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Epilogue

Postpsychiatry Today

The postepistemology revolution I depict in the last chapter will not occur soon. This kind of paradigm switch (or "regime change," as Foucault would call it) will require time, commitment, political work, and dramatic changes of mind-set within the psychiatric community. Those of us devoted to postpsychiatry cannot await this future. Fortunately, much can be done without a postepistemology revolution. In this epilogue, I consider how postpsychiatric strategic efforts can make a difference in today's psychiatry—and, at the same time, lay the groundwork for a future larger-scale paradigm switch.

Even without a revolution in psychiatry, postpsychiatry can begin the process of building the knowledge base for the cultural studies of psychiatry and creating a critical psychiatry network. I discuss cultural studies of psychiatry scholarship in chapter 5. This scholarship reads the psychiatric literature against the grain to unpack the cultural, political, and economic dimensions of psychiatric categories and interventions. People can access and utilize this work immediately. No revolution within psychiatry is required. In addition, postpsychiatry can also work now to create a critical psychiatry network. Such a network makes coalitions and connections between postdisciplinary scholars and consumers/survivors. It builds a momentum greater than individual efforts can, and it provides a forum for actively intervening in contemporary psychiatric issues.

For inspiration and guidance, a particularly pertinent model for these

two related strategies is disability studies. Disability studies has made remarkable inroads in a relatively short period of time through the use of two simultaneous strategies. It creates new disability scholarship, and it builds active disability networks. Let me briefly review disability studies and how it can serve as such a model. Similar to the cultural studies of psychiatry, disability studies scholarship unpacks stereotyped biomedical disability representations to understand how "representation attaches meanings to bodies" (Garland-Thomson 1997, 5). Michael Oliver gives a good sense of these disability decodings, dividing stereotyped disability representations into the key themes of "individualism," "medicalization," and "normality" (1990, 56, 58). *Individualism* refers to the perspective that disability is a "personal tragedy." This frame undergirds a "hegemony of disability" that views disability as "pathological and problem-oriented." It concentrates all supportive efforts on individual medical "prevention, cure or treatment" (Oliver 1996, 129). And it leads to a ubiquitous *medicalization* that legitimizes a professional infrastructure for acquiring knowledge about, and intervening upon, the disabled individual.

Notions of *normality* are utilized within the processes of medicalization to intervene in disability. The "norm" creates a dichotomy where the normal and the pathological, the able-bodied and the disabled, and the "valued" and the "devalued" become coconstituted cultural dichotomies that carry tremendous social weight and interventional pressures (Davis 1995). One side of the binary defines the other, and both operate together. In Rosemarie Garland-Thomson's words, the two sides operate as "opposing twin figures that legitimate a system of social, economic, and political empowerment justified by physiological differences" (1997, 8).

Together, these stereotyped disability themes of individualism, medicalization, and normality direct the health care industry toward a near-exclusive preoccupation with individual biomedical cures. Rather than adjusting social environments to meet differing bodily needs, biomedical intervention seeks to restore, or cure, the individual "abnormal" body to its "normal" (or as "normal-as-possible") able-bodied state. By working out these disability themes in increasing nuance and detail, disability studies builds a scholarship base that allows them to be perceived and understood.

But disability studies does not stop with articulating themes and building a scholarly knowledge base. Disability studies also joins with disability activism to resist these individualizing and medicalizing approaches to disability. Together, disability scholars and activists encourage community interventions that focus on consciousness raising and collective action. Similar to other new social movements (such as feminism or civil rights movements), this consciousness raising helps create new disability identifications. These identifications allow disability activists to form political connections with people who have been similarly treated. As Oliver points out, "by reconceptualising disability as a social restriction or oppression, [disability identifications] open up possibilities of collaborating or cooperating with other socially restricted or oppressed groups" (1990, 129). These collaborating groups become a powerful coalition toward collective action and social change.

My point here is that, as with disability studies, work in postpsychiatry is a real possibility *today*. Postpsychiatry can build a cultural studies of psychiatry knowledge base without waiting for a new psychiatric regime. U.K. psychiatrist Duncan Double has already started the process of putting together a Critical Psychiatry Network. The Critical Psychiatry Network (CPN) not only reads psychiatry against the grain but also works to intervene and to join with activist efforts against some of the worst features of contemporary psychiatry. As CPN states in its position statement:

> We believe that there is a need to resist attempts to make psychiatry *more* coercive. In its attempts to take forward this agenda, the Network has:
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> —Made clear its opposition to compulsory treatment in evidence submitted to the Government's Scoping Group set up to review the Mental Health Act.
> —Submitted evidence to the Government, arguing against the idea of preventive detention.
> —Carried out a survey of senior English psychiatrists to seek their views about preventive detention.
> —Worked closely with other groups, coordinated by MIND [National Association for Mental Health], in trying to influence government policy. (http://www.critpsynet.freeuk.com/position.htm)

This combination of cultural studies of psychiatry scholarship and critical psychiatry network building will make an increasing difference in mainstream psychiatry. And no approval from mainstream psychiatry is required for this kind of work.

But how could this postpsychiatry scholarship and coalition building have a significant effect in psychiatric training? To reach future psychiatrists, postpsychiatry needs to reach institutional psychiatry. To do that, postpsychiatry requires a bridge between the main campus, medical schools, and psychiatry training programs.

A particularly hopeful possibility for this bridge work is the relatively new interdisciplinary domain of *medical humanities*. Medical humanities first entered the academic scene in the 1970s, and it is the one place where scholars from the humanities and the medical professions regularly interact. As of yet, medical humanities has had little exposure to postpsychiatry and cultural studies of psychiatry scholarship. But that could change rapidly. Medical humanities has recently started to embrace aspects of postmodern narrative theory and has even made initial steps toward psychiatric application (Morris 1998; Martinez 2002). As Richard Martinez puts it, "medical humanities has increased interest and curiosity about narrative theory and application in the behavioral health fields" (2002, 126). For that interest to grow, cultural studies of psychiatry scholars will need to engage with medical humanities, to contribute to medical humanities journals and conferences, to apply for medical humanities jobs, and to encourage graduate students to consider medical humanities as a viable research and publication option. As that happens, medical humanities will become an institutional bridge site for the cultural studies of psychiatry. From there, it will increasingly infiltrate psychiatric education and gradually yield a new form of psychiatric clinician.

These new psychiatric clinicians, postpsychiatrists (as I will call them), will be aware of theory and cultural studies work, and they will take such insights into the clinic. As specific intellectuals, they will begin the process of transforming both individual clinical encounters and also the nature and mind-set of clinical practice more generally. How that will actually evolve will depend on the people and the dynamics involved, but let me try to sketch what that transformation might look like.

With the emergence of postpsychiatrists, I envisage the clinical world changing in a number of ways. First, there would be a shift in emphasis from cure toward coping. By overprioritizing "the cure," psychiatry creates a world where inquiry—designed to help the suffering—invests more in science and truth than in strategies for coping. Modernist psychiatry believes that schizophrenia, for example, will only be cured by understanding the truth of the illness. But discovering "the truth" is only one approach to schizophrenia. Overemphasizing the truth leaves out

the politics, the ethics, the aesthetics, and the experiences (both painful and pleasurable) of schizophrenia. All of these other aspects of schizophrenia influence the impact of "schizophrenia." Tending to these dimensions of schizophrenia may not "cure" it, but it will go a long way toward helping people cope with the experience.

Another way to say this is that postpsychiatrists would deconstruct the very founding distinction of the field: between "mental health" and "mental illness." Postpsychiatrists would sidestep this sharp binary to recognize how patients *and* clinicians are always and inescapably an interwoven mixture of both (and neither) mental health and illness. For a postpsychiatrist, eradication of illness is impossible because the signifier of health means that illness is always already there. "Health" and "illness" coconstitute each other. They do not represent referential mirrors of the world. The meaning of one depends on the other. The focus of the clinical interaction would be less the eradication of "disease" and "illness" and more "living with," "adjusting to," "muddling through," and "coming to peace."

Second, postpsychiatrists would not regard themselves as "experts." Rather, they would see themselves as "servicepeople." Postpsychiatric servicepeople would be more comfortable with a modest professional wage (rather than trying to keep up with surgeons' and lawyers' fees) and more at ease with equalizing power differentials within the treatment setting. With power differentials closer to equal (and with a more balanced emphasis on coping), psychiatric categories and theories of mental illness would become more humble and would lose some of their status. Psychiatric categories and diagnoses would be dereified. As a result, postpsychiatrists would find it easier to take seriously patient models for suffering, and they would find it easier to work within alternative and self-help strategies for clinical improvement. In addition, more down-to-earth postpsychiatrist clinicians would lessen the spirit of "seriosity" (or overseriousness) so evident in the clinical world. This spirit of seriosity derives primarily from the huge chasm created between binaries of health and illness. If people are always already both healthy and ill, the fall from health to illness is not so serious.

Third, if postpsychiatrists were servicepeople, rather than high-class experts, the microgoals of the clinical interaction and the macrolegitimacy of psychiatry as a profession would depend more on human values than on scientific studies. At the microlevel, postpsychiatrists would advocate for an autonomy-based practice rather than a beneficence-based practice. In an autonomy-based practice, psychiatrists would

spend less time doing treatment "outcome" studies to determine which treatment is beneficently "best" or "legitimate" and more time articulating and exploring the treatment desires and goals of their clients.

For postpsychiatrists, it will seem impossible to completely compare treatment methods based on beneficent "outcomes," because there are as many different outcome goals as there are singular clinical interactions. Some people may pursue scientific cure; others may prefer life-skills building and coping. Some will be concerned with maximizing pleasure and others with maintaining beauty. Some may desire longevity and others comfort. Some may feel at ease with machine or synthetic chemical interventions; others may prefer only "organic" based treatments. Some may wish to psychotherapeutically weave clinical problems into a new interpretive horizon that reframes and thus lessens the problems (or at least helps organize the problems into a more satisfactory "life story"); others may wish to devote their mental energies elsewhere and approach their clinical problem with as little reflection as possible. Thus, the microgoals of the clinical interaction will be determined by the singularities of particular patient desires more than by a preconceived calculus of treatment outcomes.

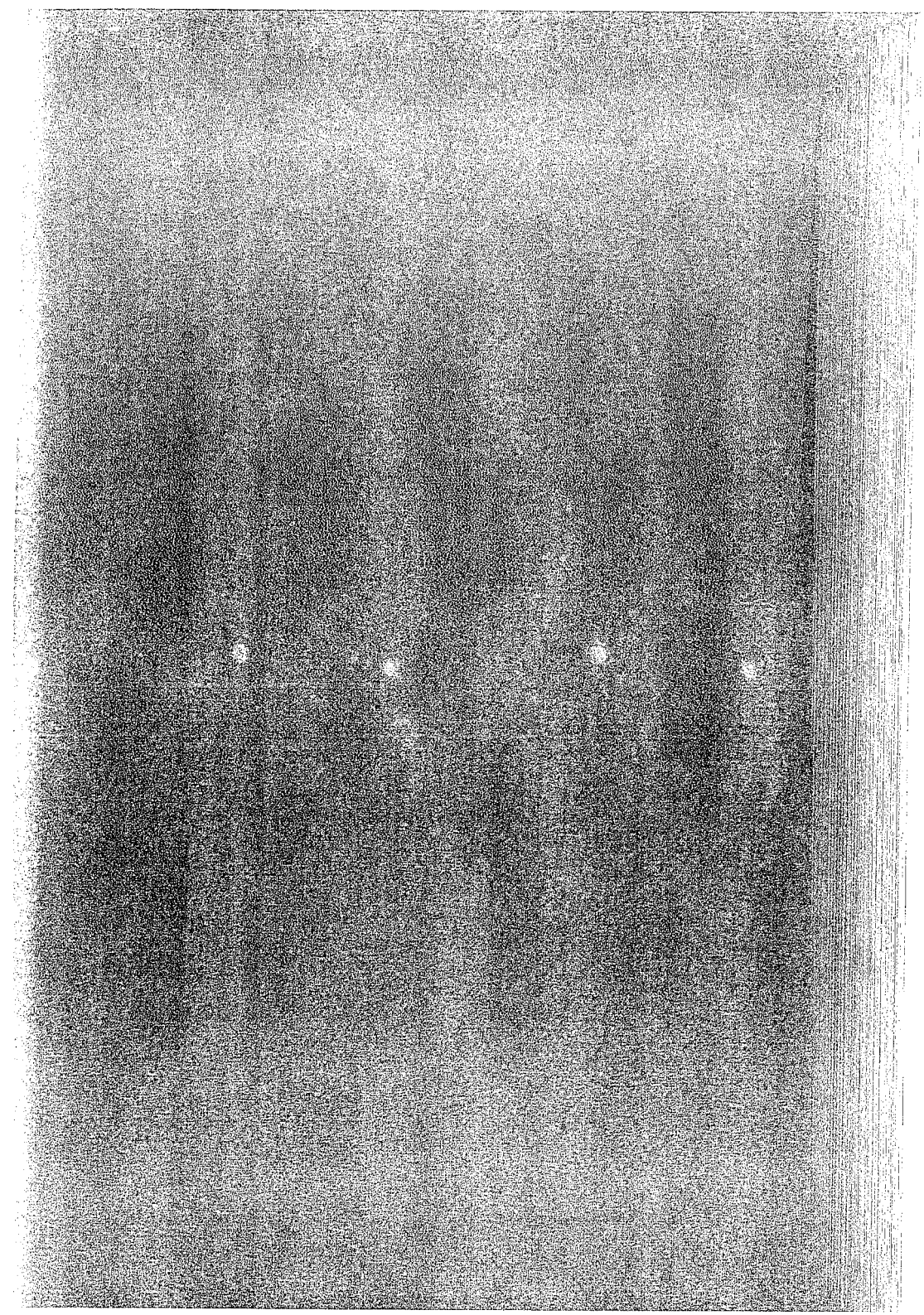
Similarly, for the postpsychiatrist, psychiatry does not have to "prove" its legitimacy at the macro (sociopolitical) level through scientific measurement of treatment outcomes. Rather, psychiatry achieves sociopolitical legitimacy (or fails to do so) because of more ethical, political, and aesthetic concerns. In other words, the route to psychiatric legitimacy comes through gaining the trust of the greater community, not through the force of Truth. The legitimizing justifications needed for maintaining "psychiatry" as a profession available for those in mental anguish would be as much ethical, political, and aesthetic justifications as they would be scientific "truth" justifications. There is little need for "science" in justifying hospice care, after-school programs, vocational retraining programs, national parks, or art museums, and there is little need for science in justifying psychiatric care. These activities are done, or not done, because there is a sociopolitical consensus that they are right to do. In other words, psychiatry should exist as a profession only because it contributes to making the kind of culture we believe in and the kind of world we want to create. Who are the "we" in this case? Whoever believes that there is a role for psychiatry in the service of people with mental pain and suffering, and whoever is willing to struggle and compromise to create such a world.

Another way to articulate the new species of postpsychiatrists I have in

mind would be to say that postpsychiatry shifts the emphasis of the clinical encounter from *knowing the other* to *caring for the other*. Here, I make one last allusion to Foucault. In many of his later works—such as the last two volumes of *The History of Sexuality* (1987b, 1990) and articles like "Technologies of the Self" (1988b) and "The Ethics of Care for the Self as a Practice of Freedom" (1988a)—Foucault explores how Greek and Roman cultures understood themselves. Reading a number of texts from these classical eras, Foucault investigates how people in these cultures came to understand and approach themselves: "what they are, what they do and the world in which they live" (1987, 10).

Foucault argues that these texts point to different forms of self or different forms of subjectivation. Greco-Roman cultures exhibit technologies of self that, instead of being predominantly based on a principle of knowing oneself, are based around the maxim "Take care of yourself" (1988b, 22). For Foucault, these classical modes of self are chiefly about cultivating and tending to oneself as a kind of practice or process. They are in sharp contrast to later Christian modes of subjectivation that predominantly revolve around a universalizing notion of self that takes the form of "obedience to a general law [and is] a type of work on oneself that implies a decipherment of the soul and purificatory hermeneutics of the desires; and a mode of ethical fulfilment that tends toward self-renunciation" (Foucault 1990, 238–39). Very different from this epistemological and self-renouncing mode, the technologies of self in antiquity were much more oriented toward questions of *askesis* (Foucault 1987b, 30). *Askesis*, as Foucault summarizes, is "an exercise of self upon the self by which one tries to work out one's self and to attain a certain mode of being" (1988a, 113).

Foucault suggests that the precept of "Know yourself" has been overemphasized in modern societies. We spend too much time trying to know our IQs, our grade point averages, our career status, and our multiple diagnoses. We spend too little time following the maxim "Take care of yourself." As a result, the practices of *askesis* have been forgotten (Foucault 1988b, 19). Foucault is keen to clarify, however, that this practice of self is "not just an early version of our [present] self-absorption" and is not anything like the Californian cult of the self (1984a, 362). Caring for the self is very much an ethical and collective practice; it is "not an exercise in solitude, but a true social practice" (Foucault 1990, 51). Foucault points out that these practices of self "found a ready support in the whole bundle of relations of kinship, friendship and obligation," and therefore such cares of the self, rather than



absorbed, actually worked through and intensified social relatio
(1990, 53).

In this final homage to Foucault, I envisage postpsychiatrists caring f
rather than striving to know/diagnose their patients. Such clinicia
would encourage patients to care for themselves and, at the same tim
would be involved in their own *askesis.* Doctor and patient would both
involved in this common, social, and supportive practice of caring f
the self. Such a postpsychiatric shift in clinical thinking and practi
does not require a revolution. It simply requires the development of
multidisciplinary postpsychiatric community that corrects the curre
scholarly imbalance of mainstream psychiatry and embraces the impo
tant insights of humanities theory. I offer this book as a step along t
way.