

Our psychiatric future and the (bio)politics of Mental Health: dialogues with Nikolas Rose (part 4)

Nosso “futuro psiquiátrico” e a (bio)política da Saúde Mental: diálogos com Nikolas Rose (Parte 4) (resumo: p. 13)

Nuestro “futuro psiquiátrico” y la (bio)política de la Salud Mental: diálogos con Nikolas Rose (Parte 4) (resumen: p. 13)

Sérgio Resende Carvalho^(a)

<sergiorc@unicamp.br> 

Henrique Sater de Andrade^(b)

<hsatera@gmail.com> 

Luana Marçon^(c)

<18.luanamb@gmail.com> 

Fabrcio Donizete da Costa^(d)

<fabricio.costa@hc.fm.usp.br> 

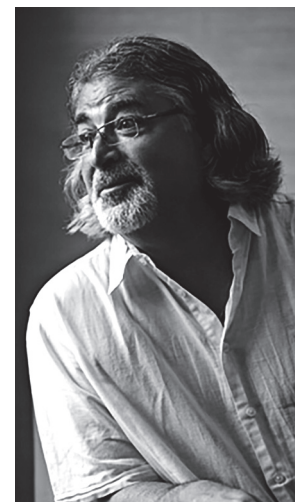
^(a, b, c) Departamento de Saúde Coletiva, Faculdade de Ciências Médicas, Universidade Estadual de Campinas. Rua Tessália Vieira de Camargo, 126, Cidade Universitária Zeferino Vaz. Campinas, SP, Brasil. 13083-887.
^(d) Departamento de Moléstias Infeciosas e Parasitárias, Hospital de Clínicas, Faculdade de Medicina da Universidade de São Paulo. São Paulo, SP, Brasil.

continue on page 12

continue on page 12

Here we present the last of a series of four interviews with English sociologist Nikolas Rose. We explore central aspects of the recently published work entitled “Our Psychiatric Future: politics of Mental Health policies”, which has as background issues and problems that we consider absolutely relevant for facing the complex and difficult challenges posed to the implementation of Brazilian Public Health system and to the reform of Mental Health in our country. In this interview, we seek to discuss with the author: psychiatry as a (bio)politics; the ‘epidemics’ of mental disorders; the role and consequences of psychiatric diagnostic practice in defining what is defined as mental disorder or illness; the use and abuse of psychiatric drugs in the contemporary; strengths and weaknesses of discursive psychiatric practices in ‘developed’ countries; limits and possibilities of users’ participation in Mental Health.

Keywords: Psychiatry. Mental Health. Medicalization.





Here we present the last of a series of four interviews with English sociologist Nikolas Rose. We seek to explore central aspects of the recently published work entitled “Our Psychiatric Future: politics of Mental Health policies”¹, which has as background issues and problems that we consider absolutely relevant for facing the complex and difficult challenges posed to the implementation of Brazilian Public Health system and to the reform of Mental Health in our country.

In this interview, which follows a set of other reflections that dialogue with Rose’s work²⁻⁴, we seek to discuss with the author’s insights and problematizations around issues such as: a) psychiatry as a (bio)politics; b) the ‘epidemics’ of mental disorders’; c) the role and consequences of psychiatric diagnostic practice in defining what is defined as mental disorder or illness; d) the use and abuse of psychiatric drugs in the contemporary; e) strengths and weaknesses of discursive psychiatric practices in ‘developed’ countries; f) limits and possibilities of users’ participation in the discourse, policies and practices of care in Mental Health.

1) To start this interview, we want to ask you what motivated you to write about “Our psychiatric future”? How is this book related to your previous works and your current research interests? Finally, what was your target audience in your latest book?

I’ve been working on some of these themes for a very long time. In 1986, I edited a book with Peter Miller called “The Power of Psychiatry”⁵. And ever since then, I’ve been teaching and working with people who are engaged either as practitioners or as psychiatric service users. In fact, my concern with Psychiatry as a practice goes right back in my days at university and my engagement with anti-psychiatry and with various ‘alternative’ types of provision that were being developed in England at that time. This book has a slightly different target and therefore a different form from the books that I’ve been publishing recently. It’s intended to be a more direct and accessible intervention into contemporary psychiatric practice. In this book, I try to analyse the various elements that I have previously explored genealogically and relate them directly with contemporary psychiatric practice. And to propose some ways forward. When I was writing the book, I was impressed by a paper that I had read by Didier Fassin which was called “Another politics of life is possible”⁶. I suppose the theme of this book would be “Another biopolitics of psychiatry is possible” and its aim was to set out what might it look like. I’ve been pleased since the book was published that it seems to have been read by psychiatric practitioners in several countries. They may not agree with it. But the questions which I posed in the book are key questions to debate if one is going to think about what a different Psychiatry might be for the future. In particular, I argue that we should not just have a focus on the need for more mental health professionals who will try to treat people who were diagnosed with mental disorders. My argument is that we need to engage with the social and political determinants of mental disorders, the things that lead to mental distress in the first place. That is to say, we need to adopt a social medicine approach to Psychiatry. This is, of course, the focus of my department at King’s College – Global Health and Social Medicine. It is also the basis of a new big research center that we’ve established at King’s College London on Society and Mental Health.



In a sense, this book is laying down as a marker for the beginning the work that is necessary, to go beyond simply pointing to ‘the social determinants of mental health’, to develop a new psychiatric biopolitics.

2) In the first chapter, you say that psychiatry “is intensely political” and it should be seen as “a political science”. How can psychiatry impact on our daily life and on our future?

There’s a tendency to think of psychiatry as both now and historically a practice that is concerned with the diagnosis and treatment of people with mental disorders. Of course, it is that. It has tried to do that since the middle of the 19th century when modern psychiatry emerged. But psychiatry has always been engaged more generally in social and political questions. We can take a couple of historical examples of that. The best known one is the role of psychiatry in arguments about degeneration and the emergence of eugenics in the late 19th and early 20th centuries, when psychiatrists and psychiatric arguments played a key role in many countries where eugenic practices of one sort or another became central to politics. Or if you think of a more progressive involvement in the first half of the 20th century, at least in Europe and North America, there was a large and influential movement for Mental Hygiene which said that we need to improve mental hygiene in the home, in the factory, in our communities. Because it’s only through improving mental hygiene that we will minimize all the forms of maladjustment that cost our society so much. In its role in the mental hygiene movement, psychiatry is again not confined to the identification and treatment of people with mental disorders. It engages fully in the biopolitical questions of how one manages the mental health or minimizes the mental disorders or other kinds of harms.

Today, of course, psychiatry, in the most general sense of the “psy” disciplines, has moved very powerfully into the ways in which people understand themselves, their self-technologies and to the ways in which people articulate and judge their mental states. And, indeed, in the ways in which they act upon their mental state. So large numbers of kids in school are beginning to learn a psychiatric language to understand their distress, which may account for the rising rates of diagnosed mental ill health in schoolchildren, at least in the UK. But also, a growing number of mobile apps and Internet sites where people self-diagnose their psychiatric problems and are taught to make use of various kinds of different psychiatric techniques, such as kinds of cognitive behavioural therapy, or versions of mindfulness and so on, in order to manage their distress in their everyday lives. These are some of the ways which psychiatry has had an impact, since the 19th century, way beyond the narrowly defined “mental health” apparatus.

The last bit of your question was about “our psychiatric future”. I guess the question is how pervasive one wants psychiatric expertise and the technology psychiatry to be in everyday life as we move through the 21st century. We already know that psychiatric drugs play a large part in many people’s lives. We already know that there are arguments that say there should be more psychiatric intervention in low and middle-income countries where there are still fewer psychiatrists. So, should “our psychiatric future” consist of increasing the numbers of experts who seek to use their expertise to treat people who are in mental distress? Or is there another way that



we could think of another biopolitics in which psychiatry plays its part? Which is to do with mitigating and minimizing all those things in our social environment and all those forms of adversity that lead people into mental distress. That is the challenge or the dilemma which we are debating at the moment in the United Kingdom.

3) In the second chapter, you describe and reflect about the increase estimates of mental disorders nowadays. You argue that we should pay attention at the ways that we diagnose disorders, the political and ethical questions of mental pathology as a social burden and the comprehension that numbers are always political and indispensable to government. What do you think about the description of a global “epidemic” of mental disorders?

Let me begin by talking about the numbers. We know historically that numbers play a large part in political arguments and in relation to psychiatry and the history of psychiatry. This question of calculating the numbers, and then the costs – or the “burden” - of the mentally disordered played a big part in the arguments about eugenics. Of course, when people use the term “burden” today, they use it in a different sense that has been developed since the World Bank and the World Health Organization developed the indicator of “disability adjusted life years” [DALY years]. They use that to calculate the burden not of dying with disorders, but of living with disorders. So, burden then and burden now are very different. But they both imply that the things that we call “mental disorders” are purely negative events to which we unfortunately have to attend. I dislike this idea of burden, and what it implies, but that could be another longer discussion.

Anyhow, it is clear that the numbers play an important political role today. For instance, it is widely quoted in the United Kingdom that 1 person in 4 in any one year could be diagnosed with a DSM (Diagnostic and Statistical Manual) mental disorder and 1 person in 2 across a lifetime. Those figures are intended to show that mental illness is something that could happen to everybody. That is intended to reduce stigma by showing that mental illness is not just something that affects a few crazy people. It is everybody’s business. It is also intended to draw the attention of politicians to the issue, to show them that there is a big issue affecting millions of people on which they need to spend resources. Clearly, those numbers are part of an important political strategy to bring resources into the field of mental health: we need more psychiatrists, we need better mental health services, etc. You can see the same strategy in the numbers that were produced in the Movement for Global Mental Health. They relied very heavily on estimates of the numbers of people in different countries who are affected by mental disorders. They used the numbers to claim that here was a major scandal affecting the lives of hundreds of millions of people worldwide that was not being attended to. So, it’s clear that the numbers play an important political role. Maybe that is inescapable.

But if one steps back and looks at the numbers and the ways in which these numbers were created there are of course all sorts of criticisms one can make. That “1 in 4” number relies upon all sorts of very disputable estimates. This is just an example of the way that these numbers are powerful rhetorically and they’re compiled with



their uses in mind. All numbers are. My argument here is that before accepting them and reusing them, we should step back a little bit and see how they were put together.

To move very quickly to the last part of your question about a global epidemic. If you look at the United Kingdom, although the data is not very good, it shows that actually the numbers of people diagnosed with mental disorders have stayed remarkably consistent over the last 20 years. There are only two groups of people where you see significant increases. Young people at school and young women who are self-harming. So, the idea that the figures are going up and up and it's something to do with the pathological nature of our society as a whole is misleading. But you do have to then ask yourself why is it that for these particular groups of people the numbers are increasing. When those numbers came out, the first response of our "psychiatric establishment" in the UK was to say that we need many more mental health professionals. We need more psychiatrists in schools, quicker access to mental health services, teachers trained in mental health awareness and so on. Nobody asked the second question, which maybe should be the first question: why is it that so many more people are experiencing what they think of as mental disorders? For me, that has to be the first question. If you look at these numbers that are produced in the Global Mental Health movement, you do need to ask yourself what is the political function of those numbers when the vast majority of those people who make up those numbers do not define their condition as a mental disorder and do not consider themselves to be in need of treatment by experts. Are these increased numbers a good thing or are they a bad thing? They make a claim for the radical expansion of 'psy' expertise, but perhaps that's the wrong argument to make. Hence many make the argument that actually what we need in those societies is something other than the importation of psychiatric expertise from the Global North.

4) In chapter "Does Psychopharmacology have a future?", you write that psychiatric drugs "are prescribed by general practitioners to millions of people experiencing problems managing their everyday lives. Many seek them out, in the hope that, at the least, the drugs will provide them with relief and help them cope, and perhaps even restore them to a feeling of normality, to enable them to 'feel like themselves again'". Do you consider this spread of psychiatric drugs as a worldwide phenomenon refers more to a success story of the growing recognition and treatment of mental illness or as a problem in how we approach the experience of adversity?

If I have to make a choice between those two with a gun to my head, I'm going to say the second (laughs). But that leaves us with the question of how we approach the experience of adversity, where we need to be a little bit more specific. We can take the question of Japan, for instance. I'm drawing here on the terrific work of Junko Kitanaka in her excellent book on depression in Japan⁷. Kitanaka shows that in Japan, until quite recently, the state we now call depression was understood in a way that encompassed both bodily and mental malaise. When a person was depressed, they were both physically and mentally drained, they were weak, distressed and suffering in mind and in body. This was a way of thinking rather similar to "neurasthenia"



in 19th Europe. The treatment was rest, was teaching better ways of managing stress, managing the work life balance and so on and so forth. But from around the start of the 1990s, you see a twin emergence. On the one hand, this traditional way of thinking about the malaise of body and soul is replaced with the diagnosis of depression. On the other, we see the introduction of Prozac and similar drugs for the treatment of depression. The diagnosis, as used by the experts, the language used by Japanese people, and the use of the drugs, have gone hand in hand. In Japan, nonetheless, there is more of a holistic approach, recognizing that we need to deal with the social situation of individuals, as well as just giving them the drugs. Of course one needs to be more specific about this, but the general point is that to think of all the conditions that people experience as mental distress, as common mental disorders that are treatable by drugs – or indeed by CBT [Cognitive Behavioural Therapy] – psychiatry whether in sub-Saharan Africa, Brazil or in Southeast Asia is highly problematic.

That links to my view that the efficacy of these drugs is greatly overstated. The effect size for mild to moderate depression of most of the SSRI [selective serotonin reuptake inhibitors] drugs is very small and often no greater than placebo. Further it is by no means clear that the beneficial effects - we're talking here about probabilities in large populations, not about individuals - outweigh the problems, especially the problems that arise from long term use of these drugs. When people stop taking their SSRIs, they experience many unpleasant symptoms. This is not surprising because the SSRIs changes the balance of neurotransmitters and receptors across the body – in the gut, in muscle, everywhere. The problem is that these symptoms on discontinuing drug treatment are often regarded both by the individual and by their doctor as a relapse into depression and therefore the drugs are restarted. Or a different version of drug is prescribed. And that leads to a situation where people are not just taking these drugs for short term relief, they are thought of – and think of themselves – as chronically mildly depressed and therefore they become long term users of the drugs. My cynical friends would say: “Well that’s jolly good for the drug industry. You really want people to be taking the drugs all the time, if you’re going to make money out of it”.

I think the reasons people – doctors and their patients - place so much faith in drugs is actually more complicated, as I argue in the book. Nevertheless, similar problems arise in the use of drugs to treat serious mental illness. The work of my colleagues at Kings College, in particular, Sir Robin Murray and his group has argued, very cogently, that the long-term use of anti-psychotic drugs has a damaging effect on the brain. And again, when someone comes off those drugs and experiences all sorts of symptoms, that’s often thought of as relapse. So, they’re put back on the drugs. Whereas in fact the symptoms on discontinuation are just the consequence of their system trying to re-balance its neurotransmitters in order to cope with the absence of these drugs.

So, in short, I think that the drugs we currently use in psychiatry have a limited role in short term treatment to provide people with immediate relief. We don’t know how they work. We don’t know how they work in brain and apart from a few molecular events very close to their site of action, very close to the receptor sites. We have no idea of how they work across the multiple intersecting brain circuits. And the effects are often overstated.



We also see a peculiar phenomenon which you find in a lot of drugs. When new drugs are first introduced, they seem very effective. After they have been in use for a long time, they seem much less effective. Why is that? I don't know. Maybe people place a lot of faith in new drugs. The doctors and the patients really, really want the new drug to work. When a drug becomes old, they really hope and believe that the next drug along, the next new drug, will work. I don't think it's all the result of the way the drug industry peddles its wares. I think this is bound up with complex beliefs that individuals have about the part that medication can play in sustaining or regaining their normality. We're all drug users. We all go to the pharmacy and buy aspirins or our paracetamol. Many people go and buy their "vitamin X", or their "vitamin Y", or their "Vitamin Z". We are all believers in the pills, in the pills that resolve our ills. This has consequences in psychiatry which may be particularly bad. People take a lot of vitamins and most are a waste of money. But they normally just excrete the ones they don't need. But it is not so simple with the psychiatric drugs.

5) In Brazil, we are recently living important setbacks in the field of Mental Health that are sustained, among others, by political actions made by important sectors of the "biomedical establishment" that is present in the academy and services. As a result, Brazilian government published this year guidelines that interrupt the process of shutting down psychiatric hospital beds and asylums, stimulate the involuntary hospitalization of drug users with the aim of abstinence and discourage care practices based on "Harm Reduction". It is common for these political groups often to uphold their proposals by referring to propositions and psychiatric practices of central countries. From this background, it is possible to reflect on our context by correlating it with your statement that "any attempt to address mental distress in 'the Global South' needs to learn from the failures of psychiatry in the Global North, more than from its imagined successes"?

I recently read an argument in a paper on Global Mental Health that contained two key arguments. First, that we now understand the nature of mental disorder. Second, that we have effective means of treating it and that these should be available to everybody across the world. I think both assertions are wrong. We neither understand mental disorder, nor do we have effective means of treating it. We haven't done very well in Mental Health in the Global North.

That doesn't mean to my mind that we should go back to hospitalization, to involuntary treatment. Not at all. We recently had a review of the Mental Health Act here in the UK – the Act that contains the provisions for involuntary detention and involuntary treatment in mental hospitals. That review indicated that what we're seeing in the UK is more and more people in hospital under coercion, under the provisions of the Mental Health Act. That is because it is very difficult for those who are experiencing extreme mental distress to find places of sanctuary or places of asylum within the mental health system on a voluntary basis. And this is by no means a good thing. I don't really know why anyone should believe that there are good lessons to be learned from the Global North in the understanding and treating of mental distress. There are some attempts which are good, but most have not really succeeded. For instance, I welcome the attempts to reduce stigma, to make it more possible for people to speak about their



mental disorders, to make families a little bit more willing to understand and speak about the mental disorders of family members. But these attempts – often involving celebrities ‘coming out’ and talking of their mental health problems - have not really changed the highly stigmatizing views of many communities towards people who are subjectively different. I don’t think our communities here in the UK or across Europe are particularly accepting of those who behave, think, value, judge, dress differently. It is true, of course, that more and more people in the Global North are taking psychiatric drugs, but – even leaving aside the question of whether they work – this simply suggests that we have not got to grips with the causes of mental distress as we have, for instance, in the case of lung cancer. We are trying to treat the ‘disease’, but we are not doing much in the way of prevention – in finding out what it is in our societies that drives so many into mental distress in the first place. So, I’m not sure what lessons from the Global North that should be learnt in the Global South. I think there are perhaps some things that those in the Global North can learn from the way in which mental distress is dealt with in some countries in the Global South by non-professionals, by other members of the community, by peers and friends and so on. Not necessarily by taking the person to an expert psychiatrist, and certainly not, by placing the person in a psychiatric hospital against their will, unless this was a facility that offered true sanctuary.

If you asked me to show you a success story in the Global North, I would probably point you to Trieste. As you know better than me, many developments in mental health policies in Brazil were based on the experience of Basaglia in Trieste. To change the mental health system in Trieste, an area with around two hundred and fifty thousand people, was a work of 40 or 50 years, against lots of opposition from the local people in the area, and requiring a real political will both to get it going and to sustain it. Even then, those transformations have some weaknesses – for example they were largely led by professionals, not my mental health service users. But in any event, what was involved was a very big political struggle, as well as a fundamental change in the style of thought in psychiatry. I’d like to be pointed to another good example of success in the Global North. I don’t know too many good successes in the Global North. (laughs) We’re taking a lot of pills. People are doing a lot of CBT [Cognitive Behavioural Therapy] and everybody has mindfulness apps on their smartphones. But I don’t really call that a model of ‘success’ to be exported across the world.

6) One central piece of your book is that “psychiatry and the profession associated with each other claim their legitimacy not only in their objectivity but also because they are committed to helping and not harming those who analyze, diagnose, and treat” (Rose, p. 151, 2018). And, deepening this debate, you affirm that not always the strategies of user engagement in mental health services have advanced in the struggle against psychiatric power. Quite the contrary, they keep a medical source intact, and can be part of neoliberal rationalities and technologies. Considering their role, can you reflect on this affirmation?

There are two parts to that question. For the first part, I want to stress that almost all the psychiatrists and mental health professionals that I have met over the last half century have a genuine wish to help the people that they deal with. In my country



and perhaps in yours, psychiatry and Mental Health as a profession is not very highly regarded. It's not very highly paid. You'd make a lot more money if you were working somewhere else. So, we have a lot of dedicated people working in this area. I am not critical of the dedication of those people. I was recently at an event with practitioners and students of global mental health, and I made arguments similar to the ones that I make in my book. Many of them seem to think this was like a personal criticism of them, but it was not. I think they're working in very constrained circumstances where they have very few options available for them. And they're not taught in a way that enables them to think differently. Let alone to believe that they can begin to act differently. Quite often what their response to me was: "Well, you may be right. It may all be down to adversity, but we can't do anything about that. We're just psychiatrists. What could we do? We have to wait until society changes. This inequality and adversity are all part of the market capitalist system and there's nothing we can do to change that; we just have to deal with the consequences". And my response to that is "No, there are lots of things that you can do at very small levels. And you can also take a public position and argue very strongly that certain policies developed in our current form of market capitalism are highly damaging to mental health". For example, welfare conditionality – the policies that try to get people into work at all costs no matter is known to have really bad effects on people with mental health problems. These policies make access to Social Security benefits dependent on constantly trying to get into work, and in some cases, they have driven people with mental health problems to suicide. I don't think the argument is well advanced by criticizing the motives of psychiatrist. Of course, there are bad psychiatrists as well as there are bad politicians, and no doubt there are bad university professors. But that's not the main issue. The main issue is to urge psychiatrists and other mental health professionals to be more vocal about the conditions that lead people to poor mental health and to use their professional power and expertise to argue for prevention in this area, as in other areas of medicine.

Now about the involvement of users: I think gradually over the last 20 years or so, the professional bodies in psychiatry and psychiatric policy makers have come to believe that the legitimacy of their position relies, at least to some extent, on their approach being affirmed by the people they claim to treat. That is to say, there is a gradual move to involve users of mental health services in the debates over psychiatric policies and practices. But often those who want to make radical criticisms of the current practices of psychiatry are not welcome at the table. Often, they find their position at the table very problematic and want to leave. In part this is because there are huge disparities in authority between the users and experts. In addition, the experts are being paid even when they're sitting in a meeting with the psychiatric service users. But the service users, if they're lucky, get their bus fare, a sandwich and a cup of coffee. They're not being paid. So, there are both material and symbolic differences. And, quite often, the users find themselves as part of a legitimization process – that is to say, the involvement of mental health service users in the process is used to legitimate whatever policy is decided. The policy makers say these policies were developed with the involvement of mental health service users, whereas in fact they had one meeting where two mental health service users present amongst 25 mental health professionals. And the mental health services users did not walk out of the room.



Secondly, I think some of the more radical strategies that have been advocated by mental health service users very rapidly get taken out of their hands and turned into professional tools. You can think of “empowerment” which started as a radical demand to overcome the power differentials between service users and professionals. Now every professional want to “empower” their clients, which means to reduce their dependency. Which often means to say: “Oh! Don’t ask us for help. You know you’ve got to learn how to help yourself”. Or you can think of “recovery”. This also started as a radical movement, if you read the passionate autobiographies of those who initially developed the ethos of Recovery: “We don’t necessarily want to live what you call a normal life. We want the right to define for ourselves what would be a good life for us to lead”. Now, we have Recovery houses that are highly normative, that have a very specific view of what Recovery looks like. And which are largely staffed by mental health professionals, or by ex-service users who become Recovery professionals. They become paraprofessionals, worst paid, with less authority, but still professionals. This tendency for service users to become co-opted into the mental health apparatus is the dilemma which I was trying to hint at in this part of the book.

7) After criticizing the modern enterprise of psychiatry, you affirm that it needs “to embrace pluralism, and centrally, to include among the multiple perspectives that of service users and their ‘lived experience’”. This statement seems to suggest the pertinence of seeking a multidisciplinary path that values different knowledge and professions. But in Chapter 9 this impression is mitigated when we read statements such as that “a new kind of psychiatry” could “lead on an agenda for public mental health and to highlight the impact of social inequalities and other social factors on mental health”. Is it the case that psychiatry takes the lead or, should it place itself at the side, not necessarily in a position of hierarchy, of different knowledges and practices that operate in the complex field of Mental Health care?

Yes, psychiatry should place itself alongside mental health service users. I don’t take the view that was taken in the famous and influential book by Judy Chamberlin many years ago called “On Our Own”⁸, which argued that the only way that psychiatric service users – she referred to them as mental patients because she was writing at the time of the ‘de-carceration’ of the mental hospitals - could overcome the hierarchy of authority was to completely step away from the medical and psychiatric professions and manage everything on their own. I don’t take that view for two reasons. The first reason is that we live in the real world. And in the real world, although they’re not the most powerful of the medical professions, psychiatrists are in a powerful profession. The Royal Colleges that we have here in the United Kingdom and the similar bodies in many parts of the Global North, have power, they have influence, they can affect government policy quite directly. If those people start arguing for a different kind of psychiatry, if they use their power, if they use their expertise to argue for something different. I think that’s important. And many of them would like to. Especially some of the ones that I’ve talked to. Many of them would like to know how they might best do this. Let me give another very short example. Two days ago, I was talking to a room of a hundred and fifty youngish early career psychiatrists, mainly working in the area



of global mental health, making some of the arguments that I've made. And they said to me: "Well, why don't we ever hear those arguments in our training? Why aren't we trained in those kinds of things?" "Yes, we all know about the social determinants. But dealing with those is not our business". But I think you can make these the business of psychiatry and you can hope that some psychiatrists will indeed take up those arguments.


But if they do so, psychiatrists need to recognize that they are one form of expertise amongst others. And they also need to recognize that the formal, the official forms of knowledge that they are learning in their textbooks come from one particular standpoint. It's conventional now to talk about standpoint epistemologies, forms of knowledge that depend upon the position that you're standing from⁹. That can be used to say: "well, okay, the knowledge claims of marginal groups just come from their standpoint." But we need to recognise that the knowledge of powerful groups also comes from their standpoint, the way they're trained, the way they evaluate evidence, the way they think of proof. Their great commitment to the randomized controlled trial as quotes the gold standard... That's also a standpoint epistemology. And it has many criticisms even within the proponents of randomized controlled trials. [laughs] So psychiatrists and other mental health professionals have to recognize that there is one form of knowledge, with one kind of epistemology, one style of thought that has got its own roots in history and has its own power consequences. And they've got to recognize that there are other epistemologies which come out of a different position in relation to mental health. Which perhaps use different forms of evidence, different forms of proof. But which are not because of that of a lower epistemological status. Of course, just because one person who is a mental health service user says something that they believe, that does not make it true. These 'subjugated' or 'marginalised' knowledge claims have to be evaluated like other knowledge claims. Epistemologists and philosophers from Bachelard to Popper have shown that forms of knowledge are communal. Their validation depends on their acceptance within a knowledge community. They thus are shaped by a community that share a particular way of developing and of evaluating knowledge. So, the knowledge of a marginalized group comes out of that community, and the evidence and experiences of members of that community, and the analysis of that evidence within the community.

So, in answer to your question. I don't think psychologists should take "the" lead, but I think psychiatrist can take "a" lead in certain areas of the world in which we live to argue for a different kind of psychiatry. And in arguing for a different kind of psychiatry, they also have to use their power to help to open the doors for the knowledge of psychiatric service users to enter. And those doors are inching open. They're just inching open. If you read the recent Lancet Commission on Global Mental Health and the "Sustainable Development Goals"¹⁰, you can see how the doors for mental health service users are just beginning to open. It is true that the recognition that their knowledge might be on a par with the knowledge of other experts is both said and forgotten in the body of the report. But something is happening. Many people are pessimistic. I'm not so pessimistic. I think if you just, for instance, if you just read the three Lancet commissions that have been published over the last 15 or 20 years on Global Mental Health, you can see how they have changed their position. Those commissions across that twenty- or so-year period are inching towards the kind of arguments that I make towards the end of my book. Things are moving, but not altogether in a bad direction.



Authors (continuation)

Silvio Yasui^(e)

<silvioyasui@gmail.com> 

Authors' affiliation (continuation)

^(e) Departamento de Psicologia Evolutiva Social e Escolar, Faculdade de Ciências e Letras de Assis, Universidade Estadual Paulista Júlio de Mesquita Filho. Assis, SP, Brasil.

Authors' contributions

All authors actively participated in all stages of manuscript preparation

Copyright

This article is distributed under the terms of the Creative Commons Attribution 4.0 International License, BY type

(<https://creativecommons.org/licenses/by/4.0/deed.en>).



References

1. Rose NS. Our psychiatric future: the politics of mental health. Cambridge: Polity; 2019.
2. Carvalho SR. Governamentalidade, 'Sociedade Liberal Avançada' e Saúde: diálogos com Nikolas Rose (Parte 1). *Interface (Botucatu)*. 2015; 19(54):647-58.
3. Carvalho SR, Lima EMFA. Poderes da liberdade, governamentalidade e saberes psi: diálogos com Nikolas Rose (Parte 2). *Interface (Botucatu)*. 2016; 20(58):797-808.
4. Carvalho SR, Teixeira RR. Políticas da própria vida e o futuro das práticas médicas: diálogos com Nikolas Rose (Parte 3). *Interface (Botucatu)*. 2017; 21(60):221-30.
5. Rose N, Miller P. The power of psychiatry. Cambridge, New York: Polity Press; 1986.
6. Fassin D. Another politics of life is possible. *Theory Cult Soc*. 2009; 26(5):44-60.
7. Kitanaka J. Depression in Japan: psychiatric cures for a society in distress. Princeton: Princeton University Press; 2011.
8. Chamberlin J. On our own. London: Mind Publications; 1988.
9. Harding SG. The feminist standpoint theory reader: intellectual and political controversies. Hove: Psychology Press; 2004.
10. Patel VS, Saxena C, Lund G, Thornicroft F, Baingana P, Bolton D, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018; 392(10157):1553-98.



Aqui apresentamos a última de uma série de quatro entrevistas com o sociólogo inglês Nikolas Rose. Exploramos aspectos centrais do trabalho recentemente publicado, intitulado “Nosso futuro psiquiátrico: políticas de políticas de saúde mental”, que tem como pano de fundo questões e problemas que consideramos absolutamente relevantes para enfrentar os complexos e difíceis desafios impostos à implementação do SUS e à reforma da Saúde Mental em nosso país. Nesta entrevista, procuramos discutir: a psiquiatria como uma (bio) política; as “epidemias” dos transtornos mentais; o papel e consequências da prática diagnóstica psiquiátrica na definição daquilo que se define como transtorno ou doença mental; o uso, e abuso, dos medicamentos no contemporâneo; fortalezas e as fragilidades das práticas discursivas da psiquiatria nos países “desenvolvidos”; limites e possibilidades da participação dos usuários na produção de discursos, políticas e práticas de cuidado na Saúde Mental.

Palavras-chave: Psiquiatria. Saúde Mental. Medicalização.

Presentamos aquí la última de una serie de cuatro entrevistas con el sociólogo inglés Nikolas Rose. Exploramos aspectos centrales del trabajo recientemente publicado, titulado “Nuestro futuro psiquiátrico: políticas de salud mental”, cuyo telón de fondo son cuestiones y problemas que consideramos absolutamente relevantes para enfrentar los complejos y difíciles desafíos impuestos para la implementación del SUS y la reforma de la salud mental en nuestro país. En esta entrevista, buscamos discutir: la psiquiatría como una (bio)política, las “epidemias de los trastornos mentales”, el papel y las consecuencias de la práctica diagnóstica psiquiátrica en la definición de lo que se define como un trastorno o enfermedad mental, el uso y el abuso de los medicamentos en lo contemporáneo, las fortalezas y fragilidades de las prácticas discursivas de la psiquiatría en los países “desarrollados”, límites y posibilidades de la participación de los usuarios en la producción de discursos, políticas y prácticas de cuidado en la Salud Mental.

Palabras clave: Psiquiatría. Salud Mental. Medicalización.

Submitted on 10/15/19.

Approved on 11/05/19.