

Biomedical Psychiatry and its Concealed Metaphors: An Anthropological Perspective

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ABSTRACT

The idea that power relations structure social life is self-evident to most anthropologists. Western medical knowledge or biomedicine, and by extension science or scientific knowledge, however, has until relatively recently been exempt from anthropological scrutiny in political terms. An understanding of biomedicine as a system of knowledge that is not a copy of facts but a representation of them has entailed a break with the traditional separation of folk knowledge and scientific knowledge in anthropology, making it possible to include biomedicine in the repertoire of ethnographic objects. The peculiarity of biomedicine as a cultural system, seen from this perspective, lies in a paradox: its self-characterization as a set of non-ideological discourses and practices is a representation that conceals its ideological and power-saturated nature. Through an analysis of DSM-IV-TR, this article explores some of the representational strategies through which this concealment takes place in biomedical psychiatry: the asocial and universal character of mental illness categories; the neutrality of clinical practice; and the non-moral nature of clinical criteria and judgment. These are concealed metaphors in the true sense, for not only do they speak of something without naming it but they also deny their own existence as metaphors.

Key words: anthropology, DSM-IV, medical anthropology, mental health

Introduction

The idea that power relations structure social life is self-evident to most anthropologists and can be easily traced back through the anthropological literature of the last 150 years. Ever since Maine's Ancient Law¹, which postulates that kinship can also be regarded as a primary sociopolitical structure, anthropology has been aware of the ubiquitousness of power. There is, however, a sphere of discourse and social activity that has traditionally been exempt from anthropological scrutiny in political terms, at least until three decades ago²: Western medical knowledge or biomedicine, and by extension science or scientific knowledge.

One reason for this lack of political analysis is the fact that anthropology, as a social science, aspires to the status of scientific knowledge, and any attempt to treat science as one ethnoepistemology among many others implies that the anthropological gaze may even be trained on anthropology itself as an object of study. If the Human Genome Project³ or biomedical theories of stress⁴ can become ethnographic objects, then why not Lévi-Strauss's structuralism⁵ or Csordas's embodiment paradigm⁶

In fact, this self-reflexive leap was the innovation of North American postmodern anthropology, and in some cases its only contribution. As reflective readers of the intellectual production of their own discipline, ethnographers became the informants of their own personal anxieties concerning the construction of ethnographic texts. In most of these postmodern texts, however, the protagonism of the author as the main character eclipses the possibility of deep ethnoepistemological reflection on the construction of scientific rationality.

A second reason for reluctance to treat science as an object of study is the clear distinction between folk knowledge and scientific knowledge in cultural anthropology. Traditionally, anthropology regarded these two universes of discourse and practice as essentially different and irreconcilable, and as a result indigenous medical systems and lay medical knowledge were considered appropriate ethnographic objects but not primary health care centers or psychiatric theories of depression. The development of social studies of science and technology, cultural studies of Western biomedicine and what Heath

and Rabinow have called the anthropology of new genetics and immunology⁷ highlighted the erasure of the folk/scientific dividing line. This should not, however, be regarded as a rejection of scientific rationality itself, but as a consequence of rigorously applying the scientific method. Young⁸ tells us that »The culture of science says that no meaning is immune from scrutiny«. Science cannot be an exception to itself.

Not all obstacles to a sociocultural study of science have their origin in anthropology and, therefore, in the researcher. Some of them originate in the object of research. As Habermas pointed out⁹, one of the constants of scientific thought, at least in its more positivist incarnations, is that all forms of self-reflection by the researcher have been eliminated. In this way, Habermas argues, scientific thought has fallen into the contradiction of focusing on the terrain of objects in order to unmask »the fictions of the natural world of life« while dismissing the researcher's reflexivity as a metaphysical „phantasmagoria«. This may explain the positivist illusion that scientific categories are a »copy of facts,« possible only if the researcher and her/his social context are omitted. This in turn may explain some of the resistance to an anthropology of science and scientific knowledge. How can we account for the »transparency« of scientific knowledge? How can we define the political and social dimensions of science if science is isomorphic with reality?

The problem of the supposed transparency of science is one of the most significant challenges facing contemporary cultural anthropology. In comparison with more traditional knowledge structures such as myths, which tend to make explicit their values, their cultural singularity, their local moral world and to some extent the political dimension of their symbolic expressions, scientific discourse has proved particularly opaque to cultural analysis because it presents itself as a non-ideological, universal, apolitical and objective system. Anthropological studies of biomedicine have attempted to solve the problem of transparency, which renders power invisible, in a variety of ways ranging from hermeneutics to critical theory. Some authors^{10, 11} have applied the Geertzian idea of cultural system to the terrain of biomedicine and thus restored to view its concealed sociality. Others, such as Taussig¹², have gone further and shown the logical correspondence between biomedicine and the political economy of capitalism. Although none of these authors say so explicitly, however, what has allowed them all to make biomedicine their object of study is the realization that transparency is not inherent in biomedicine but an ideological representation of it.

This can be couched in more schematic and synthetic terms: biomedicine is not a copy of facts but a representation of facts that presents itself as an objective system of knowledge in order to conceal its social and political dimensions. But to what extent is this true? And if it is true, how does biomedicine construct the invisibility of its social power? In what follows, I will try to answer these questions by analysing four principles that mask power in biomedical psychiatry: asociality, universality,

neutrality and amorality. These four principles are concealed metaphors in the true sense, for they not only speak of power without naming it, but they also deny their own existence as tropes.

Concealed Metaphors

Asociality

In her controversial book *Death without Weeping*, Nancy Scheper-Hughes¹³ analyses the social consequences of hunger in Brazil, a dramatic phenomenon that has changed considerably with the recent implementation of social policies aimed at improving the living conditions of the poor and reducing morbidity and mortality. After describing the living conditions that prevailed in the favelas of the 1980s and their impact on the health of this population, she suggests that the government's strategy at the time was to medicalize hunger, individualizing a large-scale social problem and thereby draining it of its political potential. In this way, she argues, biomedicine short-circuits the development of a social conscience.

Some years before, in his article »Reification and the Consciousness of the Patient«, Taussig¹² had also highlighted biomedicine's desire for power. Following Lukács¹⁴ work on the reification of class consciousness among the proletariat, Taussig illustrates his argument with the case of a 49-year-old working-class patient diagnosed with polymyositis. Taussig argues that the signs and symptoms of his informant's disease are not merely biological dysfunctions. In his words:

»I am going to argue that things such as the signs and symptoms of disease, as much as the technology of healing, are not 'things in themselves', are not only biological and physical, but are also signs of social relations disguised as natural things, concealing their roots in human reciprocity.«

Taussig perceives symptoms and signs as meaningful realities that condense critically sensitive and contradictory components of culture and social relations. »The manifestations of disease are like symbols,« he writes, pointing out that health practitioners make diagnoses with »an eye trained by the social determinants of perception.« However, biomedicine and its practitioners reject this view in favour of an orientation which allows the illness experience to be dehistoricized and desocialized; that is to say, it is reified with the aim of reproducing a particular social order: the capitalist system.

To support his analysis, Taussig uses Lukács' argument that the Western notion of objectivity was in fact an illusion created by capitalist relations of production; instead of piercing this illusion, Marxist authors such as Lenin and Engels accepted it uncritically, and perpetuated in their writings. In its refusal to recognize the social component in the signs and symptoms of illness, Taussig argues, biomedicine reifies human relations, and this in turn gives rise to what Lukács defined as a »phantom-objectivity«, a mystification through which capital-

ist political ideology is reproduced in the name of a supposedly objective »science of real things«.

Both Scheper-Hughes' and Taussig's work suggests that biomedicine is politically instrumentalized. In the first case, the context is a population suffering from chronic hunger. In the second, an informant refuses to accept the individualization of her disease and therefore questions the arbitrariness of biomedical knowledge. However, our curiosity is aroused at this point not only by the phenomenon of instrumentalization but also by what makes this instrumentalization possible. What is the source of biomedicine's ability to individualise illness? What makes people regard health problems as something personal that cannot be blamed on the structure of social relations or political-economic conditions? In other words, what makes the power expressed through biomedicine invisible? To a considerable extent, the answer is provided by Taussig's concept of reification, but it needs to be made more explicit and gone into in greater detail.

There is no need to accept Taussig's argument that every manifestation of disease is social rather than biological in order to observe that biomedicine has a tendency to reify phenomena. Medical terminology itself gives us clues about this reification through the distinction between sign and symptom. The sign, also known as physical sign or objective symptom, is the objective evidence of a disease defined by the professional. Examples of physical signs are fever, eczema or even the radiographic representation of pulmonary emphysema. By contrast, the symptom, also known as subjective symptom, is the subjective evidence of a disease. Some manuals define symptoms as patients' descriptions of an experience that is uncomfortable for them. This distinction between sign and symptom is characteristic of most medical manuals and dictionaries, and it serves to distinguish between the physical manifestations of disease and cultural constructions such as an Igbo idiom of distress for the somatic manifestations of a mental disorder: »Things like ants keep on creeping in various parts of my brain«¹⁵.

One of the strategies of biomedicine is to convert symptoms into signs, patients' accounts into biological phenomena that can only be treated in the somatic dimension. In this way, social processes are reified: by removing the patient from the sphere of disease, the clinician is free to treat only biology. Perhaps this can be seen more clearly in the following example drawn from my field notes.

We are in the outpatient psychiatry department of one of the most important public hospitals in Barcelona. At quarter past eleven a patient, Mrs. R, entered the consulting room.

In response to the question, »What brought you in today?« she said, »Oh, my God! Life has no meaning since my husband died«. The clinician scrawled »feelings of hopelessness« on his report sheet as the patient continued with her narrative, explaining that her daughter was now grown up and wanted to live on her own. She said that she felt useless because she had always dedicated

herself completely to her family and now she had no family. Her mother had died a couple of years earlier and she felt that »the walls were closing in« on her. The clinician did not wait for the patient to elaborate, and asked, »Do you feel tired in the mornings? Have you lost weight recently?«. The patient did not really understand why he was asking these questions and continued to talk about her everyday problems. The clinician reacted rather impatiently and asked, »Have you ever thought about suicide? Do you sleep well at night? How long have you been feeling like this?«. The patient answered that as a good Catholic she had never contemplated suicide and considered it a mortal sin, and went on to speak of her feelings of sadness, isolation, loneliness and uncertainty about the future. The session ended with the psychiatrist recommending treatment with an antidepressant. The patient retorted, »These pills aren't going to get rid of what I've got«.

I offer this case not because it is necessarily paradigmatic of all therapeutic relations, but because it serves as an example of how a narrative of symptoms is reified into signs of disease. The clinician assumes the position that Lacan¹⁶ captured as the knowing subject in contrast to that of the unknowing patient who turns to the psychiatrist in search of relief, both for her distress and for the anguish it causes¹⁷. Patients describe their feelings, relate their symptoms and tell the story of their affliction. From this wealth of detail the psychiatrist salvages only a few facts that serve as the basis for a diagnosis. This salvage operation involves converting »Oh, my God! Life has no meaning since my husband died« into »feelings of hopelessness«. If in the telling the patient's story seems to wander from the subject (»My daughter's grown up now and wants to live on her own«) the psychiatrist may listen patiently for a bit, but finally asks, »Do you feel tired in the mornings? Have you lost weight recently?«. The patient gets the point and tries to be more focused. Once again the psychiatrist interrupts with more questions: »Have you ever thought about suicide? Have you ever thought that life just wasn't worth living? Do you sleep well at night?« The patient responds to these questions, but in biographical and moral terms. Again the clinician tries to narrow it down to »How long have you been feeling like this?«, or »Are you taking any medications?«, thus converting the story into an inventory of facts reshaped in terms of diagnostic criteria.

Situations similar to the one outlined above have been defined by Brown¹⁸ as the opposition between the patient who tells a story (his or her own), and the psychiatrist who follows the story as he would a mystery, in search of clues and evidence. At first this idea seems suggestive. Think of the traces of pipe tobacco smoke still floating in the air, the mud on the shoes of Mr. X, the microscopic piece of Persian carpet that gives Sherlock Holmes a vital piece of information for solving the case. In an apparently similar fashion, the clinician untangles the patient's tale, not to take pleasure in it but to convert it into a language of facts: »low energy«, »insomnia«, and »poor appetite«, but also »feelings of hopelessness« and

»low self-esteem.« Symptoms are reduced to the same level of objectivity as the mudstained shoes or the pipe smoke in a process of inference through which what the patient says is transformed into the logic of real facts, natural signs whose meaning depends on the logical and conceptual framework in terms of which the receiver of the message interprets them. In this way the original meaning is erased because it is inexpert, ignorant of the true code by which facts acquire meaning: weight loss, feelings of hopelessness, poor appetite, suicidal thoughts and insomnia as manifestations of depression.

However, clinical procedure and criminal investigation are not entirely similar. Like Holmes, the psychiatrist also wants to find out »whodunit«, but has the advantage of a ready-made classification. In addition, the signs of interest to a psychiatrist are natural and universalizable, while the detective has to confront a potentially infinite variety of individual situations because human will has intervened, a »motive« grounded in intention. This is why, despite Brown's suggestive title, »Psychiatric Intake as a Mystery Story«, the resemblance between the clinician and the detective is only apparent, and the interpretive processes move in opposite directions: while the detective reads human will into footprints, pipe smoke and other physical evidence, the clinician naturalizes a narrative of experience.

This process of reification and biologization is especially clear in psychiatry, but it can also be observed in the rest of biomedicine. Social scientists are often surprised by the use that biomedical literature makes of social and cultural phenomena. It treats risk behaviours, cultural habits, socioeconomic status or social class as if these variables were biological and independent of social context¹⁹. As Taussig points out, the function of biologization is not only to reify social realities, but also to obscure the power-saturated nature of this process.

Universality

Closely related to this process of desocialization is an approach that uses another metaphor, that of time, to construct transparency and render power relations invisible: universalization. The signs and symptoms of disease treated as if they were the same in different historical periods and cultural contexts²⁰. Although we cannot deny the value of this idea in the treatment of many diseases, we should not regard it as an unshakable premise. There are, in fact, no criteria of normality that exist independently of the sociocultural characteristics of different populations. And this principle of relativity (not necessarily of relativism) is applicable not only across cultures but also to different social groups sharing the same cultural context. It is well known that the same physical disorder is experienced very differently by a Wall Street executive, a lumberjack, a monk, and a combat pilot. Hypotension, for example, may pass unnoticed by the monk but may be a most worrisome disorder for the pilot²¹.

If biomedical knowledge is limited, like all knowledge, by the construction of categories and criteria that establish the nature and reality of facts, can these criteria be

totally independent of the context of cultural values, aesthetic forms, and political-economic conditions within which they have been produced? Obviously not. Faced with biomedical categories of normality and abnormality, we should ask: normal for whom? And normal for what? The distinction between the normal and the pathological is not value-free but socially normative. As Canguilhem points out in *La Connaissance de la vie*, »Toujours le concept du »normal«, dans l'ordre humain, reste un concept normatif et de portée proprement philosophique« [The concept of the normal, in the human order, always remains a normative concept of inherently philosophical import]²².

Perhaps this universalization is most pronounced in biomedical psychiatry, which has been challenged by the so-called culture-bound syndromes specific to a particular culture, among which windigo, susto and koro are the best-known examples. Common sense suggests that if local diseases and syndromes exist, then universal definitions of pathology should be questioned, but contemporary psychiatry has moved in the opposite direction, reifying and universalizing not only diseases but also the psychosocial characteristics associated with them. Let us take a look at some examples.

In its chapter on multiaxial assessment, the DSM-IVTR²³, the diagnostic manual par excellence of contemporary psychiatry, discusses examples of diagnoses and recording of data. The first of them is the following:

- »Axis I: 296.23 Major depressive disorder.
Single episode, severe without psychotic features.
305.00 Alcohol abuse
- Axis II: 301.60 Dependent personality disorder.
Frequent use of denial.
- Axis III: None.
- Axis IV: Threat of job loss.
- Axis V: GAF = 35 (current).«

Information about the patients is introduced into a structure consisting of various axes. The first axis is for the so-called »clinical disorders and other conditions that may be a focus of clinical attention«; the second is for »personality disorders and mental retardation«; the third for »general medical conditions«; the fourth for »psychosocial and environmental problems«; and finally, the fifth for »global assessment of functioning«. Of these five axes, the first three are the ones that are normally included in clinical reports, while the last two are generally used only in research, and are considered secondary in clinical practice. But the basic problem is that the individual who gives form to this wealth of categories, diseases, disorders and circumstances is practically annulled as a referent, because the various disorders are expressed in a logic of their own that needs no biographical shape. The emphasis is on diseases and not on patients, reinforcing the idea that an individual »suffers from a disorder« rather than »is disturbed«. The cataloguing of the disorders inhabiting the patient's body (»major depression«, »alcohol abuse«, »dependent personality disorder«)

reasserts the model of »suffering from,« and weakens the links between the disease and the patient's being. The patient is thus converted into a mute space in which different pathological species coincide. It is of little importance that an appendix included in DSM-IV (and DSM-IV TR) provides a glossary of culture-bound syndromes and appears to stress the importance of cultural and social factors in the aetiology, course and outcome of mental disorders. The patients' voices have no place in the multiaxial system of DSM-IVTR. This naturalistic approach denies us access to large or small worlds of meaning, to the cultural categories and political-economic relations that a complaint may contain. It disregards the possible understanding of the patient's narrative in favour of a botany of mental illnesses.

Instead of relativizing diagnostic categories such as »depression«, »alcohol abuse«, »dependent personality disorder« and »frequent use of denial«, I want to focus on the universalization of social factors supposedly linked to these categories. A case in point is Axis IV, »threat of job loss.« Unlike changes in glucose levels or the hyperactivation of the dopaminergic pathways, »threat of job loss« is not a variable that can be defined in universalistic terms. In the first place, the concept of a »job« refers to social contexts in which formalized types of work are dominant, and therefore not to all social contexts. In the second place, although the »threat of job loss« is becoming more and more generalized in formalized work contexts, it does not apply equally to all occupational sectors or to informal sectors. Finally, people who experience the »threat of job loss« perceive and experience this situation in a variety of ways. The significance of the »threat of job loss« depends on such varied things as religious morality, work values, patterns of masculinity and femininity and their association with the job, and social class. The meaning of »threat of job loss« possesses what Clifford Geertz (cita) called an »aura of factuality« because it is inextricably linked to a moral world inhabited by both patients and clinicians. This, however, does not mean that it is a universal fact, since the anthropological literature teaches us that »threat of job loss« may be as exotic for a Yap or a Trobriand Islander as »loss of influence in the tabinau« (a residence group associated with magar or working the land) or »not being in the kula« (a ceremonial exchange system in the Western Pacific) is for us.

Neutrality

If diseases are objective deviations from a biological norm and therefore independent of social background, if they can be universalized without taking into account local realities, then it seems viable to believe in the neutral, objective and rational nature of the biomedical knowledge system itself. In other words, both diagnosis and treatment are perceived as neutral processes in which the values of the professional are neither important nor relevant to clinical practice and medical research. Biomedicine (and biomedical psychiatry) emerges, then, as a knowledge system free from metaphors and unaffected by social, political and economic factors.

The functionality of this assumption is, according to Mishler¹⁹, obvious:

Thus, the view of medicine as a science serves to justify physicians' control over technical, esoteric knowledge, and at the same time such control supports claims for professional autonomy and self-regulation.

The idea of the autonomy of the professional group is one of the most frequently reiterated arguments in biomedical literature and one of the pillars on which the notion of scientific neutrality has been built. The following quotation from an article by Klerman²⁴ demonstrates the extent to which corporate self-regulation in psychiatry is an article of faith:

In discussing the history of psychiatry, one of my premises is that professional groups, such as medical specialities, are able to determine their own destiny to a greater extent than most other occupational groups.

The force of this assertion is scarcely blunted by the final words of the quotation: »to a greater extent than other occupational groups«. It is hardly surprising that biologically oriented psychiatry should amplify the ideological features that define the biomedical model. Historically, psychiatrists have struggled to defend their territory among the medical sciences, with the added burden of knowing that successes in their field paled into relative insignificance beside the achievements of biomedicine in terms of understanding disease aetiology, pinpointing the location of disease in the body through imaging techniques, and effective treatment. Klerman's statement reveals an ideological project that transcends the history of psychiatry: the history of medicine controls itself, it is in command of its own destiny.

The myth of neutrality and objectivity has been transferred seamlessly from biomedicine to clinical psychiatry. Again, to quote from one of the defenders of the biomedical model in psychiatry:

Whether the diagnosis is...mania, schizophrenia, or obsessional neurosis...course or outcome is more important than whether the individual is male or female, black or white, educated or ignorant, married or divorced, well adjusted or not, religious or not, etc.²⁵

Here diagnosis is seen as a neutral activity that should not be affected by human diversity in any form: ethnicity, sex, age, religion or social class. What is important is the diseases, their treatment, course and outcome, not the social characteristics of the patients. Nevertheless, this conclusion is contradicted by data on the hospitalization of patients in the United States according to their ethnic group:

Blacks and Native Americans are considerably more likely than Whites to be hospitalized; Blacks are more likely than Whites to be admitted as schizophrenic and less likely to be diagnosed as having an affective disorder; Asian American/Pacific Islanders are less likely than Whites to be admitted, but remain

for a lengthier stay, at least in state and county mental hospitals²⁶.

The differences between Guze's expectation and the results of the study by Snowden and Cheung speak for themselves. Where Guze perceives only the objectivity of science, the facts suggest the partiality of its practitioner. The differences in diagnosis, psychiatric hospitalization and length of hospitalization according to ethnic group reveal the fragility of the supposed neutrality of clinical medicine, which is maintained by unreflexive practices that render it impervious to social realities. It is hardly surprising that cultural anthropologists have perceived biomedicine as a peculiar cultural system whose ideological nature is revealed, paradoxically, in its rejection of ideology and its neutral self-representation in strictly scientific and technical terms.

Amorality

A final characteristic of biomedicine that allows its power to be obscured is a definition of knowledge that places it outside the realm of morality. This attribute clearly overlaps with the points mentioned above and with others that can be discerned from a careful analysis of biomedical discourse. The principle of amorality is closely connected to the attempt to desocialize and universalize biomedicine and, likewise, to the attempt to construct an aura of neutrality. In practice, however, this principle shows some contradictions.

The American Psychiatric Association's DSM-III-R²⁷, the predecessor of the DSM-IV and DSM-IV-TR to which I have referred above, includes a scale for assessing the intensity of psychosocial stress. In principle, this is not a problem. However, if we study the scale closely we observe that it unambiguously states that »broke up with boyfriend or girlfriend« has a stress value of 2, while »marital separation« has an intensity of 3 and »divorce« a value of 4. At no time does it explain why divorce is worse than separation and for whom it is worse, because the professional's judgment clearly takes precedence over the patient's. Nevertheless, by an extraordinary process of reification, the social fact is treated as an undeniably universal phenomenon and not as what it is: an exclusively moral assessment.

Moral and ideological principles are also concealed in the diagnostic principles of the DSM-IV-TR. For example, to diagnose an »antisocial personality disorder« three or more of the following items are required: (1) »fails to conform to social norms with respect to lawful behavior...«, (2) »deceitfulness, as indicated by repeated lying, use of aliases...«, (3) »impulsivity or failure to plan ahead«, (4) »irritability and aggressiveness«, (5) »reckless disregard for safety of self or others«, (6) »consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations« and (7)

»lack of remorse«. The DSM-III-R even used as a diagnostic criterion »Has never sustained a totally monogamous relationship for more than one year.« This is no longer used as a criterion in DSM-IV, although it has not disappeared completely from the manual because it is used as an example to explain the diagnostic criteria of this disorder. But let us take a closer look at possible combinations of three criteria; for example, »failure to conform to social norms with respect to lawful behaviors«, »deceitfulness, as indicated by repeated lying, use of aliases«, and »lack of remorse«. Is this combination not applicable to members of political opposition groups operating clandestinely in a dictatorial regime? Even the general diagnostic criteria introduced into DSM-IV and DSM-IV-TR to prevent confusion between »personality traits« and »personality disorders« – for example, »an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture« or »the pattern is stable and of long duration« – are so vague that they can easily be applied to any number of individuals and behavior patterns. Therefore, it is hardly surprising that studies of prison populations have revealed percentages of antisocial personality disorder as high as 80%. On the contrary, the surprising thing would be to find lower percentages using these criteria. There is obviously something wrong with this decontextualized use of social and cultural variables. In fact, antisocial personality disorder is a clear example of this obvious contradiction between a biomedical ideal of amorality and the impossibility in practice of adhering to this model.

Conclusion

By denying the social and political dimension of illness, biomedicine (and biomedical psychiatry)^{28, 29} found a solution to some of the conflicts which could have paralyzed its technical development. Biomedicine (and biomedical psychiatry) is not only a science; it is also a technique that requires a certain ability to respond quickly, and problem-solving took precedence over reflection on the power structures that constitute its corpus of knowledge. In recent years, these structures have been revealed by medical anthropology's attempts to elucidate concealed metaphors. This paper is part of the effort to show that scientific objectivity is a cultural assumption, and thereby to make the artifices of the invisible visible.

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BIOMEDICINSKA PSIHIJARIJA I NJENE SKRIVENE METAFORE: ANTROPOLOŠKA PERSPEKTIVA

SAŽETAK

Ideja da odnosi moći strukturiraju društveni život očita većini antropologa. Zapadno medicinsko znanje ili biomedicina, a time i znanost sve su do nedavno bili izuzeti od antropološkog povećala u političkom smislu. Razumijevanje biomedicine kao sustav znanja koji nije kopija činjenica već njihova predodžba dovelo je prekida tradicionalne odvojenosti narodnog znanja i znanstvenih spoznaja u antropologiji, čime je bilo moguće uključiti biomedicinu u repertoar etnografskih objekata. Osobitost biomedicine kao kulturnog sustava, gledano iz ove perspektive, leži na paradoksu: njezina smokarakterizacija kao skup neideoloških diskursa i praksi je predodžba kojom skriva svoju ideološku prirodu, zasićenu s moći. Kroz analizu DSM-IV-TR, ovaj članak istražuje neke od reprezentacijskih strategija kojima se to prikrivanje događa u biomedicinskoj psihijatriji: asocijalni i univerzalni karakter kategorija duševnih bolesti; neutralnost kliničke prakse, te nemoralna priroda kliničkih kriterija i procjena. To su pritajene metafore u pravom smislu te riječi, jer ne samo da govore o nečemu bez da to imenuju već oni također poriču svoje postojanje kao metafore.