did anything, we had to impose the current model on ourselves – those requirements were the entry way for reimbursement. And if we couldn’t get reimbursement we had to close up shop. The ACA includes more people, which is great, but it’s with all these medical requirements. It was clear that a number of the people we saw, what they needed was social support, housing – there’s not money for safe housing. We were forced to think about a shelter, which is not what you’d call safe housing. Shelters, at least in San Francisco, whatever role they fill they’re incredibly dehumanizing. Nobody

considers them safe. Most people I talked to on the street felt safer on the street. At the get-go, housing, some cash for clothes was impossible unless we went the disability route. Some people, their families were nowhere – there was no source of social support, and without that we were stymied. It was artificial, how we linked people – “Well, go to this church.” Even if we could get them into some kind of housing, which is the minimum, and get them SSI, their lives were going to be so totally empty, and that’s really all this system right now is shooting for. That’s the most optimistic this society is; those of us really pleading for services – we’re not shooting for the moon, we’re shooting for the grass. We really couldn’t help with suffering. Those were some of the limitations we faced.

**\*\*There’s a request for panelists to highlight what was most important to the theme.\*\***

**Pat Bracken:** It’s not simple and it’s not straightforward because we’re in different places and come from different places, but we’re trying to create a space where dialog can start. How might we use this in being part of the revolution? I believe that we should perhaps focus on the question of “mental health expertise.”

This is crucial as it underscores the current hegemony of medical psychiatry. We should be asking, over and over: why is this person seen as an expert? How did he/she come to have that position? Why do you invest certain people with the power to make decisions?

In “speaking truth to power,” we are united by a critical position vis á vis the current notion of expertise. In this room, we have service users who have been harmed by psychiatry, we have academics and others who have engaged with the discourse of psychiatry and pointed out its limitations and contradictions, and we have practitioners (psychiatrists) who are happy to question the power and authority that has been bestowed upon them.

**Roberto Mezzina:** We are facing a strange dilemma. We have this emerging movement of nonexpert professional approaches who are similar to experts by experience. On the other hand, we have the challenge of complexity we have to tackle. We have to find a way of studying that. At the moment it seems relevant to study what subjectivity means – a person in a complex social system, how can we explore complexity? For us, creating practical alternatives can be the only way. We explore by changing, constructing. On the other hand, diagnosis seems to be an important focus – for me if it remains a contradiction it’s fine, but all these systems are classifications. On the other hand, if diagnosis remains the passport to travel it means receiving

responses, sometimes very bad. I think complex services must be multifaceted, so that people can access by problems, not by diagnosis. People should be able to set a demand. I think it’s very clear that the most important thing is challenging medical assumptions, which are close to prejudices and other representations. And, I agree families are the most important witnesses of the change because they check the overall process of which they were very critical in the beginning of institutionalization. But when we approach them by diagnosis, sometimes they listen to new words rather than hear something about their concerns. Even in Trieste when we used the psychological approach it was not so brilliant. Medicine is a very poor support to meaning. In non-European cultures they extract experience in a different discourse. I think we should go back to this idea of not accepting diagnosis.

**Hugh Middleton:** I punted an exercise to you this morning…but the family has displayed itself in a wonderful way. We’re all here, we should hold onto that – it transcends gladiatorial conflict between these roles, it’s actually about bringing these roles together to make sense.

**Sami Timimi:** In terms of thinking more broadly, I want to understand the anthropological perspective. In trying to look at psychiatry, how much you can help us with reading the tea leaves? I want to be able to think about how to use events like this to bring about change, rather than be a place where we have interesting discussions. There seems to be broad agreement about what some of the problems are and some understanding that there are alternative models. And there are quite a few, and some are more humane. We do have models available which can be developed to provide services that are more genuinely helpful to people who’ve found themselves in very difficult places. How do we get that? Some ideas are in the academic sphere about how to do research, some are how to use the current neoliberal realities to create services that sit in competition, and there are others we haven’t had time to discuss – how do we work with media? How to work with cultural symbols? I’m hoping that bit of what we do over today will further develop. I’m hoping this is the start of something productive. The Critical Psychiatry Network has been productive.

**Christopher Zubiate:** I was teaching abnormal psych at Foothill College. We were discussing Maslow’s hierarchy of needs – and an Italian student asked what love is. I think that part of assigning meaning is love. What I’m looking for is how to take approximations of the Trieste experience and get people to want to pay for it – not because it costs less but because it does more. We’ve talked about diagnosis – my response is to make it as simple as possible so professionals can get on with it… I want people to come work to be able to do their work without diagnosing. I want people not to make a straw man out of the DSM V. The last thing I would say is that the work we do is not that complex; the system is complex. Spending $XX million to lockup 200 people is crazy. The reality today is very humbling.

**Robert Okin:** I think I kind of summarized what I had to say before.

**Woman:** One thing that strikes me is that idea of learned ignorance. I think a feature of critical psychiatry is learned ignorance, where people learn what they don’t know. There’s acknowledgement that the role of the professional psychiatrist is different from others, but it’s different from ignorant ignorance.

**Observer:** It seems like there is broad agreement – that one aspect of the dystopia in clinical practice has been shaped by disaster capitalism cashing in on disasters that are not personal but based on state violence, institutional racism, and other structural oppressions. I think that If we’re going to move from there toward a utopian vision absolutely taking forward the utopian visions from Trieste. And we have to remember that trauma is a huge factor made by interpersonal behavior not just on a small scale but on an institutional scale. A culturally responsive practice is a needed component of any trauma sensitive practice.

**Panel II. The Madhouse and the Prison – Criminalization of Madness, Sadness, and Addiction (1:30 –**

**3:00pm)**

Angela Garcia (Stanford) Helena Hanson (NYU)

Nancy Scheper-Hughes (UC Berkeley)

**Angela Garcia:** I want to start by saying something I didn’t intend. I’m happy that the conversation began to turn toward issues of meaning and family. That’s where I situate myself as an anthropologist. I’ve been noticing that the terms naming, diagnosis, and language come up, but not listening so much. I think of the question, *Is listening something that philosophy is capable of doing?* Has diagnosis substituted for listening? This author wants to prick up the philosopher’s ear to tone, accent and resonance. What does it mean to be listening? I think that’s really pertinent to this group – To be listening allows us to be open to the possibility of anguish and perhaps possibility of transformation.

I come to this question of listening and this form of the experience of anguish of suffering through research on addiction, primarily on heroin, with highly marginal groups, traditionally dispossessed both in a clinic – which also meant in a prison because they were continually cycling – but also in their homes. It was within the family, within the home that care took place. There have been many therapeutic spaces that haven’t been represented here today. These spaces are spaces of caring. A force of living takes place there and also

dying. These spaces are also quite dangerous – it’s not just the danger of the hospital or diagnosis, but also of the overwhelmed family and community that has very little means to do something. But they nevertheless

try. One of my calls is for a critical psychiatry to be attentive to those spaces. Working on addiction in the US led me to working in Mexico – I can’t work on addiction in the US without working on addiction in Mexico as well as on the trauma and violence that happens there. What happens in the home is more than what happens in the individual home but what happens in the US and its relationship to other spaces across borders. I’m working with a psychiatry student, Brian, who’s been doing fabulous fieldwork – we’re working with people who are making do, creating spaces of care that are often spaces of torture, pain – what

do people make do with? What do they create? I’m interested in hearing briefly how his work in Mexico City

is going to reshape his trajectory as he goes into psychiatry.

**Brian [Angela’s Stanford University Research Associate]:** I was working in places where there is no other institution – no state, no police, no water, no electricity. When a group of recovered addicts forms an institution, which is often punitive and violent, it is sometimes a good thing because it is a place of safety even though they acknowledge violence is done there to them. It’s uncomfortable to me. I find myself defending this as a phenomenon of care when colleagues say this is harmful. I see this as something which has a lot of benefit. It’s an institution provided by peers, a strange mix of recovery movement with psychiatry. There is no psychiatrist, psychologist – you couldn’t have them if you wanted them.

**Angela Garcia:** This is what the majority of treatment looks like in Mexico. It’s families and individuals putting people into these situations. We’ve now come to these groups – in Oakland, Menlo Park, San Francisco. The migrant communities in San Francisco are creating these centers for themselves. I think we have a responsibility of understanding therapeutic spaces that do not qualify. To this I would add immigration detention centers where many of these individuals end up. There’s a need to listen, to be attentive, to experiment with a kind of quality and practice of listening that is resistant to naming and allows the listener into the space of anguish and then to imagine that something happening in Mexico is violent – and also something else. [Mentions funding through government anti-narcotics work.]

**Helena Hansen:** Lately I have been involved in a series of debates about how to get psychiatrists to address social determinants of health. This has been the topic of a series of emails on the American Association of Community Psychiatrists listserv, the topic of discussion at the Robert Wood Johnson Health and Society Scholars national meeting last week, and the subject of an article I published in *Health Affairs* two weeks ago about understanding the DSM as a social determinant of health by tracking the effects of DSM revisions on the demographics of diagnosis. Then it dawned on me: before we talk about how psychiatry can address the social determinants of health, we have to ask how psychiatry itself already *is* a social determinant of health. And wealth. And race.

Because critical psychiatry emerged in reaction to the total psychiatric institutions of the 60’s, I’ve been asking myself how has the landscape of institutions changed since then? And what does that mean for our approach now? Part of the answer probably includes The War on Drugs, which feeds mass incarceration, and Welfare Reform, feeding dramatic growth in social security disability benefits as a safety net of last resort for the poor, which hinges on their achieving a diagnosis of a severe mental illness and being prescribed antipsychotics and other strong psychotropics that demonstrate the severity of their illness.

Another part of the answer includes efforts to mainstream addiction and mental health treatment into general medicine, which has funnelled treatment into the form of brief, periodic medication checks and prescriptions for pharmaceuticals as dictated by EBM (evidence-based medicine), as well as expanding race and class segmented markets for those pharmaceuticals.

These institutional trends are shaping the daily life and life chances of individuals, and they are reproducing race and class on the population level.

To start with the War on Drugs and Welfare Reform, I see them operating in the hospital where I work. The seventeenth floor of my hospital is part of the New York City jail system. One of my most painful

experiences in training was working with Troy, a young Jamaican migrant living in the South Bronx who was transferred from that floor to our dual diagnosis unit when his charges for waving a gun in the middle of a paranoia were dropped.

He’d had many bouts of paranoia after smoking marijuana and crack. But when he was not paranoid, he was an attentive father. He used his disability checks to pay rent for his daughter Lianna and her mother, he walked Lianna to and from school everyday in a part of the South Bronx carpeted with crack vials and guns. Troy struggled with nightmares from childhood sexual trauma, and repeated re-traumatization that he suffered in prison. He wanted desperately to leave prison behind and be present for Lianna to make sure she didn’t suffer the same.

Troy was recuperating well, but my efforts to discharge Troy and reunite him with his family were foiled by a call from his probation officer informing me that he would be rearrested for outstanding drug charges. I met with his clinical team hour after hour to strategize about helping Troy to avoid rearrest. Up his dose of antipsychotics and chart as many symptoms as possible in order to buy his lawyer time to negotiate with the prosecutors? Given that our hospital management was limiting lengths of stay, should we beg his long term psychiatrist at another hospital to accept his transfer there so that he didn’t get discharged and therefore become subject to re-arrest? But that involved a delicate balance of making him look, as the team would say, not so sick that they’d refuse him, but sick enough that he needed hospitalization. Troy upped the ante in frustration and punched a wall so hard he broke his hand. This ruined our chances for transferring him to another hospital. By the third day, hospital administrators forced us to discharge him, and police officers waited outside the door to ambush him with handcuffs.

Troy’s story illustrates a few points. Three decades into the War on Drugs, not only do we have the highest incarceration rate in the world, but our prison and jail systems have become the largest providers of psychiatric services. The majority of those in prison are there on drug charges, and the majority of people with addiction have a co-occurring psychiatric diagnosis. So psychiatric and carceral institutions are blended, and the proverbial distinction between sick and bad is directly challenged by the structure of these

intertwined institutions, and what we can do therapeutically is severely limited by it. And of course, the majority of those in prison are black or brown and poor, the vast majority of them come from a handful of census tracks in American cities that are the poorest tracks. And the rate of social security disability benefits for people living in those tracks has skyrocketed in the wake of Welfare Reform, whose term limits to benefits has forced poor people to seek severe psychiatric diagnoses, and treatment with high dose antipsychotics, in order to qualify for disability benefits, one of the only remaining safety nets our government offers.

What does this suggest for us in a contemporary critical psychiatry movement? We may need to join forces with prison reform, and work to dismantle the War on Drugs in order to capture the majority of institutional psychiatric injustices. I’m encouraged by a new group that I’ve joined in New York City, called *Prisons to Public Health*, of discontented corrections officials, organizations by and for incarcerated people, public health and mental health workers. The logical end of their thinking is not only *reversal of mandatory drug sentencing* and targeted searches and arrests in poor neighborhoods, but also the *abolition of prisons*. This makes me think we should, in critical psychiatry, be calling for dual abolition of prisons and mental

hospitals. In the process, we have to confront the drug laws and drug trade as major drivers of mental health, through drug use and also through institutionalization of poor people. We have to act on the public abandonment of the poor through Welfare Reform, regressive housing policies and neighborhood

disinvestments, and the corresponding pharmaceuticalization of poverty that has been the price that many people pay for survival.

The flip side of psychiatric expansion into institutions of poverty like prisons and welfare is the mainstreaming of psychiatric treatment into general medicine, where it is also shaping white affluence.

Melding with Medicine/“Integration.” This relates to biopsychiatry’s crisis of identity, the legacy of the Decade of the Brain, its ambition to become truly scientific specialty, plus pressure from health reform to cut costs by integrating mental health treatment into general medicine clinics.

One story I’ve been tracking that illustrates this principle of integration and how it relates to addiction, race and class is what I call the *War on Drugs that Wasn’t*. This story begins with the FDA approved Oxycontin in 1996 as a “minimally addictive pain opioid pain reliever” and Purdue pharma’s promoting it among suburban and rural GPs for patients with moderate pain such as lower back pain, some of whom quickly learned to crush the time release capsule and inject or snort the contents. Within six years, Oxycontin and other prescription drugs overtook heroin as the major substance of abuse in the US. Most of the users were overwhelmingly white and middle class, and the American response was not to criminalize them, but rather to pharmaceuticalize them. In 2002, Buprenorphine, commercially known as Suboxone, a drug with pharmacological properties similar to methadone, was approved by the FDA and embraced by addiction specialists, the U.S. Congress, and “Decade of the Brain” era NIDA researchers. It was billed as a state-of- the-art neurospecific smart drug for addiction that would clean addiction of its messy social trappings, and Federal law was changed enabling general medicine doctors to prescribe it from their offices, reversing a prohibition on opioid maintenance treatment that had been in place since the 1914 Harrison Act.

NIDA and Congress were looking for a less stigmatized and regulated treatment than methadone for largely affluent and white Oxycontin addicted people. This required orchestrated changes to Federal law and DEA regulations allowing private office based treatment, as well as internet-based provider referrals and internet

ad campaigns to establish buprenorphine as a drug limited to those with the means to pay a specially certified buprenorphine prescriber. This strategy worked: in the US, 91% of those on buprenorphine are white, over half have a college education, and buprenorphine a blockbuster drug at $1.2 billion in sales in 2012 the U.S. alone, dwarfed only by Oxycontin’s sales at $3 billion in the U.S. per year.

Buprenorphine is paradigmatic of the current mantra in health policy of integration of addiction and mental health care into general medicine. This is an appealing idea to a wide range of psychiatrists because, in theory, it expands access to treatment, and puts psychiatric problems on par with physical problems in their importance and their treatment as “real” biomedical problems. The received wisdom is that getting addiction and mental health treated *in general medicine reduces the stigma* of treatment for mental problems.

First, the stigma of addiction and mental health problems is not reduced, and in fact may be heightened, for people who are stuck on the wrong tier of a two tiered system, like poor people in methadone clinics who don’t have access to buprenorphine prescribers.

A second problem with that theory is that many people find they are *more isolated* with their “mental” problems in primary care settings, where they get cues not to discuss them, from staff that don’t have skills or time or resources to address them.

A third problem with that theory is the way that in a general medical setting, even more than in a psychiatric setting, all treatments get whittled down to those that can be given in the monthly medication checks that GPs

are equipped to provide. Using evidence-based medicine decision trees developed from Randomized Controlled Trials of psychotropic drugs, and, at best, brief courses of manualized Cognitive Behavioral Therapy that in any case, is not available form GPs.

The one thing that so-called “integration” of services really achieved is to expand the number of people getting medicated for mental health and addiction problems. GPs of course write far more prescriptions for antidepressants, antianxiety drugs, and now, opioid maintenance medication for opiate addiction, than psychiatrists. And therefore it is GPs that are responsible for psychotropic drugs being the most profitable single category of pharmaceuticals on the market.

But an additional item that the story of buprenorphine points to is the segmented, stratified nature of psychotropic drug marketing. Buprenorphine’s manufacturer exploited minute physiological differences in action between buprenorphine, an opioid, and methadone, an opioid, amplifying those differences and tying them to a time tested logic of race and class that has led to vastly different regulations and treatment settings for vastly different patient populations. What I came to see in buprenorphine was the flip side of the pharmaceuticalization of poverty that I started with – the pharmaceuticalization of affluence. Another example is ADHD, which diagnosed and treated in a bimodal way, with poor children on Medicaid getting second generations antipsychotics to tranquilize their “behavioral problems” and affluent children getting long acting stimulants to enhance their academic performance….psychiatry and psychotropic drugs are shaping class and race at both ends.

We need to call into question policies and segmented pharmaceutical marketing that create inequalities or disparities in addiction and mental health treatment, while highlighting the ways on both ends of the class spectrum relationships to peers and mental health workers are being replaced with relationships to drugs.

Third moment: Where does the emptiness and isolation that this negation of relationships leaves us? And how can psychiatry serve as a positive, transformative determinant of health? There is a community garden in the hospital where I work, that on any given weekend is being cultivated by patients and staff from the dual diagnosis clinic. The psychiatrist who created the garden 24 years ago, Annatina Miescher, is also a visual artist, who describes her clinical work as *art with found objects.* She says that her work is not to cleanse people of their pasts but to help them gather the shards of their life and put them into new and beautiful arrangements.

Much of this work happens in the garden itself, where weeding, planting and harvesting is a productive metaphor for people who are recovering from trauma and rebuilding their sense of self. This also happens in the creative arts therapy groups that take place inside the clinic, that use music, visual arts, video self- documentary and even cooking in a communal kitchen, to help people find their identities and connect with each other. The groups are peer-led, and decisionmaking in the clinic happens through Patient government. People who have finished their course of treatment often volunteer in the clinic and help to usher new people into the fold. There are some dramatic success stories, like Ruben, a Puerto Rican man who was homeless before coming to the clinic, and had his first experience with art in art therapy group at 57 years of age, went on to win statewide art competitions and to have international gallery exhibits. But the real proof in the pudding is the extent to which people support each other outside and inside of the clinic, celebrating birthdays and anniversaries, helping each other find housing and jobs, memorializing those who die.

Many of the people that get referred to our clinic come from the City’s homeless shelters…cut off from family and neighborhood…institutionally abandoned.

Dr. Miescher taught me that there is a place for a garden in psychiatry clinics. Broad-based social change is necessary to have a real impact on mental health and psychiatric abuses, but psychiatry can also be a positive social determinant of health. Hospitals and clinics are where people who are isolated, abandoned, and stripped of their sense of value …as the film about Trieste conveyed last night, small things that help people to connect with who they are, and connect with others, go a long way.

The problem now is that since these so-called small things are not among the service and outcome measures that hospitals are paid and measured by, because they’re seen as expendable, they are now being expended in the midst of budget cuts, art therapists and therapists in general are being laid off.

As Pat Bracken pointed out, to get these apparently small things fostered by public policy and funding, they need to be a significant part of both the politics, and the evidence base of psychiatry. Critical psychiatrists need to be active in defining what is studied, what counts as evidence, and what is the outcome to be measured. In addition to symptom checklists and medication adherence, we need social connectedness, identity and sense of wellbeing. I agree, with Pat, that this will require forms of research and knowledge that don’t have a central place in academic psychiatry now – ethnography, social network analysis, institutional analysis, discourse analysis. I am hoping interdisciplinary groups just like this one can foster the mental health practitioner/survivor/user/social science and humanities cross disciplinary collaboration that this will take.

**Nancy Scheper-Hughes:** I worry about the language of care, of family, users/consumers, and moral economies. These are key words that we put a great deal of hope in. Angela [Garcia] knows that I’ve questioned their uses in her excellent studies of drug users and service providers in New Mexico and now in Mexico City. The kinds of detoxification centers you’ve described in Mexico and Oakland can also be found in Guatemala where people are turned in by their families and communities, kidnapped and deprogrammed. These practices have to be questioned. The family is not always warm and caring. I’ve sometimes said, to the contrary, that the family is the original institution of violence. [She describes having gone to Argentina to learn about organ harvesting at the National Asylum for the mentally deficient (Colonia Montes de Oca).] It was a veritable death camp that had never been interrupted after the period of the Dirty War. Only now is it being reformed. Taking Basaglia’s notion of peace time crimes – what kind of crimes happen in war and peace time? When Basaglia started he had a déjà vu experience of being a resistance worker – the whole sense of it was the same. That allowed him, like Goffman, to use the power of analogy to break away from routine thinking.

At Colonia Montes de Oca there was a long history of complicity with the regime of malevolent neglect by the psychiatric and custodial staff. The families had all deserted these people. 95% of the 1200 – 1500

people who die there are very mildly mentally and socially impaired from having been hospitalized. Even the staff who’ve been complicit in this depersonalization express anger toward families who never come to visit their relatives who are deposited for life in the national asylum. So, I would caution that when we use the word care, is it really care? I think about Marguerite Fetlowitz’s book on the Dirty War called *A Lexicon of Terror.* The lexicon of terror is also seen at the mental asylum in the words that staff use to divide staff into categories – profoundly, moderately and mildly cognitively impaired. The categories include people who are labeled “gatosos” – those who crawl on all fours, who urinate indiscriminately. Another category are those who were deposited as NNs, without names or social-civil identities. Abandoned by their families, they are stripped of their humanity. One thing I’ve learned is how quickly a person can be reduced to a social and psychological and physical nothing. But the other amazing thing is how quickly one’s lost humanity can be restored. When I lost my faith in the project, Dr. Claude Snow, the international forensic anthropologist, told me, “Nancy, I think you found yourself a little genocide at Colonia Montes de Oca.” Despite the gaps in the

statistical data … the number of people that disappeared was astronomical. The case I’m trying to make is that a militarized country loses its moral compass and changes its language in such a way that terror is allowed. It crawls into everyday life, institutions, and churches. How the church responded is another topic I’m concerned about. The way psychiatrists said they responded was allowing people to disappear and kill themselves. I insisted they try to apply the Basaglia-Trieste methods in reform. People kept in cages (dozens in the same cage, naked) until 2007 were suddenly liberated and the former inmates are employed turning the cages into rabbit hutches. The Director said, “We’re going to start the de-institutionalization process with the very same pavilions where inmates were kept in cages.” Today they are fully dressed. They are still

mentally impaired, but their humanity has been restored to them….What kind of society is this? This is modern, post-Dirty War Argentina, but it’s also us today in California.

There are 33,000 mentally ill people in California prisons – 12,000 are in solitary confinement. People say that lawsuits are happening. But you have to go, and it’s harder here than in other countries because they’re tucked away. I visited with Angela Davis in 2000 – what I saw was like Montes de Oca – cages people were kept in when they were taken out of solitary confinement. We have people in it for 30 years. It is left to wardens to decide how to do it. Every 120 days we take people out, we bring them to a table. We have a social worker, nurse, whatever. This table is within the prison, cells surround it, and people are yelling and screaming. The prisoner is brought chained in one of these. I’m sitting next to a social worker who couldn’t hear what the guy was saying. The man in the cage said he threw shit at warden because he was going crazy. Jerry Brown says, “The UC students went on strike because of pay cuts – what they ask for is nothing. Our money goes to prisons.” I’d say what’s going on is somewhere between a gulag and an ethnic *limpieza* - because it’s racialized. I agree with Loic Wacquant who says, this isn’t about political economy – it’s about removing people from sight – to warehouse them out in the desert.

In Guantanamo we are force-feeding people on hunger strikes. Pelican Bay has hunger strikes. These are wartime tactics, and they’re part of everyday life in CA. What happens in Abu Ghraib, Guantanamo, all of this is linked to economy and culture that since my birth has been about war. We have to deconstruct the way we think about things. We need a lexicon of terror – I’m ashamed of not only the US, but most especially of the state of California – Mississippi has a better prison system than we have. At least Mississippi stopped putting difficult inmates into solitary confinement where they can only become more crazy.

**Panel II Discussion**

**Andrew Phelps:** Professionals take advantage of their control of the process. There is an advocacy of a systematic, organized process. The governance of the APA is part of maintaining the system. That is also true in certain local and departmental situations. Thus there is an identified tendency involved with Stanford social psychology which acts to reinforce that larger process. That is part of the phenomenology we must engage if we intend to be a movement. {After the conference, Andrew Phelps notes work that speaks to the concern he mentions here: Ken Gergen’s “The Ordinary, the Original and the Believable in Psychology’s Construction of the Person.”}

**Steven Segal:** The world’s a complex place. To paraphrase Oscar Wilde, real solutions are not ideologically

pure and never simple. I say this not only as an academic, but as a recipient of services, as I grew up in Bronzeville in Brooklyn, New York in a children’s institution. I bet I would have a hard time finding anyone here, advocates of deinstitutionalization, who’s spent more time in an institution than I have. I think the destruction of the children’s institution was a mistake – our child welfare system stinks. It is iatrogenic; it creates problems it seeks to avoid. I learned values, skill, education, and have friends that endure until today in a children’s institution. My neighborhood was one of the poorest and worst neighborhoods in the city. In my neighborhood, the public housing projects were palaces – people aspired to live in them. I appreciate the efforts of the people you work with in Mexico to organize their own places, to find a better life, even if accompanied by violence. What we think of life, of aspirations, the good life – I can tell you from following

427 people in residential facilities that their outcomes were different depending on where they were. They were not unitary. People who left and became “independent” were more independently integrated into the community but those who stayed had better health, better mental health, more assisted living activities. We should think before we tear down. If you don’t have something better, what’s down the road can be much worse.

**Anne Lovell:** I think that’s the point of Basaglia’s model: it was never about just deinstitutionalizing. It was always about continuity, developing spaces outside the asylum that responded to people’s needs. This was the 1970s Marxist redefinition of need. When deinstitutionalization is just an economic process, obviously it is not concerned with what to build or create afterward. It becomes dangerous for us to not put the whole picture together. We need to put hospital closure in a systemic perspective.

**Angela Garcia:** The question of perspective is important. As Helena Hansen was talking I was thinking of peers in Mexico City and elsewhere doing things that aren’t always therapeutic – what are the conditions of possibility that lead to a garden vs. a storefront where people are verbally abusive but form intimate relationships. That context, history is important. I want to argue for the term “care” but to think about its valences: textures which often don’t feel very caring, are often not. But ultimately that is what people are trying to do. That might also be naïve. But the alternative, when working in a place with such trauma, feels more frightening. To try to get close, understand, participate – and then think about how we can begin there. That’s what I see ultimately peers trying to do for each other without much support from outside.

**Sue Estroff:** I want to pick up idea about caring. “Services” and “care” are not the same thing. I think what we’re talking about is trust, reciprocity, equity. Care moves us toward ideas of intimacy, of personal choice in a place where I’m not sure we, when talking about treatment, should go. I think when we talk about compassion, beneficence, on a social level this differs from social attachments we may or may not have with people with whom we work. I think, more granularly, it’s about caring *for* vs. caring *with*. There’s a way in which caring *for* is both presumptuous and also in a way infantilizing. I would say caring is not enough and our job is to create opportunities for resources people want and need – not what we tell them – that don’t annihilate opportunity for trust, reciprocity and equity to happen.

**Hugh Middleton:** One perspective is to pull those together in an expressed interest in the nature of living

space, different types of living space, and what makes a living space a flourishing space or damaging experience. It could be a focus of research.

**Helena Hansen:** I think spaces have been a heavy theme – how to look at how they’re structured.

**Orla O’Donovan:** We had an example of that earlier today.

**Joshua Moses:** Someone asked me if I cared when I interviewed them. I do, but there’s a limit. A question: it seems that you’re moving out of your jobs, with gardening, etc. – you’re working your way out of psychiatry. Is the end game to get out of psychiatry?

**Pat Bracken:** I’m passionate about the role of medicine in mental health. Suffering doesn’t fall into neat categories. We are embodied so our suffering involves multiple aspects of being – social awareness, emotions. There’s an important role for physicians who are trained. But we need a much more sophisticated way of thinking – but whatever else it is, the mind isn’t just another organ of the body. I don’t think a role for medics is ruled out.

**Orla O’Donovan:** Is that what you mean by post-psychiatry?

**Pat Bracken:** Yes, it’s moving beyond idea of psychiatry as something beyond technical.

**Roberto Mezzina:** I have some comments. First about space: there is growing evidence that among social determinants we can include spaces for health. In Trieste there was involvement of an architect who collaborated with us and redesigned social habitat – someplace that can foster relationships, can reflect a sense of dignity. Places that are locked can become awful institutions. We need to develop places where people can meet and develop relationships. The other point is about gardening: we had criticism at the root of the movement of work therapy – a German idea: the idea (s.c. “Ergotherapy”) was that this was just opportunity for work – it can be exploitative and not therapeutic. Sue Estroff said before, it’s not just about caring, it’s about creating opportunities, what they call comprehensive services.

**Christopher Zubiate:** On space and class: One of the biggest problems I have is where do you put programs? It’s hard to say, “I’ll create a state-of-the-art location that also exists because it’s an economically feasible way to care…and it’s going to be next to your house, and yours and yours.” People have memories

of being next to horrible places. The psychology of place dictates very much what I can do. There are

unique opportunities about the way people live. There’s something backward about me getting richer to give care and you getting poorer, and something asinine about 2 people with disabilities necessarily making good roommates for each other.

**Stefania Pandolfo:** I want to raise a question from Angela Garcia: There is violence in the therapeutic spaces in Mexico City, a sense in which there isn’t empowerment – there are people going by themselves or taken by families. Someone said that of course if recovery happens that way, who are we to say it’s not recovery? What does it mean to take seriously as a therapeutic process what Angela was talking about? Because it does call into question the terms we were using. It calls into question what we were talking about this morning. What does it mean to confront the experience of the person in front of us in relation to what Angela was saying – that’s not just specific to Mexico. There is something maybe in history of psychiatry about those relationships. My sense is that it’s not enough to say that’s culturally Mexican. I think it addresses us in a certain way, forces us to think about ethics of care and relationship.

**Angela Garcia:** I can give an example. I was working in New Mexico in a population with a high rate of heroin addiction. The big idea was to have people gardening. But it was throwing salt in the wound because they didn’t have land and were 1 or 2 generations removed – gardening failed terribly. So re: the question of where will this lead? A job at Walmart? The idea of what works culturally does need to be interrogated. I think the violence that occurs in Mexico and other parts of Latin America – it’s explicit. It’s not hidden, it’s acknowledged – I’m not saying it makes it any less violent. It forces us to consider the nature of caring and therapy and violence and the way it’s textured not only there but also here. Somehow, when we’re confronted with an image of violence, the fact that is the violence we often respond to most vehemently, that also needs to be questioned. There’s something about superimposing a kind of philosophy that is even more dangerous.

**Observer:** The business of we’re all equal, when they live with violence day in and day out, there’s this idea they know the guy, the therapist thinks it can’t be that bad (Some of comment lost.)

**Robert Okin:** It seems to be we’re trying to decide between different levels of violent. Why are we trying to choose between them? If it’s culturally congruent, is it less violent?

**Nancy Scheper-Hughes:** This wonderful psychiatrist, Kaipers, who served as psychiatrist for the Black Panthers – has put together a class action suit: we can win this one in California to limit solitary confinement to 20 years rather than 30 years. If we do this, several thousand people can get out. It’s this question of how much violence are we willing to take? Sometimes incremental good is at expense of the larger social good?

**Delphine Brody:** What is behind the dynamic of criminalization of madness? Was it this lack of compassion, empathy – what is behind this separateness, this not feeling interconnected? Why is it that we think if we are not connected we are not responsible? There is a lack of agency…what is behind this lack of critical thinking. I see an excess of individualism, moralism’s triumphs – this creates these separations. I work in art, it’s such a powerful tool to change people…and gardening allows us to connect again with nature. How can we restore interconnectivity, etc.? How can we create a new system of values that supports this?

**Andrew Phelps:** There’s a culture problem, and the culture is called, when you have oppression, what happens? When you don’t identify things as oppression that are, what do you do? The culture of behavior management as it’s practiced is basically a culture built as an oppression characteristic. Living underneath it is no different from Jim Crow, or male dominance or something else. It’s a culture that has to be shifted. I went into that and thought behavioral management is not science. I went and got a PhD in math and showed they didn’t have their math right. But I hope that bringing that into anthropology will help lead to culture change.

**Helena Hansen:** And on the note of psychiatry as a social determinant of health, per Joshua Moses’ asking why we don’t take up the work of social psychiatrist Mindy Fullilove on the traumas of place and displacement stemming from racial segregation urban renewal in this country, and her prescription for spatial race and class reunification of city neighborhoods.

I think a utopian vision would be psychiatrists not being needed because there would be so much interconnectivity. I think it’s no accident that the program at the hospital where I worked was helped by a psychiatrist who was also an artist who recruited a team from the arts and different skills. She had a position that allowed her to carve out this space. Coming back to Mindy Fullilove and her work – she’s worked with partners, but she’s been an essential element of that as a translator and analyst in framing this as a health intervention. The best of psychiatry that we can draw on is that one when we bring together things that seem unrelated. I wanted to end on this note of structural competency – how clinical institutions can take institutions of poverty, race and class into account. To get beyond monopoly of expertise that doctors have – to create collaborations with schools, housing. There’s an irony built in that we’re trying to draw on our institutional position and the cultural and social capital that we supposedly can draw on and we work against our own expertise. I think we need both halves. There’s that tension – we have to think about it.

**Panel III. The Political Economy of Madness and Recovery (3:00 – 5:00pm)**

Antonio Maone (Italy) Sue Estroff (UNC) Joshua Moses (McGill) Andrew Phelps

Steven Segal (UC Berkeley)

**Antonio Maone** [uses slides, video]: I’m interested in the possible bridge between housing, psychiatry, anthropology and recovery. In mental health one of major goals is social inclusion. Housing is a fundamental tool for social inclusion. Psychiatric Rehabilitation in fact pursues this goal. But, curiously, one of the biggest problems is the fact, disappointingly, that the structures aimed to achieve social inclusion become homes for life, detached from the community and, actually, means of segregation.

A doctor from Basaglia’s team, in the 70s, contracted out a home for 2 patients. [Shows related film clip in which the landlord objected to renting to these patients and they left. Next clip shows people with schizophrenia who, 30 years after, are living independently in an ordinary housing with flexible support. Next, shows graph of this supported housing initiative in Rome, and the residential stability it achieved:

97.8% over more than 10 years.]

They delink housing from care so that housing doesn’t become an institution. The house is a dwelling or home, it is personal. Support is flexible, not regular – it depends on patients’ needs, ongoing negotiation in level of care.

Is this a case of well-implemented mental health service? Not exactly. [Antonio Maone explains that he and his team had to force boundaries of the mental health system to make it happen and themselves took personal responsibilities and risks – the system refuses to agree.] During the first 5 years there were many obstacles

we were actively hindered, not by neighbors or landlords, but by mental health services itself and some family associations.

[Shows graph of how system works in Italy: no psychiatric hospitals since 2000 – but more residential facilities year by year from about 1/10,000 population in 1990 to more than 5 in 2010.]

All over Europe residential facilities are engendering new forms of segregation – we’re not sure why. General attitudes toward risk containment may matter. Psychiatrists are the heart of the problem – they had more negative stereotypes than the general population.

Some lessons…

**Old paradigms New paradigms**

· Skills· Evidence based practices

· Train and place

· Rules

· Professionalism

· Avoidance

· Capabilities· Common sense

· Place and train

· Breaking the rules

· Time and commitment

· Approach

**Sue Estroff:** We’ve had a lot of words, and I want to offer images that haunt me. I’d like you to be able to call out whatever comes to mind…this is not a projective test. One of my goals is to try to get you to change your point of view.

[Shows a picture of a tree.] A lot of us think that trees grow up from the roots. What if I flipped it over and said they’re diving from above?

[Quotes Foucault from  *Madness and Civilization.*]

[Shows image of blindfolded white person in white coat “looking” into microscope.]

[Shows list of bases of clinical practice: evidence, eminence, vehemence, eloquence, providence, diffidence, nervousness (the holiday issue of BMJ)]

[Image of woman with the words, “Do not speak for me, listen to me”]

[Quote from Boivink 2007 – the idea you’re the author of yourself. Who gets to speak for and represent whom and on what basis?]

But there’s a danger of fetishizing stories and narrative. Some people critique patient porn, stealing the stories of others. Resilience and recovery are resignified when what is meant to be a resistance account – are “sanitized and commodified without disrupting their own practices.”

[She quotes Pat Deegan -- recovering is journey of the heart, not to become normal but to embrace human vocation or becoming more deeply, more fully human.]

[Recommends Mark Vonnegut’s latest work.] Islands of being sick or being well depends on what’s foregrounded or backgrounded. The lingering question of the burden of proof shifts to users – you prove to me you’re alright. It’s the second look that people with disabilities will get.

[Sand sculpture. Person’s head is on ground with hand on top] Is the person rising up or being pushed down? One of the key tasks of critical anthropology and psychology is to take seriously this idea “Don’t let

treatment interfere with your recovery.” Take this at face value rather than anthropologizing or politicizing

it.

As we push back, there is a “yes, but”: yes we believe subjectivity is important, but do you have a reliable scale?

**\*\* Note: Sue Estroff said quite a bit that is not recorded here.\*\***

**Joshua Moses:** Earlier today I was thinking about my work in the Arctic. I have been working with indigenous communities there and elsewhere and was reminded of a Woody Allen joke: two ladies at a resort are talking, and one says to the other, “The food in this place is so bad!” And the second one says, “Yes, and there’s so little of it!” People say the services are terrible and that they want more. I don’t understand what’s going on…

Almost as disconcerting as suicide is research on it. There’s a sense we haven’t gotten any further in understanding since Durkheim. I was looking at an issue of *Culture, Medicine & Psychiatry* on suicide – there was no real engagement with issues of livelihood, labor work. There was a culture framework, and no serious engagement with how people do these things. I started thinking, given that work affects how we value and are valued, and it seemed silent – it seemed relevant to what I was seeing. I was in a meeting in Ottawa with a mental health agency talking about work with indigenous communities on culturally adapted interventions. I asked about what about work in areas of unemployment and was told that they don’t do work on unemployment. Someone else was doing work on job training for aboriginal people in the Northwest Territories – of 99 trainees, 1 person got a job. This was a program designed around American positive thinking. Yet the causes of distress continued to be framed around culture. The Northwest Territories has a very large GDP due to natural resources, but there’s more and more homelessness and less and less services. They were contacted by service providers so these could make argument for more services, housing. People offering services don’t have advanced training. It was the RCMP (Royal Canadian Mounted Police) –

they’re federal but contracted for local work – they ended up caring for the homeless. They interviewed one official and she said, “It would be nice to have another option. …we’re not trained, which is kind of sad because we know most of the clients we taken in are seniors…we do our best but there’s not much we can do….” Up there is a regional center that was started by a mining company. The company was doing exit interviews with white collar employees who were complaining about the homeless, so they kicked in money for a drop in center during business houses – a way to sweep people off the street during the day. It didn’t address underlying issues.

Another example: in a place with at least 50% unemployment rate, there’s a higher-than-average suicide rate, and the local government invests in historical trauma certificate program. The idea is to restore traditional culture. There’s also a large nickel mine nearby and no discussion of its impact on community.

A final example: I was at a suicide prevention meeting with indigenous communities. The keynote speaker, a burn surgeon, talked about experience, and finished by saying there needs to be fire safety training. They said common sense needs to be taught and this was a cultural problem. Community members asked the surgeon if they’d been to where they lived – they boarded up windows because it was impossible to get new windows. I imagined the surgeon doing his best, but at the same time they were trying to describe community context

and he couldn’t see it…and he framed response in cultural terms. In aboriginal communities, the way things get framed is in terms of culture.

The *CM&P* article called for cultural explanation, more ethnography. Sometimes looking at everyday lived experience is helpful – but for many there’s no experience of every day let alone inhabitable future – frequently you can learn more about health in indigenous areas from looking at commodities in stock index. We’re dealing with global processes that dispense with, displace people. Any psychiatry that would

ameliorate this has to engage with politics in ways that it is largely unaccustomed to and must confront power in new ways, and at times realize it has little or nothing to offer. And that’s my frustration with

anthropology, too.

**Andrew Phelps:** I call myself the “behavior object.” I’m trying to bring into focus the problems we’re having in pulling this process together. I’m glad this workshop is doing something to engage these problems at a new and better level. I thought I would speak to the political economy of moving things forward based on my experience in the client/survivor movement. The overview is called, “We’re opposing the present culture of behavior management.” How do we do such a thing? About 12 years ago we worked out a document – a process based on respect. {He offers a link later: [http://users.cwnet.com/phelps/apbor.htm}](http://users.cwnet.com/phelps/apbor.htm) In

2001 with some of the former leaders of the movement we made NO – the National Organization. We said, “We want to construct a national organization in a way that ensures that process is respected and inclusion really does happen.” We wanted people to speak to one another on the basis of respect. Eventually we ran into difficulties because however much we wished to have respect things would break down. What do we do when they break down? There’s all this negative stuff, infighting.

That’s superficial – the deep aspect is stereotyping. How do we deal with that? The system isn’t going to tell us, so we start to look at things like the clinical gaze. The deepest reason is the oppression caused by the clinical gaze relationship. We had to look at that. We are working every day to move the work forward. For example, we brought in Paula Caplan who walked off a committee that was making PMS a mental disorder.

I got a speaker from NOW to sponsor …our work. She’s gone on and written a book called  *Bias in Psychiatric Diagnosis* {He later shares a link to her work: [http://batstar.net/mhca/pc\_talk.htm}.](http://batstar.net/mhca/pc_talk.htm) The third level is what we in our movement are starting to call Occupying Our Behavior. We imagine we have some integrity – my friend Sharon spoke up about the way the room was organized earlier today. We’ve looked at what that means if what we’re trying to do is challenge the way psychiatric work is done. [Quotes Pamela Inaba who does peer counseling in LA, commenting that we have a concern, that we think we have integrity

[{http://batstar.net/gaz/pamela4.htm}.]](http://batstar.net/gaz/pamela4.htm) If the start is, “You’re one of those,” that’s not acting with integrity. So, we need to learn the integrity of people who have been building a movement. We’re really at the previous stage but we’re heading in the right direction. The final thing you work toward is reinstitutionalization – creating a new social reality. It’s closer to putting people in houses in Rome. Society lives in a way that radically engages human beings, their madness, we learn to do it. Giambattista Vico (1668-1744) was a professor of rhetoric and natural religion at Naples. His critique transcends the Trieste experience – he decided social science had to be changed, and wrote a book, *The New Science*

[{http://art3idea.psu.edu/boundaries/related/vico.html}.](http://art3idea.psu.edu/boundaries/related/vico.html) Joyce’s *Finnegan’s Wake* is built around Vico’s social science.

**Steven Segal:** Once two national leaders of the service users movement took me out to lunch. One asked me to evaluate the programs they were running. They received money from SAMHSA (the US Substance Abuse and Mental Health Services Administration) and their county to run user-led drop-in programs for people

with mental illness. They wanted to know how effective they were. I visited four of their agencies and was impressed with degree of support and respect showed to all in the program. I visited job interviews for a position…about 5 people applied. One candidate was hearing voices during their interview, but they conducted interview in a really respectful way. The person I would have chosen was the person they chose. I got a sense that they were giving people jobs that allowed people to value themselves. The programs were giving some sense of empowerment to people through jobs.

This contact mushroomed into a grant on consumer services and then the founding of the Center on Self-help Research—an organization that was run by researchers and services users. The Center sponsored several clinical trials on consumer-run services: one on consumer case manager effectiveness, one on crisis intervention run by consumers, and then a trial on consumer-run services as a complement to community

mental health services.

The purpose of the latter trial was to look at two types of consumer-led services: Self-help Agencies (SHAs), consumer-operated service organizations, managed as participatory democracies involving members in all aspects of organizational management—where SHAs assume that organizational empowerment promotes recovery—and hierarchically organized, board-and-staff-run, consumer-operated service programs (BSR- COSPs). The BSR-COSP is led by consumer management and boards and accords less decision-making powers to their membership. This study considered the relative effectiveness of SHAs and BSR-COSPs working jointly with community mental health agencies (CMHAs) and the role of organizational empowerment in promoting social functioning, self-efficacy, personal empowerment, and in ameliorating hopelessmess, symptomology, and reducing self-stigma, all keys to recovery.

The studies employed weighted samples of 505 and 139 new clients seeking CMHA services who were randomly assigned in separate randomized control trials to one of two forms of consumer led service in addition to regular care. Respectively, the trials randomly assigned clients accepted to CMHA service, to regular county-CMHA service vs. combined SHA/CMHA service, or to regular county-CMHA service vs. combined BSR-COSP/CMHA-service. Social functioning, empowerment, self-efficacy, hopelessness, symptomology, and self-stigma were assessed at baseline and eight months in each RCT.

Combined-SHA/CMHA-service participants experienced greater positive change on all the criteria than CMHA-only participants, a result attributable to both participation in the combined condition and increased organizational empowerment. BSR-COSP/CMHA-service participants experienced more negative by comparison to the CMHA-only-participants, a result attributable to participation in the combined service. However, since the CHMA conditions in both trials preformed equally well, the results can be attributed to participation in the consumer-led organizations. In fact, one might conclude that differential organizational empowerment efforts in the SHA and BSR-COSP appeared to account for the differing outcomes. Persons with mental illness experience positive outcomes when they are engaged in responsible roles with other consumers. When placed in positions implying they are less responsible, participants do poorly.

The studies successfully demonstrate the role of meaningful participation in treatment planning as a factor in both positive and unexpectedly negative patient outcomes. They provide a better understanding of the contributions that can be made by consumer-run services to improved outcomes and show the need for more discriminating endorsement of such care based on the service’s commitment, organization, and ability to empower participants in a true self-help experience.

People need to understand more about consumer-run processes – and we need to ask ourselves what we’re doing right and wrong. Not all psychiatry or consumer work is positive; we need to be able to evaluate our processes, not just follow ideological trends – there’s too much of that in this field and not enough responsibility to the people we serve.

**Panel III Discussion**

**Hugh Middleton:** Steve Segal raises the question of research methodologies. One of your conclusions is we should be researching processes.

**Steven Segal:** We spent 2 years investigating processes of these agencies and asked agencies to tell us about their processes.

**Hugh Middleton:** Our experience is it’s difficult to get funding for anything that’s not a clinical trial, but clinical trial methodology doesn’t get at this. There’s an institutional barrier that needs to be overcome.

**Steven Segal:** What do you mean when you say RCTs are flawed? Measurement can be flawed, analysis can be flawed?

**Andrew Phelps:** There’s a lot of critical work forward that has to be done to get a handle on this experience.

**Sami Timimi:** It sounded like a traditional sort of trial. I think it’s important we continue trials. What’s important is the evidence base on outcomes…..Sometimes we get hooked up with thinking things are terribly complicated and that’s how case notes get bigger and bigger. Something that resonates for me is that there’s something very simple in what we’re saying which is about stripping away this idea: we always have prisms through which we interpret what people are saying – but if we can strip away idea of expertise, we’re more likely to listen to what people say to us. Doing clinical work is relatively easy – you have to find out what people want to work on….and facilitate that process.

A final comment on the work Joshua Moses is doing – if you hadn’t done that ethnographic work, maybe now you couldn’t attack stereotypes as you’re doing.

**Brian:** A question for Joshua Moses – how different do things look in Canada where there’s nationalized health care? Joshua Moses: centralized health care is one of the myths of Canada. My advisor says Canada is the ultimate Foucauldian state in which there are no problems. Health problems in aboriginal population are worse – resources are scarce, you can’t get providers to stick around. And money disappears. The government sort of pays. The other big dupe is these are now indigenous governments – the valorized idea that they have their own governments has a dark side in that they said, “Here’s your land back – plus 500 years of social problems. And, by the way, we’ll put a uranium mine in your back yard.”

**Anne Lovell:** The “bad food but portions too small” comment of yours earlier, Joshua, is part of the commodification process. I notice this desire for what wealthier countries have – it doesn’t matter if it’s crap, why can’t we have it too? You’re talking about a lack of response – there was a community, where did it

go? This issue of looking at a deindustrialized area – there was recognition that it’s not compartmentalized into mental health – it has to do with community, structure. Where did this go? Why do we forget? Could you comment on work on neurolization? – entire native peoples’ communities on some kind of psychotropic? At some level this is believed to be a real and effective response.

**Joshua Moses:** The first part, about what happened in terms of a community response – I’ll give a short answer: the history of land claims and the judicial process demands that indigenous people enact culture in specific ways. There was this performance of aboriginal culture. A lot of work around protective factors is that culture is a protective factor, so an idea of culture was built that took on its own momentum. At the same time you have rapid inequality. There are gatekeepers of culture.

**Anne Lovell:** I assume there’s some relationship between natural resources and neoliberal processes and that’s rapidly increasing inequalities.

**Joshua Moses:** That’s the way to read the dark side of the narrative. One reason the land was given back was to exploit it in ways it wouldn’t be exploited if held in public trust. They all happened around the same time, and it wasn’t because they got nicer.

**Observer:** I wanted to speak to common threads I heard in this panel – the pattern that emerges for me reflects my limited knowledge about trauma sensitivity and cultural humility as paramount to a paradigm shift. …. The way clients should be overseeing and ensuring compliance among service providers. Joshua pointed out there should be a voicing of First Nations people where their exploitation seems to have very

clear links to mental distress. In Steve Segal’s research there was clearly an advantage to organizations whose structure is democratic and participatory instead of top-down. I think all of this speaks for there to be a strong voice always not just from the loudest but from everyone in a democratic way – to go out on a limb to make that happen. It speaks to Andrew Phelps’s concept of Occupying Our Behavior: integrity and new social

roles can come through democratic participation and voicing.

**Panel IV. Trauma and the Experience of Madness**

Roberto Beneduce (University of Turn) Anne Lovell (Inserm)

Stefania Pandolfo (UC Berkeley)

**Roberto Beneduce:** [Begins with professional biography. He remembers bad smells of psychiatric hospital in southern Italy when he worked as a psychiatrist. Then he went to Africa as an anthropologist and experienced *other smells* of markets, poor houses, and religious rituals… His interest is now in the transformations of traditional healing practices in West Africa, and in refugees, citizenship and asylum issues.]

I think we agree about the violence of psychiatry and the violence of treatments, or the fact that in many

cases drugs are useless and ineffective. I want to question the fact that drugs continue to be used even in front of their ineffectiveness and continue to have such big success – Sue Estroff’s paper on what we can call the *aesthetics of drugs’ market* was very interesting – this market works to hide how they produce serious side effects and bad bodies. It was shocking – I know how drugs transform the bodies of patients. How is it possible to construct a so uncanny social amnesia about the side effects of these drugs? Now I want to

explain why I’m so critical of diagnosis in psychiatry. Basaglia wrote about diagnosis many years ago. We are not able to deconstruct the rhetoric of diagnosis – why does diagnosis continue to be proposed, renewed? Why do classifications multiply? What does it make possible for society, not just for individuals? What is the good in a diagnosis? At the same time, what can a symptom be? I mean: what a symptom says about

individuals and what it says about society, current conflicts and past. I am interested in demonstrating that the so called *natural history of illness* doesn’t exist. I think we can discover interesting things in looking at symptoms in this way.

[He’s interested in refugees who speak about a past that psychiatry is not able to recognize].

I’m thinking of a specific case – a young man from Cameroon. His problem was a delusion of persecution. He believed his father lost the Nobel Prize because an important scientific discovery and information was stolen by colleagues. At first I ignored the “Nobel Prize complex,” first proposed by an American psychoanalyst in 60s. Someone connected this complex to American society that gives a lot of opportunities, but only to a small number of people. When I read his history again, I learned something about the historical form of the consciousness that can be revealed even in the form of a delusion. At the same time, I think when we speak about what is *recovery*, *empowerment* and other similar concepts we have to remember that all

these dimensions are characterized by the ability of subjects to act in the History, in particular contexts, not just in the present. Or, in other words, the ability to put him/herself into a long trajectory, not only individual but collective.

What is culture? It is the specific form of historical consciousness, the ability to think historically and to act in the present. Culture is not just about exotic symbols, traditions, identities and so on. Anthropology told many years ago how we can usefully think about “culture.” I want to remember just an article about “culture as power” I read many years ago, and referred to natives in Canada. In that case the high risk of suicide was directly connected to the lack of power, cultural dispossession and political expropriation. I think we can take this image for what we call schizophrenia or psychosis, and keep in our mind that diagnosis often contributes to cut, to separate individuals from a larger history.

A second anecdote: another image of a patient I met many years ago. This man was diagnosed as schizophrenic. He was what we call a “child of war”: his history was born in the violence of the world (he born after the end of World War II, he was a “mulatto”). I remember his name, Aldo: this man refused a surgical intervention necessary to extract a bullet from his leg. He was not involved in a conflict in the town, he was just the accidental victim of a firefight in a poor quartier of Naples. But he stubbornly refused the surgical intervention: given he had since a long time psychiatric disorders, I was told to speak with him and to try to convince him to accept the treatment (to psychiatrically treat him in order to make him surgically

“treatable”…). Why Aldo was refusing the surgical operation? It wasn’t fear. Many years after I understood the possible reason of his refusal at that time my colleagues qualified as the last testimony of his schizophrenia. In my opinion his “symptom” was the desperate effort to connect his private history (his suffering, the lack of a father, the color of his skin, the racism that wounded him since his childhood) to the collective History (the war, its violence, the untold history of his mother’s suffering – raped by an American soldier). In keeping that bullet in his leg he probably found the possibility to find a sense: the bullet had

finally filled up that “hole,” and made possible a connection between individual suffering, “schizophrenia,” and History and its madness. How would he tell all this without that bullet in his leg? The embodied History is not only an accident, passively experimented: it is an active search too for a place within History. Without this *knot* he was in a no man’s land.

A third story concerns another patient, a woman I’ve been seeing for 4 years. She continues since then to speak about spirits. This case is insightful when I remember what a Nigerian scholar wrote recently about the relation between spirits (*abiku*/*ogbanje* phenomenon) and the Black condition: “Disconnection is a large psychological, economic and political problem for Blacks in the 21st Century.” I think our duty is to heal disconnections and accept that spirits just try to re-connect what has been forgotten, hidden, or “disconnected.” Spirits speak about a long history of violence, slavery, diaspora, separation. Now, this

woman who was involved in sex trafficking, as a prostitutes, evokes spirits and speaks about her poor, expropriated life in terms of a new slavery – is it a repetition of history in her present time? Are her symptoms (confusions, delusions) a metonymy for other scenes of suffering, madness and violence?

My examples try to put the more general question: what kind of relationships between anthropology and psychiatry is possible and desirable?

Are symptoms allegories of the past? Benjamin says that “Allegories are in the realm of thought what ruins are in the realm of things.” I think we have to explore these *ruins*. After all, they are the only place where it becomes possible to reconstruct a true subjectivity – a word that risks being empty if we don’t remember collective History.

A second aspect of allegories: Fanon talked about his search for a *situational diagnosis* – it was not ontological; he was interested in exploring the “reactive psychosis,” i.e. to place the individual breakdown inside History.

We might suggest an example of how a diagnosis can name a form of suffering and at the same time conceal something else. PTSD is an easy example of concealment: something new emerged in the 80s – guilt, but with PTSD, many people who receive this diagnosis were involved in acts of violence *without any necessity*, not acceptable from a cultural point of view, and in some cases associated with *pleasure*. I think psychiatric anthropology has to analyze in deep what we call dirty words: torture, humiliation, death, mockery of dead bodies. These last 30 years produced humiliation, torture, and pleasure in a new form. And when soldiers coming from Iraq or Afghanistan suffer, we diagnose them as people affected by PTSD. Finally, we use the same diagnosis for perpetrators as well as for victims. In this strange coupling we contribute to annihilate all differences – and more we speak about victims (a moral concept), more we forget the oppressed (a term calling for political analysis…). When we speak about psychic suffering, we risk to forget the sadist system of organized violence (Abu Ghraib, Guantanamo) directly connected to these wars and to symptoms. PTSD diagnosis reflects “US”… If we want to destroy the hegemony of Western diagnosis, we have to look at the epistemology of these concealments.

**Anne Lovell:** I wanted to talk about my recent work in New Orleans, where I arrived soon after Hurricane

Katrina and to focus on what disaster presented for the people who experienced it as opposed to for

observers. And how this relates to understanding Basaglia. So 1) let’s look at the hurricane as revelatory – an “analyzer” – of processes in mental health. 2) And let’s consider the tabula rasa – starting from supposedly clean slate – in mental health after Katrina, after the entire infrastructure of mental health in New Orleans

was destroyed – the labor force left, the facilities damaged beyond repair. It was the largest outmigration of health labor force in US history. One way this relates to Basaglia is through a parallel with the tabula rasa in Italy when Basaglia started working: Italian psychiatry was in a less “advanced” state than in other European countries, and everything had to be invented. Katrina, too, created the possibility of rethinking paradigms, inventing new practices.

Katrina is revelatory about how people live with vulnerabilities: we’ve talked a lot today about care as individual choice, the user, the consumer, the psychiatrist – and about dyadic situations. What struck me in observing post-Katrina was that one could not think of *the* user or the vulnerable *one* in the family configuration, often people living in or caring for an extended family. About 100,000 people didn’t leave despite mandated evacuation, because people didn’t have cars. But there was another reason, linked to how individuals’ vulnerabilities are intertwined with each other. The typical situation might be a woman with schizophrenia who is part of a 15-member household, 4 generations, and in every generation there are multiple disabilities and illnesses to respond to. One also needs to think in terms of “syndemics,” how multiple conditions and diseases of poverty overlap and interact with one another at once, and how this is embodied, both individually and socially. Katrina, exposed this reality; many people – cars or not – did not evacuate because the condition of a loved one kept them behind. For example, perhaps the mom was on oxygen permanently or debilitated from chemotherapy or experiencing a psychotic break, and no one could transport her or she was too scared. In a more general sense, when it comes making decisions, families with multiple “users” too often have to balance and decide whose need they can respond to. This is perhaps why someone won’t evacuate. Yet many of discussion today seem to assume that, individuals can simply make individual choices, without relationality.

I would like to make two other points based on my study: 1) about diagnosis and 2) about reification. In New Orleans, mental health professionals complained about what I call the “PTSD helicopter” – the “national” researchers hovering about to validate their ideas about PTSD on a newly traumatized population. In the language of locals, they were affected by “Katrina brain” – hence the disjuncture between diagnostic definitions brought from elsewhere and what was going on at ground level. Today the language of trauma can be used by everyone, but the “democratization of diagnosis” has unwanted side-effects. Sometimes the diagnostic language of psychiatry is simply irrelevant to bringing a family back together, or recuperating a living space after disaster. Another irrelevancy – after Katrina (and after post September 11), enormous federal funds were allocated to allow people limited contacts with a counselor. This took place all over Louisiana, including in places not affected by Katrina. Outreach workers and counselors were often consumers, defined as anyone who’s experienced a hurricane. (In Louisiana, that’s basically everyone).

Yet democratizing trauma somehow left out people with who had already experienced serious mental illness *before* Katrina, including many who had been homeless before or experienced the not-so-rare violence of bullets flying overhead, that the militarization of Katrina brought back. Much of their lives were marked by loss, trauma, abuse. Yet this trauma does not fit the psychiatric paradigm, which is more concerned with how “normal” people are traumatized by “abnormal” events. Hence the invisibility of pre-existing vulnerability despite the democratization of trauma and the injunctive language of sentiment.

My final point concerns how we respond to trauma, the time of disaster and trauma and the process in time of re-symbolizing trauma. Many people with severe mental illnesses are considered to be living in dead time anyway. Yet most of the ethnographic work that I have done, and not only after Katrina, reveals time to be

the source of a major disjuncture between how psychiatric services are organized and how users live. Disaster response, when it includes people with mental illness, ignores that the disaster hits everyone at a different point in their life and illness history. The importance of recognizing multiple temporalities, or the intersection

of the time of disaster with a point along the flow of someone’s life, has two consequences. It forces us to rethink responses based on the erroneous assumption of uniform experiences of trauma, and it points to re- symbolization as a process in need of time. In other words, it critiques the paradigmatic embrace of psychiatry as a kind of reification. After Katrina, everything had to be re-invented on the tabula rasa of what had been mental health care. But the old psychiatric paradigms prevailed.

**Stefania Pandolfo:** I wanted to make 3 points. I’ll make them just as titles. [She shows a picture of a wall painted with a serpent.] Something in this picture addresses us in a disturbing way – it cannot be controlled or rendered discursive but it can be woven, circumvented, invited in different ways. If there were time I would talk about this image, which I encountered in a poor neighborhood in Morocco by a man I named M. When he is mad he paints the walls of his house where he lives with his companion, his wife. I’ve been talking with them for 7 or 8 years. These frescos were wiped out, white washed. I participate in their life in a way that’s ethnographic but that is different from other ethnography – it produces hesitation, interruption, surprise, pondering. This is an image made before 2005. He wanders the street, he goes onto fugues, he travels, he uses Christianity – crossing and crosses – and then he comes back. He’s never been diagnosed or to the hospital. His wife has been. When he comes home he’s melancholic and wants to commit suicide. He said that out of that something emerged – this image, which came from him, but it wasn’t him because he wasn’t there: it composed itself. Weeks later he recognized it as an image. He put his bed underneath because once the image was on the wall that was the only safe place he could sleep. He was explaining the image: if we want to explicate the painting, there is the serpent, the torment of life….it is poisonous. As for the sword, it is the force that conquers all things. Next to the sword, here is the painter. [She references God

– is this the painter?] No one is victorious except for God. Because God, only God is sovereign. All that happens in the life of the creatures, of human beings, all successes and failures happen with the permission of God. ….. We talked about form, what is this form that can spring from madness? It’s form that’s fundamental to subjectivity itself. The other point is that there is never a cure in this context – it’s not about healing, it’s about an encounter with madness that makes possible for the man and his wife to come back together, to begin with life again knowing the serpent is always there and engaging in their relationship with their daughter, family, neighbors. The experience of madness is what makes this life in the margins possible in a way.

**\*\*Note: Parts of this presentation are left out.\*\***

Just one more word – I would try to follow the serpent in the practices of an imam with whom I work who practices what could be called exorcism. In the experience of illness there is an interpellation that opens up the possibility of representing the divine. He positions the process of healing in political terms – people are speaking of history in larger terms that calls for a larger response that happens in the space of the subjectivity of that person.

**Panel IV Discussion**

**Andrew Phelps:** … I tried to bring Paula Caplan here. She speaks to the meaning of trauma and the history of diagnosis. She develops this as her agenda and should be networked with.

**Nancy Scheper-Hughes:** One word on trauma: Anne and Roberto suggest that everyone is involved in trauma. But I don’t agree with the notion that how can you have a phenomenon, a symptom, syndrome that works equally well for perpetrators and victims. All the late-modern truth commissions have had to deal with the fact that some people move positions between victim and perpetrator. In South Africa, for example, I questioned Albie Sachs, then serving on the first Constitutional Court, about an egregious apartheid perpetrator saying in front of the TRC (Truth and Reconciliation Commission), “Do you think this was easy

to do this [to torture political prisoners]?” – who claimed that he too was a victim of the apartheid state. But Albie Sachs said it was wonderful because it was an acknowledgement of history. Better that a perpetrator claims they’re also a victim because they are acknowledging the grotesque damage of the former regime. It was not to create a tabula rasa but a narrative everyone could live with. Our argument that PTSD doesn’t work for people experiencing continual trauma …