

Cultural Scripts: The Elusive Role of Psychotropic Drugs in Treatment

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When I was asked by Michael Oldani to write the commentary for a series of papers on psychotropy, I was a bit surprised. I study health care disparities in the US through the lens of sickle cell disease, a very clear genetic disorder. With sickle cell, the social constructedness of the diagnosis is not an issue whereas in the case of mental illness category fallacy remains a primary concern. As anthropologists we are trained when entering the field to presume that behavior is either normative or a response to particular cultural pressures. Anthropologists do not tend to study people in the singular as if their behavior has a unique ontology. Our methods, therefore, make it virtually impossible to see mental illness as merely brain function gone awry.

What makes psychotropy a conceptually rich and exciting intervention, although not new as Benjamin Campbell rightly points out, is that it takes us one step closer to an anthropological theory of the mind. Just to reiterate, Daniel Lord Smail identifies psychotropic mechanisms as, “The mood-altering practices, behaviors, and institutions generated by human culture” (p. 161).¹ By acknowledging that behaviors and experiences have the power to change our brain chemistry—think trance or a day at the spa—psychotropy suggests specific objects of study for approaching the mind/body/culture conundrum. The take-away from this set of ethnographically rich papers is that FDA-approved pharmaceuticals should not be considered revolutionary. Rather these medications are simply a different set of tools for altering our moods and behaviors. Therefore, we need to dampen both our enthusiasm and apocalyptic fears of big pharma. SSRIs, stimulants, and sedatives are simply another cultural form in the service of normalizing behavior and making people feel better by first naming a disease and then delineating a course of action.

¹ See Smail (2008).

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Michael Oldani makes this point in his chapter where, instead of trying to blame or scold high prescribers, he argues that the choice to use pharmaceuticals is as much a cultural approach to suffering as, for example, participating in a sweat lodge after the death of a loved one. And, Oldani documents, many psychiatrists “are working on a daily basis to reduce the psychotropic load of their patients by convincing them that they are *less* mentally ill than they previously believed..” (Oldani this volume).

The authors move beyond castigating global pharmaceutical markets not because there are not tremendous problems with overprescribing, dependence, and overdosing. Instead, they focus on analytic frames that help us unpack why these marginally efficacious drugs are in such high demand. For example, Sarah Pinto employs Lacan’s notion of points of convergence that fix our interpretive approach to illness; Todd Meyers focuses on the role of deception in the treatment experience; and Stefan Ecks describes the porous boundaries between experts and lay prescribers made necessary by the growing demand in West Bengal.

Critiquing big pharma directly has always been a losing battle. Critics are often accused of not understanding the science or not caring about the real suffering of patients. Even as many of the top-selling psychopharmaceuticals are losing their patents, and companies have halved their compensation to physicians, within the academy, neuroscience has reinvigorated the promise that just on the horizon are scientific discoveries capable of making us more mentally sound, rational, and productive. So rather than write against this growing swell of enthusiasm (that may reverse the downward trends in prescribing noted by Oldani), these authors show us how the link between pathophysiology and mental health is culturally elaborated.

Stefan Ecks and Todd Meyers, for example, show us how medications come to embody social relationships. Ecks shows us that because of how pills circulate among the poor in West Bengal, psychopharmaceuticals are essentially placebos. But patients’ trust in Rural Medical Practitioners translates into patients’ trust that the medications actually work. In Meyers’ study of drug rehabilitation in Maryland, he demonstrates how a sense of treatment efficacy is built around a belief in evidence-based medicine. The evidence-based approach for opiate dependency essentially replaces dependence on an illicit drug with dependence on a licit drug. Deceit mediates the contradiction between the authority of science and the experiences of patients and physicians. In other words, by focusing on psychotropy, the authors do something far more subversive than directly criticize big pharma. What they show is that a trillion dollar industry depends in large measure on people’s faith and sense of social indebtedness to one another. In the end, psychopharmaceutical drugs may be as curative as prayer, rituals, or special diets.

While overprescribing has become a public health issue in the US, there are patients whose mood disorders or mental illness fit more neatly into diagnostic categories. Examples include extreme psychosis, physically debilitating depression, and brain diseases such as Alzheimer’s. Annette Leibling helps us think through what anthropology can contribute to understanding the value of pharmacological interventions in the case of these clearer disease states. What Leibling shows is that despite clarity of symptoms, the relationship between organic disease and genes remains unclear. Notably, the brains of Alzheimer’s patients at autopsy do not look alike.

This matters because it suggests that the way we live our lives impacts our disease states in complicated ways that may be epigenetic and may be social. I think Leibing could have pushed the relevance of culture even further given that even the urgency afforded research into Alzheimer's and dementia seems to ignore the fact that people must die of something. Many elderly patients with dementia and Alzheimer's have outlived peers who earlier died of cancer, heart disease, or diabetes. While one must never question the value of a disease cure, we can question why we put more money into finding marketable drugs than into creating better nursing homes and expanding hospice care. As I was finishing my commentary, my father died from dementia. When people imagine someone dying from dementia, they think of a bedridden, non-verbal patient. But the day before he died, he was making jokes and explaining chemistry and physics to his grandchildren. The diagnosis distracted from who he was which was an old man, aged 87, who had problems with memory and whose body was shutting down. In other words, with the push for a cure comes an emotional and intellectual refusal to deal with the normal process of dying.

Even with respect to schizophrenia, the WHO funded International Study of Schizophrenia should make us question whether psychopharmacological treatments are even the most effective form of treatment.² What the WHO study showed is that recovery in less-industrialized countries surpassed recovery in countries like the US that relied heavily on pharmaceutical treatments. In places where patients were encouraged to, or forced out of necessity to, maintain interpersonal connections through work, community, and/or family, the outcomes were better. Many psychiatrists in Denmark have, as a result of crosscultural research, redefined the illness as a disorder of connection and in keeping with this model, the treatment involves working with the entire family. Sarah Pinto's analysis similarly addresses the role of disconnection in mental illness. In the tragic tale of Hema, the fraught relationship with her father was observed in the clinic, but the information did not inform the treatment approach. Instead, as Pinto argues, the trope of the disordered single woman in Delhi paired the unruliness of sexuality and desire with the unruliness of Hema's abnormal behavior and affect.

These papers remind us that simply removing psychoactive drugs from the marketplace is not a solution. We have come to rely on them because other institutional and familial support systems do not exist or are not equipped to handle abnormal behavior. Difference is not something many people in industrialized countries accept, and therefore without psychopharmaceuticals, many patients would feel at a loss for how to deal with their addictions, anxieties, alienation, or abnormal compulsions. But overmedication has, I believe, reached its peak in the US. Older drugs now have generic equivalents, and, returning to Benjamin Campbell's opening, marijuana is now legal in some states. This has opened the door for more home cures that skirt the pharmaceutical marketplace. But, in the mean time, there exists a generation of Americans who think that any fear, sadness, or anxiety means that there is something wrong that requires a drug. How do we renormalize psychic distress and even declining mental health in old age? How do

² See Hopper et al. (2007).

we recognize the undo pressures we put on women to perform moral order? How do we free children from classroom cultures that privilege children whose brain chemistry enables them to sit still for long periods of time? The hopeful take-away from these papers is that treating mental illness may not require expensive medical treatments with limited efficacy. Social investments that expand our definition of normal behavior and that integrate people with cognitive differences into communities may be expensive as well, but at least, these approaches produce better outcomes.

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