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978-1-107-03220-0 - Re-Visioning Psychiatry: Cultural Phenomenology, Critical Neuroscience,
and Global Mental Health

Edited by Laurence J. Kirmayer, Robert Lemelson and Constance A. Cummings

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1 Introduction: Psychiatry at a Crossroads

*Laurence J. Kirmayer, Robert Lemelson,
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Psychiatry today faces challenges on many fronts, with vigorous critiques of its theory and practice from clinicians, scholars, and people with lived experience of mental health problems. These critiques target the slow progress in understanding and treating mental illness, overreliance on medications and other biomedical treatments, and the lack of attention to patients' lifeworlds and aspirations, but extend to much broader concerns about the medicalization of everyday life, and even wholesale condemnation of psychiatry as a source of heavy-handed social control, stigma, and harmful interventions that actually undermine recovery. In recent years, many of the concerns of the antipsychiatry movement of the 1960s have been reasserted by a new critical psychiatry literature that builds on these earlier critiques but includes attention to contemporary questions of epistemology, political economy, and globalization (Bracken et al., 2012; Cohen & Timimi, 2008; Fernando, 2014; Mills, 2014; Moodley & Ocampo, 2014; Whitley, 2012). This renewed critique emphasizes the dehumanization of care that has come from a narrow, reductionistic medical model and advocates for the central place of the voice and agency of people with lived experience and the key role of community-based interventions aimed at recovery.

To some extent, this criticism reflects frustration with the limitations of existing treatments for many of the serious afflictions that psychiatry aims to help. Since the "Decade of the Brain" was inaugurated in 1990, we have witnessed twenty-five years of intensive neuroscience research aimed at finding effective therapies, yet relatively little has changed in terms of treatment options and approaches. Meanwhile, the rise of biological psychiatry has displaced psychosocial and psychotherapeutic approaches in psychiatric training and practice, resulting in what some observers have perceived as less humane and patient-centered care. From a critical and political economic perspective, the involvement of the pharmaceutical industry and managed care corporations has created conflicts of interest that threaten the credibility and accountability of psychiatry as a helping profession.

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Mental health problems can profoundly affect social identity and relationships. Like other illnesses, they challenge our resources and coping capacities, but unlike other illnesses, they can directly affect basic cognitive and emotional processes in ways that undermine our social functioning, sense of self, and identity. The distinctive character of mental health problems often leads to stigmatization, and the more severe forms of mental illness are recognized everywhere as serious afflictions. Psychiatry has tried to provide more humane and effective care for people who have sometimes received harsh treatment, including physical confinement and social ostracism. Unfortunately, psychiatric care also has contributed its own forms of coercion and marginalization. Hence, there are enduring concerns about the negative effects of psychiatric labeling and interventions. The recovery movement aims to address the tendency of psychiatry to view outcomes narrowly in terms of symptom management by recognizing the agency and values of people living with mental health problems as central to ethical and effective care (Rudnick, 2012).

There is also growing concern with the ways that the focus on mental health has invaded the lives of people in wealthy, urbanized countries, as seen in the proliferation of psychiatric diagnoses, overuse of medications, and the medicalization of everyday problems in living (Horwitz & Wakefield, 2007; Greenberg, 2010; Whitaker, 2010). Claims that more than 50 percent of the general population suffer from a psychiatric disorder have led prominent psychiatrists and psychologists to worry that we are losing the very notion of “normal” (Frances, 2013). Although medicalization can have real benefits in terms of problem recognition, stigma reduction, and mobilizing an effective response, it can also result in diagnostic labeling that causes demoralization and disability and that leads to inappropriate treatments with harmful effects. In psychiatry, medicalizing problems tends to locate them within the individual, shifting attention away from the social determinants of health (Marmot & Wilkinson, 2006; Pickett & Wilkinson, 2010). Social scientists have pointed to the subtler ways in which psychiatric thinking has changed our self-understanding, showing up in public discourse and private soliloquy. Psychiatry is increasingly shaping the ways in which we think about ourselves in health and illness. Everyday challenges and conflicts are framed in the metaphors of neuroscience and psychology, and the new technologies of neuroscience, including genomics and brain imaging, are contributing to new forms of identity. Critical perspectives on the “psy” disciplines and on neuroscience aim to analyze this ongoing transformation of personhood, which has potential benefits, but which may also inadvertently undermine individual agency and social advocacy (Choudhury & Slaby, 2011; Rose, 1998; Rose & Abi-Rached, 2013).

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To be sure, psychiatry and allied mental health professions have improved the lot of many people living with mental illness, but services and effective treatments are not equitably distributed. Although estimates suggest that mental, neurological, and substance use disorders account for 14 percent of the global burden of disease, according to the World Health Organization “most of the people affected – 75% in many low-income countries – do not have access to the treatment they need” (www.who.int/mental_health/mhgap/en/). The global mental health movement aims to ensure that people around the world have access to the same treatment resources available in wealthy countries (Patel & Prince, 2010). The effort to promote global mental health is framed as a matter of basic equity and human rights (Kleinman, 2009). The vehicle for correcting these injustices, however, is often assumed to be the same psychiatric interventions currently facing critique in wealthy, well-resourced countries. The exportation of Western mental health practices is viewed by critics as a kind of cultural imperialism (Fernando, 2014; Mills, 2014; Watters, 2010).

How can we understand these dilemmas, respond to the critiques, and chart a way forward? As a profession, psychiatry is a young discipline, and there is little reason to think that it will maintain its current modes of practice over the next decades. Will it disappear, supplanted on one front by behavioral neurology, based on understanding neural mechanisms of brain dysfunction, and on another front by psychology and social work, professions better equipped to address the personal and social contexts of suffering? Or, is there still a place for a reimagined psychiatry that aims to integrate biological, social, and cultural perspectives in a person-centered medicine that responds to the full range of mental health problems?

This volume builds on recent work in philosophy, cognitive and social neuroscience, medical anthropology, psychology, and psychiatry to answer in the affirmative and to suggest promising directions for a renewed and reinvigorated psychiatry. The contributors explore some of the innovative lines of research and critical thinking that are leading to an integrative view of the origins and nature of mental health problems, which can inform more effective clinical, public health, and social responses to the human predicament.

In this introductory chapter, we provide a brief overview of some key issues in the current crisis of psychiatry and some recent responses. We then outline the contributions to this volume. The concluding chapter considers the implications for the future of psychiatry of an ecosocial, systemic view that can integrate the diverse perspectives of the contributors. Our aim is to point toward a vision of the future, mapping some of the obstacles and

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promising directions to a more inclusive, humane, and effective response to the many forms of human suffering that concern psychiatry.

The Ambit of Psychiatry: What Is a Mental Disorder?

As a helping profession, psychiatry seeks to interpret and respond to the needs of people with “mental disorders.” This leads immediately to problems of defining what counts as a mental disorder (McNally, 2011). Here, we briefly address three levels of definition, which are reflected in the taxonomic structure of current psychiatric nosology.

The first and most general level concerns the overall definition of mental disorder as distinct from a state of health or well-being. Despite efforts to devise a unitary and inclusive definition of mental disorders, no single definition works for the very diverse problems that are collected together in current psychiatric diagnostic systems or nosologies, such as the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013).¹ As we discuss later in this chapter, much effort has been given to trying to refine the notion of “disorder,” but it is worth noting that what counts as a specifically “mental” disorder is also not straightforward. The concept of the “mental” has a cultural history that is related to notions of personhood, agency, and morality, with important consequences for how we respond to people with psychiatric problems (Kirmayer, 1988; Miresco & Kirmayer, 2006). Every kind of affliction – from injuries and infections to everyday misfortunes – affects our thoughts and feelings, and, if sufficiently intense, can interfere with cognitive and emotional functioning. In psychiatric disorders, these disturbances of mental functioning, experience, and behavior are viewed as primary rather than secondary characteristics of the illness, but a secondary response can become a problem in its own right, as reflected in notions of “reactive” conditions or “adjustment disorders.”

¹ *DSM-5*, the official nosology of the American Psychiatric Association (APA), offers the following definition:

A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above. (APA, 2013, p. 20)

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The second level of definition concerns the ways that broad categories of disorders are grouped together as related (e.g., depressive disorders, anxiety disorders, and feeding and eating disorders). These superordinate groups reflect judgments of similarity based on symptomatology and behavioral manifestations (Borsboom, Cramer, Schmittmann, Epskamp, & Waldorp, 2011); assumptions about similar causality and underlying mechanisms; or comparable responses to treatment (Kendler & Campbell, 2009). However, in the absence of reliable measures of these underlying mechanisms or a fixed set of symptoms that are deemed necessary and sufficient for inclusion in a particular diagnostic group, these groupings remain contentious. Indeed, the decision to group certain disorders in one category or another often reflects the historical choice of prototypes or exemplars around which each category was built by family resemblance (Young, 1995). Although this fits well with styles of clinical reasoning (Westen, 2012), it builds a high level of cultural specificity and contingency into the categories.

The third level of definition concerns specific types of mental health problems. Here, categorization leads to the recurrent dilemma of determining the right level of detail or specification to characterize a symptom and the level of severity that makes it a clinical problem. Each individual's symptoms and modes of expressing suffering are unique in some respects, and in deciding which features on which to focus and which to ignore in defining a disorder, we must either rely on their salience for the individual or fall back on a preexisting prototype or model. Panic attacks, hallucinations, and feelings of dysphoria all come in many varieties and gradations of severity that may lie on a continuum with everyday experiences of no pathological significance. Even psychotic disorders exist on a continuum with more common milder and transient symptoms (van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009).² Characterizing mental health problems therefore depends on finding the right level of abstraction and threshold of severity. The great heterogeneity of individual experience results in many cases being viewed as atypical and assigned to residual categories (e.g., "unspecified" in *DSM-5*).

A pragmatic answer to the first question, about the outer boundaries of what counts as a mental disorder, could simply point to the types of problems that have been historically assigned to psychiatry. As a medical specialty, psychiatry emerged in the 1800s from the custodial

² A 2014 report by the British Psychological Society also supports a continuum model for psychotic experiences, such as hearing voices, arguing that they don't fall into neat categories (see www.bps.org.uk/networks-and-communities/member-microsite/division-clinical-psychology/understanding-psychosis-and-schizophrenia).

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care of people with severe, chronic conditions that affected their ability to think clearly and function socially and emotionally in an appropriate manner (Grob, 2008; Pressman, 1997). Some of these conditions were found to reflect congenital, infectious, or traumatic injuries to the brain. Early success in identifying such underlying pathology in a few cases (e.g., syphilis) gave impetus to the disease model in psychiatry (Bolton, 2012).

Although psychiatry began with only the most severe mental illnesses as its “object,” the discipline’s domain expanded throughout the past century to include common mental disorders that shade into the kinds of worries, fears, and demoralization that are part of everyday challenges, adversities, life transitions, and losses. The embrace of psychoanalysis as a theory of psychopathology and treatment method encouraged this wide compass (Luhmann, 2000; Zaretsky, 2004). With this expansion, however, came growing difficulty in distinguishing the legitimate objects of psychiatric concern from the “merely” troubling or troublesome. Efforts have been made to define the boundaries of what counts as a mental disorder, both to clarify the domain of psychiatry and to forestall pathologizing normal behavior (Wakefield, 1999, 2007). But attempts to define psychiatric disorders in biological terms – whether in relation to the machinery of the brain or human evolutionary history – founder on the essentially normative nature of diagnosis (Kirmayer & Young, 1999). Mental disorders are problems that affect our social roles and functioning, and what is expected of us in these roles depends on our culturally constructed institutions and forms of life. This dependence on culture and context is explicitly recognized in the *DSM-5* definition, which distinguishes a “culturally approved response” to a stressor or loss from a mental disorder, but this context-dependence of function and dysfunction is not always given the attention that it deserves in psychiatric research and everyday clinical practice.

The Crisis of Psychiatry: Cracks in the Scientific Foundation

The current crisis of psychiatry has deep historical roots in its ambiguous position as a medical specialty, institution of social control, and secular arena for dealing with moral, spiritual, and existential problems. In the 1960s, a common critique concerned the imprecision and unreliability of clinical diagnosis. Epidemiological studies used general measures of distress that did not correspond to the discrete diagnoses used by clinicians (March & Oppenheimer, 2014). In clinical settings, there was wide variation in the use of diagnostic categories and criteria. In courtroom or

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forensic settings, psychiatrists could be found to affirm contradictory or opposing clinical assessments. These troubles were an embarrassment to a profession that claimed a scientific basis to its practice and led to concerted efforts to develop a more reliable diagnostic system. The U.S.–U.K. comparative study showing great discrepancies in patterns of diagnosis of schizophrenia and bipolar disorder (BD) between psychiatrists in New York and London (Cooper et al., 1972; Wing, 1971), coupled with the availability of lithium as a relatively specific treatment for mania, added further urgency to efforts to improve the reliability and accuracy of psychiatric diagnosis.

The introduction of *DSM-III*, the third edition of the official diagnostic nosology of the APA (1980), marked an important advance in the clarity and reliability of psychiatric diagnosis (Wilson, 1993). Earlier versions of the manual had relied on descriptions of clinical entities that required a high level of inference about internal mechanisms, psychodynamic processes, or hypothetical etiology. *DSM-III* aimed for an “atheoretical” nosology based on observable clinical data through the use of specific diagnostic criteria “operationalized” in terms of symptoms and signs. This approach enabled professionals and trained lay interviewers to consistently identify major diagnostic categories. Large-scale epidemiological studies could then determine the prevalence of specific problems in the population, an important guide to developing appropriate mental health services and an essential tool for studying the course and outcome of mental health problems.

The 1980s saw a dramatic sea change in American psychiatry, in which psychoanalysis was dethroned and replaced with increasingly biological approaches in psychiatry and cognitive-behavioral approaches in psychology (Luhmann, 2000; Paris, 2005; Shorter, 1997). Biological psychiatry assumes that mental health problems result from “broken brains” or “chemical imbalances” and focuses on drug treatments (Baldessarini, 2014; Vázquez, 2014). Cognitive-behavioral psychology views mental health problems as the result of maladaptive patterns of thought and action that can be modified through psychotherapy (Hofmann, Asmundson, & Beck, 2013).

At the same time, an ever-expanding array of human problems have been reframed as mental disorders. Whereas *DSM-I* (1952) listed 106 diagnostic categories, *DSM-II* (1968) had 182, *DSM-III* (1980) had 265, and *DSM-IV* (1994) included 297 – the precise numbers vary with how one counts subtypes and variants. *DSM-5* (2013) eliminated some conditions but added new disorders, renewing concerns about the proliferation of categories and “bracket creep” (McNally, 2011) – the lowering of thresholds and liberalization of criteria through

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constructing “spectra” – resulting in a very high proportion of the population meeting criteria for one or more psychiatric disorders (Whitaker, 2010). Is this an accurate picture of the human condition – at least in the urban, industrialized, wealthy countries where most epidemiological surveys take place – or is it an example of the aggressive expansion of professional turf and corresponding markets for medications and other treatments? A critical literature documents many recent examples of diagnostic inflation, including: labeling prolonged grief and sadness as depression (Greenberg, 2010; Horwitz & Wakefield, 2007); extending BD to cover a broad spectrum of mood variations and applying the diagnosis to adolescents, children, and even infants (Moncrieff, 2014; Paris, 2012); viewing difficulties in classroom adjustment as evidence of attention deficit disorder (ADD; Koerth-Baker, 2013; Thomas, Mitchell, & Batstra, 2013; Singh, 2008); treating shyness and other variations in social behavior or gregariousness as anxiety disorders (Horwitz & Wakefield, 2012); and broadening the use of the term “autism” to cover a very wide spectrum of traits (Basu & Parry, 2013).

Along with the rise in numbers of diagnostic categories and rates of diagnoses has come a dramatic increase in prescriptions for and consumption of psychiatric medications (Angell, 2011). Psychopharmacology is big business, and creating new kinds of problems and new indications for existing medications (repackaged and relabeled) is one way to keep the market growing (Angell, 2011; Collin, 2014; Healey, 2004; Horwitz, 2011). For example, in recent years there has been an enormous growth in the use of stimulants for ADD in both children and adults, as well as atypical neuroleptics for an extraordinarily wide range of symptoms and conditions (Olfson, Blanco, Liu, Wang & Correll, 2012).

Unfortunately, in this embrace of better living through chemistry, little serious attention has been given to the possibility of subtle behavioral side effects or to habituation and withdrawal symptoms that might exacerbate the course of illness or lead to increased rates of relapse and more severe episodes, refractory to treatment. For example, the new selective serotonin reuptake inhibitor (SSRI) antidepressants, marketed as more effective than older tricyclic antidepressants, not only turned out to be no more effective (Anderson, 2000) but also caused subtle signs of neurocognitive disinhibition as well as sexual dysfunction (including loss of sexual desire), with potentially serious effects on relationships, especially when the effects were misattributed to the relationship rather than to the medication (Fisher & Thomson, 2007). Still more disturbingly, meta-analyses of clinical trials revealed that in general antidepressants were little more effective than placebos for mild to moderate depression

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(Kirsch, 2009; Kirsch et al., 2008). The atypical neuroleptics, heralded as more effective for schizophrenia, with fewer uncomfortable side effects, also were found to be no more effective than older antipsychotic medications (Leucht et al., 2009) and to lead to serious side effects, including diabetes and metabolic syndrome, with increased mortality (Haddad & Sharma, 2007). Despite this evidence, both SSRI antidepressants and atypical neuroleptics have largely supplanted earlier medications in routine practice in wealthy countries and are used with increasing frequency for an ever-wider range of symptoms and disorders in both adults and children, including mild conditions.

Leading figures in psychiatry have recognized the problem of overdiagnosis. Allen Frances (2012), the editor of *DSM-IV*, has become a vocal critic of this expansionism. He identifies multiple sources that contribute to diagnostic inflation, including: the *DSM* system itself, which provides a loose set of criteria; drug company marketing, which engages in “disease mongering”; and insurance companies which require diagnosis for reimbursement (Frances, 2013). In the United States, the FDA, the main regulatory body responsible for protecting public health, is largely funded by pharmaceutical company user fees, an obvious and profound conflict of interest (Light, Lexchin, & Darrow, 2013). Many consumer groups are substantially financed by drug companies and, although their explicit goal may be education and stigma reduction, the link implies tacit promotion of medications (Read & Cain, 2013). As a reflection of consumer culture, popular media regularly present tentative new research findings as “breakthroughs,” contributing to fads in diagnosis and treatment.

Of course, there are real problems and suffering behind this psychiatrization of everyday life. The issue is whether the characterization of these problems as discrete psychiatric disorders leads to an appropriate and helpful response. In the case of children with behavioral or learning difficulties in the classroom, for example, psychiatric diagnoses are used to manage the uncertainty about complex issues that may involve parents, teachers, and the school setting itself, and to suggest a clear course of action that is usually focused on the child. But the labels attached to children at one point in their school career may follow them for life, changing both their own self-concept and the ways in which others treat them. Indeed, because psychiatric labels become self-reinforcing and have so many social consequences, Frances (2012) suggests that “new diagnoses in psychiatry can be far more dangerous than new drugs.”

Ironically, efforts at mental health promotion and prevention have also contributed to diagnostic inflation through efforts to detect and treat common conditions and to identify early prodromes of serious mental

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illness. Screening for mental disorders with imprecise instruments can lead to widespread labeling and inappropriate treatment for mild, self-limited conditions (Thombs et al., 2012). The desire to promote early treatment and prevention of chronicity in schizophrenia led to efforts to define a prodromal syndrome in *DSM-5* (Carpenter & van Os, 2011). The proposal led to much controversy because the potential consequences of universal screening of children and adolescents (the usual time of onset for schizophrenia) and of early intervention are almost completely unknown. As a result, the suggestion was abandoned as premature.

Many of the psychiatric medications in use today were discovered by happenstance and, as we have noted, the newer generations of medications are not notably more effective than their forebears. Experts in psychopharmacology have decried the lack of substantial progress in developing new drugs, a lack that is sometimes attributed to not looking closely enough at biological mechanisms. Whereas many hope that neuroscience eventually will provide a coherent and complete account of the origins, mechanisms, and effective treatment of major psychiatric disorders, despite enormous advances to date there has been strikingly little clinical yield from research. Some of the most promising and widely used methodologies – for example, genome-wide analyses and functional brain imaging – present serious technical challenges, including managing the “growing torrent of results” (McCarroll, Feng, & Hyman, 2014, p. 759), as well as statistical and conceptual issues in interpreting data (Stelzer, Lohmann, Mueller, Buschmann, & Turner, 2014). Genomic-, cellular-, or network-level variations found in experimental paradigms, or in clinical studies comparing people with particular types of symptoms or pathology to those who are healthy, generally identify differences that cannot be attributed to a specific gene or single locus of pathology; instead, they are part of larger, systemic changes in functioning that manifest their effects through gene–environment interactions over developmental trajectories, in interaction with other individual systems, and in response to particular contexts of learning and performance (Kendler, Jaffey, & Romer, 2011; Kirmayer & Crafa, 2014; Kirmayer & Gold, 2012; McCarroll et al., 2014). Despite the large scale and methodological sophistication of these studies, the focus on genetic risk factors or neural differences based on imaging research is far from the complex realities of illness faced by patients and clinicians.

The revision of nosology for *DSM-5* began with high hopes that it would reflect advances in neuroscience, and some of the early research conferences focused on ways of framing psychiatric disorders in terms of