Pharmaceutical Self

The Global Shaping of Experience in an Age of Psychopharmacology

Edited by Janis H. Jenkins

SAR
PRESS

School for Advanced Research Press
Santa Fe

School for Advanced Research Press
Post Office Box 2188
Santa Fe, New Mexico 87504-2188
www.sarpress.sarweb.org

Managing Editor: Lisa Pacheco
Editorial Assistant: Ellen Goldberg
Designer and Production Manager: Cynthia Dyer
Manuscript Editor: Maya Allen-Gallegos

, New Mexico 87504-2188
press.sarweb.org

g Editor: Lisa Pacheco
Assistant: Ellen Goldberg
and Production Manager: Cynthia Dyer
ipt Editor: Maya Allen-Gallegos
der: Sarah Soliz
Catherine Fox

www.sar

Managir
Editorial
Designe
Manuscr
Proofre
Indexer
Printer:

The desire to take medicine is perhaps the greatest feature which distinguishes man from animals.

—William Osler

Contents

Figures

Tables

Acknowledgments

This volume is the outcome of an advanced seminar at the School for Advanced Research titled "Pharmaceutical Self and Imaginary: Studies in Psychopharmacology and Globalization." The seminar was convened during SAR's 101st year during the week of October 14–18, 2007. As convener, I express gratitude to the participants for the papers prepared for the seminar, animated discussion, and forbearance throughout the revision and publication process. The keen sense of engagement in the seminar served to infuse the book project with a dynamism that has helped to push forward and refine the questions explored in this collection.

I wish to thank particularly SAR president James Brooks for his invitation to bring our AAA session on globalization and psychopharmacology to SAR as an advanced seminar. I also thank SAR director of the scholar program Nancy Owen Lewis and Catherine Cocks for guidance throughout the planning and early stages of this project. Leslie Shipman saw to it that our group was exceptionally well fed and comfortable in the seminar house. Lynn Baca, director of SAR Press, has been supportive in bringing this project from spoken word to print. I feel that the inspiration and history of place that SAR occupies served greatly to fire the anthropological creativity that culminates in this volume.

For valuable commentary over the last few years on earlier versions of the introduction and my own chapter for this volume, I am grateful to attendees of the executive invited sessions for the 104th and 106th annual meetings of the American Anthropological Association in Washington, DC, the Department of Global Health and Social Medicine and Department of Anthropology at Harvard University, the University of California, San Diego (UCSD) Department of Anthropology, the National Institute of Mental Health and the Robert Wood Johnson Medical School, the 2007 biennial meeting of the Society for Psychological Anthropology, Wissenschaftskolleg

Institute for Advanced Study in Berlin, Hospital General Universitario Gregorio Marañón in Madrid, the Department of Psychiatry at the University of California, Davis, the Department of Anthropology at the University of California, Irvine, "Ethnografeast IV" at the University of Leiden, and the Van Leer Jerusalem Institute.

For stimulating exchanges with UCSD colleagues on matters of culture, politics, biology, and being human, I thank Thomas Csordas, Joel Dimsdale, Jonathan Friedman, Dilip Jeste, Lew Judd, Steven Parish, David Pedersen, Tom Patterson, Nancy Postero, Joel Robbins, Margaret Schoeninger, Katerina Semendeferi, Rupert Stasch, Steffanie Strathdee, Shirley Strum, and Sydney Zisook.

I also wish to thank an intellectually spirited group of UCSD graduate students who participated in my seminars on "Culture, Self, and Psychopharmacology" and "Anthropological Studies of Subjectivity." In those classes we explored many of the issues covered in this volume, including the problematic of being "colonized" by taking pharmaceuticals and being "colonized" by not having access to them. For assistance with conference and manuscript preparation, I am particularly grateful to Whitney Duncan and Allen Tran of the Department of Anthropology at UCSD. Finally, to my husband and colleague, Thomas Csordas, my recognition of our long-lived love and élan vital.

Pharmaceutical Self

1

Introduction

Janis H. Jenkins

This volume addresses a critical contemporary issue, that is, the worldwide proliferation of pharmaceutical use. The purpose of this book is to analyze the nexus of culture and psychopharmacology in a globalizing world. The SAR seminar expanded on an invited executive session that I organized and chaired for the 104th meeting of the American Anthropological Association in Washington, DC in December 2005 entitled "Globalization and Psychopharmacology: Interrogating the Historical Moment of Discourse on Chemistry, Magic, and Science." The session examined the blurred conjunction of magic, science, and religion with respect to pharmaceutical markets and global capitalism, on the one hand, and culture and lived experience of pharmacological agents, on the other. This seemed timely given that global markets have recently moved to discursively regulate subjectivities of deficiency, excess, and desire. In Malinowski's (1954, 35) terms, disputes surrounding such moves are waged partially over the problem of how to reduce a "complex and unwieldy bit of reality into a simple and handy form." Thus we observe culturally curious public health slogans such as "Better Living through Chemistry" and "A Flaw in Chemistry, Not Character" in America or "Defeat Depression, Spread Happiness" in India. Multivocal symbolizations of pharmaceuticals such as "magic bullets," "awakenings," "placebo," "God's miracle," "happy pills," "cure," or the scientific foundation for recent "evidence-based" medical practice seem to constitute components of a transformative magic in the form of science and almost with the aura of religion.[1] Such discourse has unsurprisingly generated disputes surrounding premodern polities and modern nation-states/bodies, rationality and risk-taking, uncertainty, and what I think of as "scientific fundamentalism" (Jenkins 2005).

TACTICAL QUESTIONS FOR THE ANTHROPOLOGY OF PHARMACEUTICALS

At the seminar I charged the group with addressing a host of questions I formulated concerning the increasingly widespread distribution of psychopharmacological drugs worldwide: How are culturally constituted selves transformed by regular ingestion of these drugs—for therapeutic, nontherapeutic, or recreational reasons; whether to alleviate suffering or enhance performance; whether awake or asleep? To what extent are *Homo sapiens* transforming themselves into pharmaceutical selves on a scale previously unknown? Does the meaning of being human increasingly come to mean not only *oriented* to drugs but also *produced* and *regulated* by them? From the standpoint of cultural phenomenology, does this reshape human "being"? How are cultures, societies, and nation-states transformed by sizeable proportions of the population regularly ingesting psychopharmaceutical compounds? Are such "biological citizens" (Petryna 2002) more socially engaged and economically productive, on the one hand, or detached and politically indifferent, on the other? Do such drugs alleviate personal and social suffering that is otherwise overwhelming, or do they merely mask and dislocate the source of such suffering and impede personal and institutional action that could more broadly transform disordered social and biological conditions? How do we differentiate between "good" or "bad" drugs given historical and sociopolitical shifts in the moral economy in which they are produced? Given the power of recognizing and defining what "counts" as effects of psychopharmacological drugs, whose accounts and language do we advantage in such accountings? Finally, how does unequal distribution and access to these drugs reproduce social inequalities in health and subjective states of suffering?

To be sure, each of these questions is intricate, and the only anthropologically valid response can come from cautious, nuanced approaches to particular human problems in particular human contexts. On the one hand, who, seeing a man feeling suicidal from overwhelming voices, would not want to offer a medication that could alleviate such suffering? Who, sitting with a woman beaten and raped by military troops, would deny her some measure of relief from the pain she finds unendurable? On the other hand, what governmental bodies or nation-states should authorize antidepressant medications while denying other potentially effective treatments (such as women's collective organizations, individual/group psychotherapy, or rehabilitation)? What is the role of nation-states in regulating and providing public health awareness of helpful and safe compounds or, conversely, harmful, addictive, or life-threatening drugs? Which bodies determine this matter, and what is their relevance under the sway of neoliberal forces in global markets? In light of such considerations, I intend this volume as an anthropological contribution to the study of pharmaceuticals that is tone-deaf neither to human suffering nor the biological realities (Lin, Smith, and Ortiz 2001) of such affliction even though in this collection we focus on social, cultural, and political analyses of the problem. Analysis of particular issues is approached from the vantage points of subjective experience as well as global processes of production and circulation, agreeing with Sherry Ortner (2006) that discursive analysis may not justifiably bid farewell to the experiencing subject and with Jonathan Friedman (1994) that a global perspective cannot be achieved by lobotomizing experience from the cultural realm.

GEOGRAPHIES OF PHARMACOLOGICAL CIRCULATION AND CONVERSION

The extent of psychopharmacological use in the United States may be as high as 25 percent of the adult population. People are taking psychiatric drugs today more than ever throughout North America and Europe as well as parts of Asia and countries of the global South, reflecting the way treatment has been affected by the global dominance of biomedicine, sometimes in seemingly incongruous ways. The seminar participants considered, for example, what it means to dispense three days' worth of tranquilizers to a person living in a postconflict society who has lost everything in a tsunami and what it means to take medication in the poorest sectors of Brazil in the wake of social abandonment by one's family for ceasing to be economically productive.

Contributors to this volume draw on their recent work from five continents. They deploy a variety of strategies to explore the nexus of the subjective experience of psychoactive pharmaceuticals and global processes that shape psychopharmaceutical consumption. In formulating this problematic, I argued that a fusion is needed because studies of global processes that address the problem of psychopharmacology often do not consider the experience of medications for those who take them. Likewise, the limited set of studies of the phenomenology of medication experience has thus far not given due consideration to the economic and political dimensions of the problem (Semar 2000). Uniting these heretofore separate areas of inquiry, several key issues surrounding this historically transformative global phenomenon require anthropological consideration that is simultaneously more focused and more broad-ranging.

Concerning psychopharmacology and globalizing processes, it is important to bear in mind that while biomedicine has been reasonably labeled hegemonic—and the clout of Big Pharma does not appear to be in decline—the American influence on global biomedicine in the future may shrink commensurate with a decline of economic and political power. While the extent of that process remains to be seen in coming decades, it is important in global anthropology that "while there is surely a tendency towards a local encompassment of the global in cultural terms, there is at the same time an encompassment of the local by the global in material terms" (Friedman 1994, 12). The reciprocal connections between local and global are key to what over time can be specified for an anthropology of psychotropic drugs. As for other social processes and products, the worldwide circulation of psychiatric knowledge and psychotropic drugs cannot usefully be portrayed anthropologically as entirely negative any more than it can be cast as entirely positive in relation to mental health. Gregory Pappas and colleagues (2003, 94) make this point generally with respect to health and human potential and suggest that globalizing processes need not be conceived primarily in terms of the erosion of local worlds, but also as "formative, creating new institutions and boundaries."

CONCEPTUAL COORDINATES: PHARMACEUTICAL SELF AND PHARMACEUTICAL IMAGINARY

In this volume we are concerned with the practices and significations that shape the *pharmaceutical self*, understood in terms of the subjective experience of psychopharmaceuticals, and the contemporary *pharmaceutical imaginary*, understood in terms of the global shaping of consumption (Jenkins 2006). To be precise, if, following Hallowell (1955), we understand the self as the sum of processes by which the subject is oriented in the world and toward other people, then the pharmaceutical self is that aspect of self oriented by and toward pharmaceutical drugs (Jenkins, this volume). If, following Castoriadis (1987), we understand the imaginary as that dimension of culture oriented toward conceivable possibilities for human life, then the pharmaceutical imaginary is that region of the imaginary in which pharmaceuticals play an increasingly critical role (see Jenkins, this volume). At issue is the question of how regular consumption of psychopharmaceuticals shapes the self and conceptions of agency in postcapitalist labor markets. In this regard, I argue that the extent to which we are all pharmaceutical selves has yet to be fully appreciated (Jenkins 2005). Also central is the problem of how pharmaceutical companies and their emissaries shape patterns of medical practice, diagnosis, and prescription. Finally, this volume is intended as a contribution to the problem of how "pharmaceutical" bodies are conceptualized in relation to power, dependency, or transformation.

Concerted anthropological inquiry into the meaning and use of pharmaceuticals was set into motion by Sjaak Van der Geest (1984) and Susan Whyte (Van der Geest and Whyte 1988). Their work probed the interest in recent decades "in Western culture and its products (such that) biomedicine came to be seen as a cultural phenomenon worthy of study. As the 'exotic bias' diminished, more anthropologists from both the North and the South did fieldwork in their own societies on aspects of popular culture and everyday life. Capsules, tablets and hypodermic syringes were no longer taken for granted and ignored; they could be defamiliarized (denaturalized) and analysed in terms of the meanings people attributed to them in [a variety of] settings" (Whyte, Van der Geest, and Hardon 2002, 13). With the publication of "The Anthropology of Pharmaceuticals" (Van der Geest, Whyte, and Hardon 1996) and *The Social Lives of Medicines* (Whyte, Van der Geest, and Hardon 2002), the anthropology of materia medica was launched not only as the study of the material "things" of medicine, but also as "things" with social lives in terms of pragmatic and purposeful uses, consequences, and symbolic mediums of exchange between people. Currently, medicines "with the most active social lives" and "vigorous commodity careers" (ibid., 3) are "commercially manufactured synthetic drugs produced by the pharmaceutical industry" (ibid., 14).

Whyte and colleagues call attention to pharmaceuticals, the materia medica of nearly every local society, both as a prime example of (the moving objects of) globalization and as a medium of intimacy insofar as "they are the most personal of material objects, swallowed, inserted into bodies, rubbed on by anxious mothers, used to express care and intimately empower the uncertain individual" (2002, 3–4). A key component of medicines, they argue, is their power to transform, although such transformations can be simultaneously healing and harmful given their noxious potential. While transformations target the body, these also have effects on minds, situations, and modes of understanding (2002, 4). While this corpus of work has been highly generative in anthropology as a thoroughgoing analysis of biomedical and indigenous pharmaceuticals (Nichter and Vuckovic 1994), psychotropic drugs went largely unexamined (except as instances of noncompliance or resistance). However, a body of research more directly concerned with psychotropic medications as social phenomena from a variety of disciplinary standpoints has grown in recent years (Gardiner 1995; Comas-Diaz and Jacobsen 1995; Abiodun 1998; Breslau 2000; Cohen et al. 2001; Healy 2002; Kirmayer 2002; Ecks 2003; Oldani 2004; Schull 2006; Jain and Jadhav 2009).

Recent anthropological studies of psychopharmacology have examined sociocultural aspects of the circulation of drugs in a number of settings. Lakoff (2005, 7) has written on "pharmaceutical reason" to refer to psychiatric drug interventions that are prescribed with the intention of restoring normal cognition, affection, or volition. His work in Argentina following the financial crisis of 2001 showed that doctors' prescription of selective serotonin reuptake inhibitors (SSRIs) was contingent neither on a diagnosis of depression nor a biological understanding of mental disorder. Drugs were prescribed for the alleviation of suffering caused by the social situation and as an aid to psychoanalytic process. Dumit (2002) provided a brief but significant identification of the new paradigm of health, illness, treatment, and normalcy in the United States that not only allows for the utilization of "drugs for life," but also a logic that he believes generates the "Pharmaceutical Self."[2] With this development pharmaceutical companies have capitalized on a paradigm of "inherent illness" that further internalizes pathology (2002, 124).

Other anthropological accounts have illustrated the economic, cultural, and political practices that contribute to the growth of the drug industry and how this expansion affects health practice (Martin 2007; Petryna, Lakoff, and Kleinman 2006) and the social shaping of what Rose (2006) recently referred to as the "neurochemical self." Particularly generative theorizing of culture and medicine has been set forth by Mary-Jo Good (2001, 2007) in her formulation of the "biotechnical embrace" and "medical imaginary" that hold persuasive appeal for physicians and patients alike.

PHARMACEUTICAL PARADOXES OF LIVED EXPERIENCE

Ethnographic interviews and observations with persons who have long struggled with mental illness have led me to interpret their experience of pharmaceuticals as freighted with more than a few recurring paradoxes (Jenkins and Carpenter-Song 2005, 2008). First and foremost among the paradoxes is that even though they have experienced substantial improvement of symptoms and duration of episodes, their experience is nonetheless colored by the frustration of "recovery *without* cure." Second, for persons with long-term or recurrent mental illness, their daily lives are shaded by the ironic social experience of "stigma *despite* recovery." Third, the pervasive cultural-clinical trope that a wide array of problems can reductively be defined as "a biochemical imbalance," which, while no one's "fault," enjoins the neoliberal dictum of individual responsibility for one's own condition even so. Fourth, taking psychotropic medications invariably causes "side effects" that are met with varying degrees of awareness or tolerance of insalubrious effects. For example, taking second generation or "atypical" antipsychotics (and many antidepressants) generally involves considerable weight gain and blunting of sexual desire such that persons must "choose" to be "crazy" or fat, sexless, and genderless. Finally, transnational pharmaceutical "management" of persons with troubled minds and situations proceeds apace despite tangible and complicated needs that require psychotherapeutic and community intercession for healing and social integration (Jenkins and Carpenter-Song 2005, 2008). Taken together, I am convinced that these paradoxical conditions of illness experience can ironically create madness and suffering for individuals and their kin.

The question of why and how it is that the experience and practice of pharmaceuticals is so distinctively laden with social and cultural conundrums was posed by one of the reviewers of this volume, who also wondered whether the answer may be related to pharmaceuticals' place as an agent of globalization, reflecting paradoxes related to science and medicine and their claims on the universal. It is clear that considerably more work is required to determine both the source of these paradoxes and how they play out in different cultural settings. If the globalization of science and medicine assumes both universal application and uncomplicated reconfiguration of the self, does unpacking these paradoxes provide some purchase on a critique that might allow us to distinguish conditions under which pharmaceuticals spread following uniform trajectories or distinctive pathways? Such a critique could be applied to ambivalent and contradictory societal stances toward culturally defined abnormality in the form of mental disorder, on the one hand, and what can be termed hypernormality that is sought through pharmaceutical enhancement to achieve or exceed normality of functioning, on the other.[3] Such a critique would also highlight the way in which pharmaceutical practice continuously reconfigures the self and thus draw attention to conceptual cracks in the notion of self, both in terms of what it might be and where it might be said to begin and end.

On a pragmatic level, these paradoxes may be amplified, suppressed, or refracted in the context of globalization not only by cultural differences in receptivity to the drugs but by uneven distribution and access to psychopharmaceutical agents. As a technology of and for society and self that presents the possibility for alleviating, controlling, or muting mental illness, programs that provide psychotropic medication are forms of both social control and treatment, culturally and morally judged to be legitimate practice.

CONTRIBUTIONS OF THIS VOLUME

My own contribution develops the theme that a pharmaceutical imaginary is operative in everyday life in global society, and that in practice we are all already pharmaceutical selves to a cultural extent we scarcely recognize. Within this framework I address the problem of how subjectivity in schizophrenia and schizoaffective illness is co-constituted by the experience of taking psychopharmacological drugs and by political economic forces that shape psychopharmacological consumption. As aforementioned, the intersection of personal experience and social forces has yet to be specified: studies of psychopharmaceuticals and globalizing institutional processes have generally not considered the experience of medications for those who take them; and thus far, the limited set of studies of medication experience has not given due consideration to the economic and political dimensions of the problem. I trace the current climate to the rise of government funding for psychiatric "services" research, aggressive marketing that expands the range of conditions targeted by psychotropic drugs, poorly controlled financial ties between psychiatrists and pharmaceutical companies, and the emergence of consumer groups advocating empowerment and personal choice. I then examine the pharmaceutical self and imaginary through the ethnography of two outpatient psychiatric clinics specializing in the treatment of psychosis. Bringing Ludwig Binswanger's insights to bear, I identify existential dilemmas characteristic of the subjectivity of schizophrenia under the psychopharmaceutical regime and question the rhetorical impact on the imaginary of the metaphor of "biochemical imbalance" to account for schizophrenia.

In a novel application for this volume, Mary-Jo Good draws on the Parsonian theory of value to interpret the introduction of pharmaceuticals as a treatment for the sequelae of political violence in Aceh, Indonesia, following the peace agreement between Acehnese independence forces and the Indonesian government. She proposes that we consider pharmaceuticals as a "medium of exchange" alongside narratives of trauma for the circulation of value in relation to humanitarian resources. In the context of high proportions of the population having suffered from exposure to violence and in consequence being symptomatic for depression, posttraumatic stress disorder (PTSD), and anxiety, she recounts an episode in which an international team visited a village that had been particularly strongly traumatized. The psychiatrist listened for five hours to trauma narratives, prescribing doses of psychopharmaceuticals corresponding to the severity of the reported suffering and symptomatic response. As a result, a more focused intervention program was developed that dealt with a wide variety of cases by prescribing or not prescribing psychopharmaceuticals based on a distinction between whether individuals were in need of "mental health" treatment or only in need of "psychosocial" care. She concludes by posing the question of whether trauma narratives will maintain their currency for the self and how global psychiatry will contribute to development of an enduring and durable mental health care system in Aceh while continuing to engage remainders of violence that stimulate the psychopharmaceutical imaginary.

João Biehl reflects on the case of Catarina, a Brazilian woman abandoned by her family, institutionalized in a psychiatric facility, and subjected to an intense regime of pharmaceuticals. Her experience takes place against the background of a health system under transformation by neoliberal economics in which budget allocations for psychiatric care and hospitalization have dramatically decreased while allocations for psychotropic medications distributed without charge to the poorest strata have dramatically increased. In this circumstance, Catarina was cast as a particular kind of pharmaceutical self—a madwoman. This was cruelly ironic insofar as she in fact suffered from a genetically based chronic neurological degeneration and not a psychiatric disorder. Biehl frames his consideration of this case in terms of the philosophical reflections of Deleuze on drugs in contemporary life, with additional reference to Foucault, Freud, and Lacan. The pharmaceutical imaginary is reflected through the subjectivity of a person who struggles to maintain her integrity by writing in her journal, creating poetry, and even renaming herself as a form of drug. In Biehl's analysis psychotropic medications are moral technologies that mediate social abandonment both through creating scientific truth values and through the chemical alterations they produce, serving as mechanisms by means of which poor families and local medical practitioners do the triage work of the state health system.

Stefan Ecks continues the conversation by engaging the question formulated for this volume regarding how psychopharmaceutical practice troubles the boundaries of the self. Ecks is particularly concerned with how psychopharmaceuticals create and re-create social spaces. He shows this "sociotopic" effect in cases of impoverished psychiatric patients in Kolkata, India, placing the transformation of domestic and community space in relation to the transformation of clinical and economic space. In his argument globalization is the common ground of neoliberal capitalism and psychiatric deinstitutionalization, facilitated by the universal spread of psychopharmaceuticals. Ecks brings to bear Sloterdijk's distinction among metaphysical, terrestrial, and communicative globalization, arguing that while psychiatric universalism is a form of metaphysical globalization, the spread of psychopharmaceuticals consummates psychiatry's terrestrial globalization in a way that the colonial spread of asylums did not, "flexibilizing" space by transcending the walls of psychiatric institutions and definitively moving psychiatry into the fold of global capitalism. Evidence of communicative globalization is present in the international pharmaceutical market, with drugs produced not only in Europe and the United States but also in the global South, and a philosophy of universal availability predicated on the ideal of a homogenous global space of consumption. However, Ecks suggests that the interplay of impulses toward homogeneity and heterogeneity in globalized psychiatry is in fact best described in terms of Sloterdijk's metaphor of social reality as a heap of "foam" composed of asymmetrically related bubbles rather than as a "network" of interconnected nodes.

Byron Good examines the pharmaceutical treatment of psychosis in Indonesia, a setting in which the use of psychotropics has advanced to a considerable degree while the conceptual apparatus of professional psychiatry is by no means dominant in defining the pharmaceutical imaginary within public culture. In reflecting on his own work, Good draws attention as well to the sometimes contradictory stance of an anthropological critic of biological reductionism in pharmaceutically oriented psychiatry and an advocate of improved global mental health services that include access to psychiatric medications. He describes the prominence of global pharmaceutical companies in professional meetings of Indonesian psychiatrists, sponsoring symposia on drug treatment and providing general financial support. Nevertheless, Indonesian psychiatry is not unidimensional, with a colonial Dutch heritage and contemporary interpretations from Muslim and Hindu standpoints and a younger generation concerned with social psychiatry, cognitive psychotherapy, homosexuality, and mental health sequelae of disaster and conflict. Psychotropic medication is often dispensed in complex polypharmaceutical cocktails on the model of Chinese herbal prescriptions, with individual psychiatrists or hospitals becoming known for their characteristic blend of medications. He describes several cases of rapid onset psychoses that are quickly treated with medication that for some is suspended as soon as symptoms resolve, even if only temporarily, and for others is continued indefinitely, all without necessarily incorporating biomedical understandings of mental illness within the contours of the self.

To probe the pharmaceutical imaginary, Jonathan Metzl examines the expansion of the diagnosis of depression, the increase in prescriptions of SSRIs, and gender stereotypes. He compares the content of medical chart notations for depressed Euro-American men and women from 1985 to 2000, a period beginning just two years before the introduction of SSRIs. The charts reveal increasing medicalization corresponding to heightened gender stereotypy in the form of a significant increase in use of terms not present in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*). To describe depressed women, these were terms pertaining to marriage, motherhood, menstruation or menopause, and a language of emotion. For depressed men, an increase occurred in references to work, aggression, and athletics, apparently related to recent advertisement of the illness as a "physical" condition. Metzl attributes these changes to the interactive effects of the pharmaceutical imaginary through direct-to-consumer advertising of pharmaceuticals such as SSRIs, mass media representations of mental illness and its effects, and clinical encounters, all in cultural and historical contexts.

Tanya Luhrmann vividly describes the bleak and often harrowing world of homeless mentally ill women in a Chicago neighborhood that has been what local media labeled a "psychiatric ghetto" following deinstitutionalization in the 1960s. She describes the importance among these women of the category "crazy" understood as socially caused, permanent once it begins, and avoidable for the strong and determined, as well as the category "strong" that includes not only aggressive toughness, but also disciplined self-respect. Being crazy is associated with being weak, unlikable, and on medication for psychosis. Other medications, for psychiatric problems such as PTSD and bipolar disorder as well as for physical conditions, are neither stigmatized nor invoked in an effort to insult others, and all of these stand in a complex relation to the ubiquitous street drugs. Spanning three groups of women who resist psychiatric diagnosis and medication, who accept them, and who are ambivalent, the cultural meanings of illness and medication have pragmatic consequences for the stability of everyday life.

Emily Martin examines the phenomenology and cultural meaning of insomnia in Euro-American culture, with emphasis on sleep-aid technologies including the physical type—mattresses—and the pharmaceutical type—sleeping pills. She offers a brief history of attitudes toward sleep and the development of sleep aids since premodern Europe, as well as of the scientific study of sleep since the 1950s. Sleep medicine took off during the second half of the twentieth century, and sleep disorders were included as part of psychiatric nosology in the 1987 *DSM-III*. By the first decade of the twenty-first century, the pharmaceutical industry had responded with a number of sleep-inducing drugs. Martin presents an analysis of use of these remedies based on material posted since 1998 on a popular web site forum by people suffering from insomnia, documenting their concerns over side effects, dependence, loss of sense of control, anxiety, and phobia about sleep. The average citizen as well as the sleep-challenged shift worker and the globe-trotting corporate traveler are challenged by the increasingly convoluted cultural meaning of "natural" sleep as an ideal in an increasingly globalized world. Faced with the paradox that sleep can only be attained by ceasing to focus on one's desire for it, some struggle for the elusive good night's sleep while others imagine training themselves to need less sleep. Here the pharmaceutical self engages the pharmaceutical imaginary on the most literal terrain—the possibility of dreaming.

A. Jamie Saris extends the application of this volume's formulation of the pharmaceutical self and imaginary to the social world of heroin addicts. He frames the relation between psychopharmacological agents and addictive street drugs in contemporary global society explicitly as a problem of subjectivity that encompasses will, predisposition, and choice. The boundary between these apparently distinct categories becomes increasingly blurred as Saris traces the vicissitudes of the social life of drugs in terms of whether they are conceived as tools used for positive benefit by social agents or as insidious agents that deprive vulnerable individuals of agency. The market-driven value of "free choice" implicates the notion of will at a deep cultural level with implications for the chemical remedy of deficits to the chemical enhancement of normal states. He discusses the development of a model common to pharmacological treatment of addiction and major mental illness predicated on the existence of a predisposition to these conditions that, once activated, could ultimately only be compensated for but not cured, like insulin treatment for diabetes. In this context Saris reminds us that both recreational and psychopharmaceutical drugs have as much to do with social practices and cultural meanings as with pharmacological effects and subjective experiences. He suggests an understanding of the place for drugs in contemporary subjectivity with a novel twist on Marxist ideas of reification and fetishism and an invocation of Bateson's cybernetics to understand the systemic character of relations among drug, mind-body, and society.

In sum, the seminar participants intend the book as a novel contribution to anthropology and allied fields concerned with psychopharmacological use in the twenty-first century. For anthropology, there are four ways in which this topic is of broad import. First, the problem of the creation of the pharmaceutical self (across an array of diverse contexts) bears on the most fundamental of anthropological questions, that is, what it means to be human. Second, the manner in which the pharmaceutical imaginary structures the experience of persons taking pharmaceuticals and necessarily reinstates the classical anthropological triumvirate of magic, science, and religion as categories within which pharmaceutical discourses are rhetorically and symbolically embedded. Third, this volume brings the body into the foreground for anthropological theorizing of the different kinds of and differently valued bodies (e.g., gendered) that participate in the configuration of pharmaceutical selves. Finally, the pervasiveness of the marketing and consumption of psychopharmaceuticals globally invites an ethnographic initiative to place these phenomena firmly in cultural and historical contexts. While this volume and other anthropological works make significant strides in extending the study of psychopharmacology beyond the confines of North America and Europe, much ethnographic work lies ahead to more fully flesh out the cultural, political, and economic forces that shape the lived experience and institutional processes of production and circulation of psychopharmacology worldwide.

Acknowledgments

For exceptionally insightful and constructive commentary, I express gratitude to anonymous reviewers for SAR Press. For careful copyediting of the manuscript, I thank Maya Allen-Gallegos.

Notes

1. The study of psychopharmaceuticals is anthropologically useful to highlight the blurring of boundaries among analytic categories of magic, science, and religion. Healing has medical overtones and medical practice has religious overtones. Medical care includes "ritual" and healing practice includes "treatment." Appeal to the universal power of science is an appeal to faith in science similar to a religious attitude, while religious healing is sometimes targeted toward specific disorders or symptoms, which is similar to medicine's idea of specificity of treatment. Invoking the instance of religious

practice among Catholics, "taking" Holy Communion from a priest in full vestments is parallel in structure to "taking" a medicine prescribed by a physician in a white coat.

2. From a slightly different perspective than I have adopted here, Dumit (2002, 126) defines the "pharmaceutical self" as "an individual whose everyday experience of his symptoms is as if he is on bad drugs, too little serotonin perhaps, and in need of good drugs, like an SSRI, to balance the bad one out and bring both biochemistry and symptoms to proper levels." In my use of the term "pharmaceutical self" the emphasis is on orientation of the self regardless of whether the individual is symptomatic, while in Dumit's formulation the emphasis is on inherent illness and the proper level of medication to be taken.

3. Here I refer to the use of pharmaceuticals to improve academic or work performance (e.g., stimulants prescribed for attention deficit hyperactivity disorder [ADHD]).

2

Psychopharmaceutical Self and Imaginary in the Social Field of Psychiatric Treatment

Janis H. Jenkins

This particular pharmacological moment in history is unprecedented insofar as medications are routinely ingested for a vast range of human problems quotidian and extraordinary alike. Scientific and capitalist enterprises under conditions of neoliberal market forces have created the capacity to transform and regulate some of our most intimate experiences, a point related to the anthropologically well-recognized understanding that mental disorders are shaped by culture and history. Although my primary ethnographic case in point is psychosis as it is treated in America, the reach of the pharmaceutical self and imaginary as I am formulating these extend beyond types of affliction and ethnographic setting. In this regard it is critical to recognize that the pharmaceutical imaginary has come to pervade subjectivity as the cultural and existential ground of everyday life.[1] Thus my argument is that the extent to which we are *all* pharmaceutical selves has yet to be fully appreciated. This is already largely the case in wealthier nations and an ever-increasing possibility in a globalizing world.

CAPITAL DISORDERS OF AMERICA

In early twenty-first-century America, the social field of psychiatric treatment is vast, encompassing treating clinicians; academic teaching and research universities; professional associations; governmental legislators, regulatory bodies, and commissions; national institutes of health and medicine; health insurance carriers and HMOs; inpatient, outpatient, and residential treatment facilities; group homes for adults and foster treatment care for children; detention centers; nonprofit community outreach programs; consumer advocacy groups; popular media and Internet sources; patients and families; and the pharmaceutical industry of business executives, researchers, drug reps, and omnipresent advertisement. The degree of separation between these institutions and groups within this vast social field ranges from inseparable to immeasurable. Immeasurable, for example, is the chasm that can exist between patients and physicians or between physicians and insurance carriers. Inseparable, for instance, are the relations in a tightly contested arena of potential conflict of interest among treating psychiatrists, academic researchers, and the pharmaceutical industry.

Over the last few decades the National Institute of Mental Health (NIMH) has promoted the idea that the primary problem for mental health research lies not in a lack of scientific knowledge regarding effective treatments but rather in the short supply of implementation of such treatments in the community (US Surgeon General 1999; US Commission on Mental Health 2003). Thus psychiatric "services research" has in large measure supplanted a comparatively more wide-ranging "basic science" paradigm of funded research in the behavioral science portfolio in recent decades. Scientific review committees and programs were developed specifically to fund research and training programs for services research, and it was well understood by academic institutions and applicants that "services" was positioned by the US Congress and NIMH to garner the lion's share of research dollars for topics and programs evaluated as worthy of support.

The primary (and often the only) source of psychiatric services today is psychopharmacology.[2] The locus of most clinical discourse (both formal and informal) surrounding this treatment is the problem of patient noncompliance with prescribed psychopharmacological regimes.[3] In light of the steady decline of psychotherapy and psychosocial treatments for serious mental illness, the term "regime" appears more apt than another coinage of recent decades, that is, "pharmacotherapy." By far, transactions surrounding psychopharmacology have come to dominate the social space of psychiatric treatment in America.

The highlighting of depression as the "common cold" of mental illness is increasingly evident in the United States, for example, as a matter of corporate policy since one economic analysis estimated lost capital due to depression to be $53 billion annually (Greenberg et al. 2003). So it was unsurprising when in September 2005 a major American insurance firm—Aetna—announced plans to pay primary care doctors additional fees to screen patients for a "depression management program." This program would "screen patients and...provide follow-up consultations for patients who are either put on antidepressants or, in more severe cases, referred to psychiatrists or psychologists." The stated rationale offered by the company's vice president, Daniel J. Conti, is that from an employer management standpoint, "depression has the greatest negative impact on productivity for non-manufacturing companies... [and] is like the perfect storm for the jobs in today's workplace, the same way a bad back limited a worker on the job for my father in a factory" (Freudenheim 2005). Another source, Laurel Pickering, president of the New York Business Group on Health, put the matter this way: "People with depression are sitting around, not getting identified, impacting the business community, [and] what Aetna is doing is going to be a help" (ibid.).

In broad strokes, psychiatrist/historian David Healy (2004, 223) has written that for Northern cultures,

> the Era of Depression we have recently been living through—since 1980—has stemmed primarily from the need of pharmaceutical companies to market compounds such as Prozac, Zoloft, and Paxil...[for] cases that [previously] would have been treated by Valium and Ativan.

In fact, the marketing phenomenon observed by Healy regarding selective serotonin reuptake inhibitors (SSRIs) now has two aspects: not only did some anxiety disorders come to be rediagnosed as depression, but more recently it was "discovered" that the SSRIs can be marketed expressly for anxiety disorders, not just for depression. Combined with the moves made by service providers and the insurance industry, aggressive and pervasive marketing strategies effect more than a transformation in prescribing practices. They also shape perception of those in need of treatment. The trend to redefine patients as clients was in vogue for some decades. Over the past ten years clients have yet again been redefined as "consumers" by advocacy groups and also in psychiatric research protocols.

While the scientific and medical communities may not yet be able to pinpoint how psychotropic drugs may help the many, the popular sector of everyday commerce appears to have little difficulty in doing so, particularly since the advent of direct marketing of psychotropic drugs to the public, approved by the US Food and Drug Administration (FDA) in 1997. Pharmaceutical companies now market not only drugs, but also disorders:

depression, social anxiety, bipolar, and attention deficit hyperactivity disorder (ADHD), among others. Here we have psychologically and economically driven pharmaceutical suggestions that engage the imagination: do I have that? Is that my problem?

Still, the public is not a mass, subject entirely to passive manipulation enjoined by such ads. Many psychotropic and other pharmaceuticals are available over the Internet without mediation of a prescribing physician. Or, consider the highly active free-trade market among young adults in the United States, who regularly diagnose, prescribe, and "time share" their pharmaceuticals with friends and family with little felt need for the disposable middleman/woman, the physician, whose commodified shelf life is limited and, in any event, might not be entirely trusted. In this setting drug advertising to the consumer has led to a remarkable and peculiar psychopolitical development—that decision making regarding medications is a matter of "personal choice." In this ethnopsychology the purview of physicians may either be unnecessary or a hindrance to the ethos du jour: As a matter of cultural and economic fluidity, brain chemistry not only can but should be regulated. Further, youths assert that "we are our own best pharmacists" (Harmon 2005). For those who do receive prescriptions from physicians, symptoms of ADHD are sometimes presented as a means to obtain "smart drugs" such as Adderall or Provigil (stimulants) for overcommitted college students who feel the need for enhancement or even basic maintenance of their performance (Talbot 2009).

Popular fluency in the idioms of both drugs and disorders has spawned public Internet forums set up by "consumer groups" and pharmaceutical companies alike to obtain and "share" knowledge about so-called head meds. Such self-projects are historically instantiated as a matter of the nation-state's pursuit of happiness and empowerment that prominently include ethnopsychological themes of "med-empowerment" and, indeed, entitlement to control troubling or inconvenient personal affect, thought, or limitation. Via peer social exchange networks, Internet, and "black market" economies, consumers contribute to and circulate the significations that constitute the pharmaceutical imaginary.

For antipsychotic medications, the shift has been marked in moving away from "conventional" antipsychotics administered since the 1950s during institutionalization and following mass deinstitutionalization in the 1960s. By the 1990s the "atypical" or "second generation" antipsychotics were widely heralded in clinical and popular media as the basis for dramatically raising expectations for improvement and even recovery from schizophrenia (Jenkins and Carpenter-Song 2005, 2008).

I have tracked this development—parallel to that of the SSRIs—for atypical antipsychotic medications that include clozapine, risperidone, olanzapine, Seroquel, Geodone, and Abilify. This class of antipsychotic drugs has recently been marketed for bipolar disorder as well as for schizophrenia. One would assume this to be a daunting challenge given the relative stigma of schizophrenia and cultural cachet of bipolar. It should also be noted that in clinical and consumer practice, atypicals are also prescribed for an array of contemporary diagnoses such as ADHD, conduct and oppositional defiant disorder (Carpenter-Song 2009), gambling addiction (Schull 2006), and "identity disorder" among Hispanic and Zuni youth, as recently observed in my ethnographic work in New Mexico. And in a startling development of market expansion (early 2009), Abilify (Bristol-Myers Squibb) has been heavily marketed for depression (*Oprah* magazine, television commercials, billboards) when "your antidepressant alone isn't enough," approved by the FDA as an "add-on therapy for depression." While prescribing multiple psychotropics (antidepressants, antipsychotics, anxiolytics) is not uncommon, the expansion of SSRI use from depression to anxiety and antipsychotics for bipolar and now depression is remarkable. What was once exclusively a drug for schizophrenia can now plausibly be taken by (far greater) numbers for other conditions.

The barrage of advertising is by no means restricted to popular venues trolling for new patient markets but is also affecting physician markets as evident at the May 2007 160th annual meeting of the American Psychiatric Association (APA) in San Diego, California. Arriving in the airport by the thousands, visitors descended the escalators and were met by the enormous canopy of a banner looming over their heads: "Welcome to San Diego, Abilify (aripiprazole)." The gigantic Abilify ad at the airport was but one piece of omnipresent advertisement (another was the frontispiece for the daily APA meeting program). These ads are designed to stimulate the pharmaceutical imaginary of the physician-consumer. Indeed, the six-day meeting was replete with approbation for psychopharmacology across all the subfields of psychiatry.

An unintended irony of heralding antipsychotics such as Abilify was on ritual display at the Convocation of Distinguished Fellows that I attended. The climax of the convocation was to be the William C. Menninger Memorial Lecture delivered by the famed mathematician John Nash. During Nash's lecture, which he delivered somewhat apologetically without benefit of "modern technology" (relying on typewritten manuscript pages), he offered his analysis of the problem of mental illness as one of "minds not doing their duty." Drawing on evolutionary theory but also relying on his own experience, he crisply delivered his view of "insanity [as] like a work stoppage." The problem is one of "minds on strike," Nash asserted, which can occur when an individual is unhappy. In his own case, he noted, "I was frustrated when I became delusional," during which time he felt he had not received the academic appreciation he deserved.[4] After becoming psychotic with Cold War fantasies and fears, he spent a great many years attempting to reestablish and sustain logical thought. In the end he determined that it was vital that he elected "to resist all temptation to think along political lines." In addition, he denounced psychiatric medications as inadequate to the problem of recovery and dangerous in creating serious health risks. Yet John Nash's experience and dissenting perspective appeared to go all but unnoticed, and collective presumption of the necessity of taking pharmaceuticals was not questioned.

While the above ethnographic portrait of the annual meetings of the APA as a celebration of psychopharmacology is characteristic of recent decades (save for the appearance by Nash), it is vital to note a likely cultural and political sea change in the hegemonic representation of drugs at such events in the future. The shift in the publicly observable symbolic displays and rituals surrounding psychiatric drugs is likely to take place in light of a series of recent events. First is US congressional investigations of conflicts of interest by physicians and pharmaceutical companies. The conflict came to light through vigorous efforts on the part of two US senators to identify physicians who had failed to report income (large sums in some cases) they had earned from pharmaceutical companies for consultation and presentations of research that typically focused on drugs made by the very company making payments to the physicians. The controversy exploded in April 2009 with the prepublication release of a scathing report by the Institute of Medicine. In their report the IOM called upon doctors to stop taking gifts (of all sorts) and payments from pharmaceutical companies. Coming from the most influential and prestigious national medical advisory group, it was widely expected to make an institutional difference in American psychiatric public culture. In fact, this development has already led to changes in medical school training and publication practices of scientific journals. Such changes are also being effected by small but vocal groups of medical students who have chosen to protest the state of affairs within their own institutions.

The IOM made several specific recommendations to break the ties between industry and medical practitioners, the most controversial of which was the recommendation to stop industry influence over continuing medical education courses to meet state licensing requirements. In the case of psychiatry, and in the wake of specific congressional scrutiny of conflicts of interest in the form of unreported income paid by drug companies to highly prominent psychiatrists, public trust has been sorely tested. In an attempt to stem the tide of scandals surrounding the profession, the APA's president issued a statement declaring that APA professional education will henceforth be entirely separate from industries involved in psychiatry. US congressional investigators welcome such moves because pharmaceutical companies have been paying out billions of dollars courting physicians, spending more on giving doctors payments for marketing lectures, free drug samples, food, and medical refresher courses than on research or consumer advertising. The IOM report called for a halt to all of these practices and for a conjunction of research institutions, professional societies, medical journals, and the NIH to produce an evidence base to evaluate the implementation of the committee's recommendations.

SUBJECTIVITY, SELF, AND IMAGINARY IN BIOLOGICAL PSYCHIATRY

I turn now toward the ethnographic task of initiating a mutually informed analysis of the pharmaceutical self and pharmaceutical imaginary. I will begin with an introduction to the practices and significations that define the contemporary pharmaceutical imaginary. Subjectivity, in the view that I am adopting here, is not a feature solely of individual experience, to be distinguished from presumptively objective, anonymous forces operative at the level of global institutions. Subjectivity inheres in both levels of analysis, and in order to incorporate this insight into the terms of my analysis, the theme of my examination will be the relation between the pharmaceutical self and the pharmaceutical imaginary. To be precise, if we understand the self[5] as the sum of processes by which the subject is oriented in the world and toward other people, then a pharmaceutical self is that aspect of self oriented by and toward pharmaceutical drugs (Jenkins 2005). If we understand the imaginary[6] as that dimension of culture oriented toward conceivable potentials of or possibilities for human life, then the pharmaceutical imaginary is that region of the imaginary in which pharmaceutical drugs play an increasingly critical role.

The methodological value of this terminological choice lies in the recognition that pharmaceutical self and pharmaceutical imaginary are linked as reciprocal sides of actors' subjectivities.[7] Perhaps more simply put, the terminological pair, self/imaginary, points to the mutual grounding of the subjectivity of social actors in sensory experience and in a cultural context. Individual subjects are selves not of their own accord but by virtue of immersion in an intersubjective and institutional milieu. Conversely, social, economic, and political forces are not purely objective or impersonal forces but move and respond to people as they engage them, enlist their participation, guarantee their acquiescence or resistance, and appeal to their sentiments, fantasies, desires, values, and ideal images of themselves—in short, by tapping into their imaginary. Pharmaceutical companies are imagining (and banking on) the authority of scientifically endorsed appeals to the imaginary to persuade consumers to use their drugs. They are imagining a fundamental human desire to be socially attached to groups in culturally conventional ways. When it is stated that "we don't know how this drug works yet," the "yet" is both a declaration of faith in science and an appeal to the imaginary.

From the point of view of biological psychiatry, the very notion of "choosing" to be mentally ill is as absurd as the idea that one could "will" the disease away (see also Saris, this volume). Cultural notions of personal or familial responsibility and blame are nearly as irrational as ideas surrounding witchcraft. Wishing for a cure, while perhaps understood sympathetically by clinicians, is held to be unrealistic and thus potentially undermining of a medication regime. Shame is unwarranted and can be supplanted with scientific knowledge because neurotransmitters, with no moral or social charge, are the immediate site of the problem. This psychiatric "bionarrative" (Carpenter-Song 2007), routinely applied, is pointedly intended to counter and to alleviate popular "misconceptions." The cultural trouble, however, is that commonsense views of mental illness persist collectively in conscious and unconscious forms. They persist tenaciously to include cultural dimensions of symbolic meaning that have not been substantially transformed over the past century in relation to misdeeds and deficits of the afflicted and their families alike to include pathogenic maternal inadequacy, familial abuse and neglect, heredity, jealousy, or witchcraft and demonic possession, on the one hand, and nervous breakdown, character flaws, intellectual and emotional deficiency, religious transgressions, illicit drug use, or misfortune on the part of the afflicted, on the other. These meanings are often bundled together unevenly as inchoate blends of social and personal accounts that are provisional in relation to temporal and situational criteria.

MODES OF DISORDERED EXISTENCE: SCENES FROM AN EARLY TWENTY-FIRST-CENTURY AMERICAN CLINIC

Against this analytic background I will examine the pharmaceutical self as it is manifested in psychosis in order not only to provide a close-up of bodily and social experience, but also to emphasize that the pharmaceutical self is magnified in the case of schizophrenia patients. This analytic strategy is continuous with my argument in *Schizophrenia, Culture, and Subjectivity: The Edge of Experience* (Jenkins 2004) that the study of schizophrenia offers valuable insight for the understanding of the dialectic between culture and psyche in the constitution of fundamental human processes. I will illustrate how such processes are constituted in relation to the pharmaceutical self and imaginary in three ways. First, I examine how persons diagnosed with schizophrenia experience and express the effects of illness and treatment with psychotropic medication. Second, I further demonstrate how cultural processes are formulated in relation to regular ingestion of psychopharmaceuticals through attention to the ways in which these same patients manifest and embody gender. Finally, I explore existential dilemmas of the pharmaceutical self by invoking Binswanger's (1963, 250) phenomenological approach that allows for a cultural interpretation of modes of communication "as distinct modes of existence, of existential process and determination."

In my recent work with schizophrenia patients the ethnographic locus of the pharmaceutical self was examined in two outpatient psychiatric clinics in a major metropolitan area in the northeastern United States, populated predominantly by people of Euro-American and African American ancestry. What I will call the University Clinic was initially set up as a research site for clozapine, a "second generation" antipsychotic drug.[8] Here, patient interaction was fairly intense, often including daily visits during which they engaged in a variety of informal social activities with occasional group discussion led by a nurse at the clinic. What I will call the Community Clinic is an older community mental health facility with a less-developed research focus, where patients came briefly for biweekly or monthly medication checks. Although there was a more explicitly elaborated psychiatric ideology regarding the efficacy of medication to treat disorders of the brain in the University Clinic, the primacy of medication over psychotherapy was common in both settings, as indeed is the case widely throughout the country.[9]

Patients at the Community Clinic appeared more disengaged from their clinicians and notably less inclined to participate in research. In the University Clinic, patients' ability to form a community was fostered intentionally and unintentionally by the fact that they were monitored medically with frequent blood draws. Perhaps ironically, because it was a private, university-initiated research clinic, it became a site both for the intense inculcation of a psychiatric ideology of psychopharmaceutical miracles and for the creation of a community of patients capable of resistance and critique. Social structure and dynamics evolved idiosyncratically in relation to the clinical tasks at hand and patient needs and demands, such as the demand for a women's therapy group.

EXPRESSIVE CONSTITUTION OF THE PHARMACEUTICAL SELF

I want now to highlight the manner in which talk about illness and medication, both didactic and conversational, contributes to constituting the pharmaceutical self within the ethnographic setting of the University Clinic. My method will be to examine talk in patient discussion groups that were comprised of both men and women, and in which speech could range from tightly focused to entirely "open-ended" banter regarding how people were doing. I will compare groups led by two nurses whom I will call Dina and Guy. The comparison is not aimed at identifying different clinical styles to be evaluated in terms of therapeutic efficacy but at showing how their group process taps into and provides evidence of different dimensions of the pharmaceutical self. Indeed, given their clinical setting, they are critical venues for both the constitution and articulation of that self.

Guy, a thirty-six-year-old Euro-American male nurse, was officious and irritable, taking the stance of either ignoring patients' points of view or delegitimating such annoying "noise." His groups were focused on "educating" members on disorders, medications, epidemiology, and brain morphology.

The inherently diseased brain feeds the notion of the pharmaceutical self because if one is morphologically "sick," one needs to medicate constantly. Guy's strategy was to give quizzes designed to see if people had "correct" pharmaceutically approved information. The quizzes and associated brochures were provided by drug reps who supplied the medications for the clinic. These exchanges in the clinical setting, captured in microdetail with ethnographic notation and audiotaped sessions, revealed fascinating and often hilarious interchanges that could be right out of James Scott's (1985) *Weapons of the Weak* regarding cooperation and resistance to the heavy-handed indoctrination attempted in these sessions.

Here is an example from field notes. Guy convened this session to discuss medications with eleven members present. He began the meeting by dividing the group into two teams that could respond to questions from a medication quiz, asking anyone to list five types of schizophrenia. Several people slumped into their chairs, and some started staring off into space. Others started calling out things in the ballpark of illness but that had nothing to do with diagnosis or description. Kent finally called out "paranoia," and someone else offered "schizoaffective." Guy proceeded, with the help of his quiz manual, to try to describe different types of schizophrenia while the others talked over him, calling out various things such as "nutso," "crazy," and "bonkers," punctuated finally by Richard who yelled out, "Basket case!" Nearly all the members of the group suddenly became attentive, dissolving into peals of crackly laughter. Guy then gave a staccato assessment of the difference between slang for mental illness and medical terminology. John responded by offering "catatonic" to which Guy crisply retorted, "Hey, you're reading off my paper." There was an intermediary brokering of appropriateness of response by Guy to determine who said what out of turn or whether points would be given. Richard belched earth-shatteringly. John and Steven exchanged glances and secret smiles across the room to acknowledge Richard's behavior. Guy pressed on: "What percent of people are schizophrenic?" Several people yelled out, "One percent!" Michael called out even more loudly, "Fifty percent!" Group members looked at each other, mystified at that one. Many knowing glances were exchanged that acknowledged Michael's well-known reputation for being strange. But then John weighed in with, "Wait, maybe he's *right* and the *other* forty-nine percent go undiagnosed!" Four or five people dissolved into laughter at the joke. Guy continued to ask questions, but no one really responded, and people started to leave the room. Richard, implying that people should stick around, implored people to consider the prizes they may be forgoing by saying, "Hey, you might go home with a car or an appliance for once!"

The second nurse, Dina, a thirty-eighty-year-old Euro-American woman, was warm, patient, and in stark contrast to her colleague at the University Clinic, systematically took the stance of allowing conversational, social, and psychological space such that participants determined what to talk about in whatever narrative order and form as such emerged.

In one case only three participants could attend a given discussion session, and in this case all three happened to be African American women. The conversation contrasted markedly with the style of Guy's group. The women mused, sometimes with delight, about how they would relish killing their ex-husbands for failure to receive spousal or child support. This male abandonment, they insisted, was the very source of their suffering and vexation—and certainly the primary source for any biochemical imbalance associated with annoying symptoms such as voices and fears of people watching them or trying to do them harm. The magical idea of a "hex" having been set into motion was deftly skirted around but colored absolutely the tenor of assumptive knowledge about what was "really" going on. This was because one woman, Kinesha, felt herself to be possessed by demonic forces unleashed by her mother and her boyfriend who had turned against her. The group conversation proceeded next to the absolute rationality of removing or killing, if necessary, those who were harming them. While this particular fieldwork encounter was emotionally fraught with an intensity and tension that led to several long periods of silence, Dina simply let these be until such time as she tried to turn the tide of the conversation toward themes such as love and forgiveness and remembrance that these women in fact loved their children and that they needed to take this into account with respect to carrying out any plans for retribution. This made sense to the women, and they agreed that what they were dealing with was what everyone—"mental" or not—was grappling with: how to deal with men who seemed unable to meet their financial responsibilities through payment of child support, or how to deal with hostile kin. Thus the tenor of the session indicated that these problems were ordinary and unremarkable: everyone in the group, and many in their neighborhood, knew about or had experience with these particular issues.

In summary, the purpose of Guy's group activities tended to be ostensibly educational, emphasizing films and literature from pharmaceutical companies and the main consumer advocacy group (National Alliance for the Mentally Ill), whereas the purpose of Dina's groups tended to be the management of everyday life. The modus operandi of Guy's group was the inculcation of psychiatric ideology and testing patient participants about their knowledge with a general style of "being schooled." The modus operandi of Dina's groups was negotiation and narration of feelings, ideas, and relationships with a general style of "comparing notes." Finally, the two groups addressed radically different dimensions of the pharmaceutical self. Guy's groups mobilized the dimension of resistance and conformity, evidenced in both the joking and lack of attentiveness patients often exhibited. Dina's groups stimulated the dimension of concern with everyday life and social problems.

Overall, the tone and substance of Guy's groups more explicitly reflected the force of what I have called the global pharmaceutical imaginary, while Dina's group reflected the more intimate subjective processes of the pharmaceutical self. Yet as a matter of subjectivity, both share a preoccupation with the notion of what constitutes "normal." Here again we encounter concrete evidence of an image generated in the pharmaceutical imaginary taken up into the subjectivities of individual actors as elements in orienting their pharmaceutical selves.

COMPLICATIONS OF GENDER TROUBLE: TESTS AND MYSTIFICATIONS

A second aspect of the pharmaceutical self I will briefly discuss has to do with the experience of gender and social identity. Since persons dealing with schizophrenia struggle to remain oriented in the world, and gender is so central to cultural orientation, it throws the problem of the creation and experience of pharmaceutical selves into bold relief. During this work we learned that in large part these are people who know they are outside the norm and in the main are not happy about it. What others culturally take for granted, they cannot. Yet the gender script that preoccupies this group is remarkably conventional. Developmentally, at their cultural age (forty years on average) they should be married or living with a committed partner and have occupations that provide adequate economic resources for being a productive member of the community. Gender performance is bound up with economic performance in the sense of existing in terms of reduced citizenship or reduced capacity to participate in society by means of productive employment. In general the men feel emasculated by the illness and by the medication, and they feel weakened in social status. Their circumstances wreak havoc with desire because they feel they cannot ask people on dates, go out to public restaurants or movies, and so forth. Women say that medications alter their emotional repertoire such that they feel more remote from their feelings, particularly tender sentiments, and such that they feel mean, angry, or tough—"like a man." They feel they cannot act within the bounds of emotionally accessible or sexually attractive female comportment. Some people are resigned to this, more or less having given up on having a sex or dating life. Some volunteer that the medication has turned them into neutered people, neutered bodies.

What are we to make of this neutering? If we were to agree with Judith Butler (1999) in emphasizing the arbitrary scriptability and plasticity of gender, it could only be with the caveat that there is something prior to performance, something fundamentally human that is highlighted in these cases. For what these afflicted men and women exhibit is the modulation of the unfettered intuition that precedes and impels the performance. The absence of easy assumption for these pharmaceutical selves is experienced acutely and as problematic. This frustration does not deny gender as performance but highlights the consequences of being blocked from performance completely because one has nothing to perform: having no money for a car or entertainment, obese from medication side effects, suffering from an illness, suffering from having been told over the years by psychiatrists not to have children for fear of passing the disease on to their offspring.

An exception that proves the rule for our fieldwork team is a woman I will call Kayley, whom we began to refer to as the "female impersonator." As the central project of her everyday life, her response to her situation was to exaggerate her femininity and push the envelope of conventional cultural norms. At the time we met her she was thirty-nine years old, having had social and health difficulties since her late teens. From a working-class family, she lived with her parents and attended the University Clinic frequently during the fieldwork period. She made considerable effort to minimize an illness identity in favor of cultivating her physical appearance with an intended glamorous "hyperfemme" style as the mooring of her identity. In this respect she idealized her pre-illness youth, carrying well-worn photographs of herself that she shared with me and other members of the research team. In the series of photos her appearance moved from skilled and subtle gendered representations to parody of traditional femininity in a process of snuffing out gender performance as an assumptive domain and moving toward a highly exaggerated performance of gender. Her subjective preoccupation was with her sense of apprehension and uncertainty over whether she had "lost" her beauty and her sense of the ever-present admiring male gaze. Her gendered performance was highly stylized with overemphasized makeup, a breathy voice, and a hip-swinging walk, with feet placed directly in front of each other like a model's.

One of our primary ethnographers summed her up as "entirely Dolly Parton"—except that Dolly Parton cheerfully acknowledges that her look parodies both beauty standards and class values and feels no compulsion to change anything about her presentation of self. In this way Parton does not impersonate but embodies—is self-designed in the image of her choice. Kayley, on the other hand, was not parody but impersonation. She used artificiality as a tool to create and revisit a self, not to improve one. The social problem with Kayley's hyperfemme performance was that it was poorly played: she not only wore way too much makeup—but the bright red lipstick she fancied was invariably applied far beyond the boundaries of her lips, lending an unintended comic quality to her appearance. In addition, owing to the medication she took, she was quite overweight yet continued to wear clothes that fit her well some sixty pounds ago. Interpersonally, with peers and ethnographers alike, she very frequently asked the question: "Why are men always looking at me? Do you know?" As a matter of gender performance, I propose that we can understand Kayley's extreme hyperfemininity as an overcompensation intended to protect her against the kind of gender neutering that I have described earlier.

We can pursue these insights further by looking at a subgroup of patients—21 percent of the ninety patients with whom we worked—who reported having at some time experienced some degree of gender confusion or disorientation. For now, all I can summarize is the anthropological and existential significance of gender confusion: among this ethnographic population there is no confusion with respect to cultural codes of gender identity. In fact, people must be quite certain of the cultural standards of gender identity in order to be confused about enacting, incorporating, or experiencing them. It is never a question of whether wearing lipstick is a sign of masculinity or femininity; there was not much of a problem with or confusion about whether feeling "tough" was an aspect of feeling like a man or a woman. The locus of confusion was in how those emblems of identity apply to the self. In effect, their changing and multigendered experiential flow can be formulated as "I understand what it is in my culture to be a man or a woman, but I don't know whether the sum of my being adds up to being a man or a woman." My argument has been that for this group gender identity is inextricably and intimately linked with a well-formed, if not entirely calcified, pharmaceutical self.

EXISTENTIAL DILEMMAS OF THE PSYCHOPHARMACEUTICAL SELF

Ludwig Binswanger (1963, 250) has taught us to interpret the data derived from communication with patients "as distinct modes of existence, of existential process and determination." Binswanger suggests that "instead of a disease unit consisting of a small and perhaps also clinically and symptomatically rather varied class, we have here a unity of definite existential structures and processes" (251). Schizophrenia has to do first with an inconsistency of experience contrary to the relatively unproblematic residing in an objective, natural world, characterized not so much by taken-for-grantedness as by a letting-be of beings as they are in themselves. This letting-be is neither a self-evident nor easy activity but is "highly positive and active," constitutive of commonplace being in the world but often broken down in an existential pattern shaped by schizophrenia (252). The person living in such a state may seek a way out of this inconsistency by creating an either-or mode of being in which the afflicted person desperately attempts to cover or conceal the unbearable alternative and clings to its opposite, an extravagant cultural ideal in which he or she can become increasingly enmeshed (as above in the case of Kayley). In the effort, "normal" existence can eventually be worn away, culminating in a resignation to the impossibility of finding a way out or a retreat from normative social life.

Two observations are important at this level of analysis. First, Binswanger's concern was to describe the structure of the existential process in schizophrenia, in which the psychotic content, while unique to the biographical circumstances of each patient, was secondary. Second, Binswanger wrote in the era prior to introduction of antipsychotic medication and therefore was not in a position to reflect on how psychopharmaceuticals might intervene in this existential process. Do they act only on a symptomatic level rather than an existential level? Does the effect vary based on individual psychotic content, or is there an intervention at the level of the either-or structure designed to overcome experiential inconsistency? To what extent can we separate the effect of medication on schizophrenic process and the existential effect of its very introduction into the patient's subjective economy?

A clue to understanding the salience of these questions comes from a serendipitous coincidence in choice of words. One of the ways Binswanger (1963, 252) described the inconsistency of experience was as an inability "to reside serenely among things." One of my research participants said that an effect of medication "was serenity...my bitterness, my anger, seemed to just disappear overnight." The critical notion of serenity suggests that, at least for some patients, medication can hold at bay the titanic struggle between the unattainable ideal and its unbearable alternative so as to forestall the wearing away of existence that ends in a retreat from life. Meanwhile, however, data from this project suggest that there are at least two existential dilemmas that come to the fore as characteristic of the contemporary subjectivity of schizophrenia under the regime of psychotropic medication. If these are not strictly speaking rigid either-or a prioris (in Binswanger's formulation) that serve as desperate bulwarks against inconsistency, they are without doubt conceivable as structural dimensions of a lifeworld created in the situation of schizophrenia.[10]

The first takes the form of a polarity or continuum between the best thing and the worst thing that could happen as these are repeatedly expressed in patients' discourse. The best thing is cure. The worst thing is hospitalization. In its purest form this is a polarity between hope and fear. In a way that is thoroughly conditioned by the mundane involvement with regimes of antipsychotic medication, the fear of hospitalization is the unbearable alternative, and the hope for a cure is the unattainable ideal. For the treated outpatient, confinement in the psychiatric hospital is the ultimate in powerlessness and nonbeing. Made well enough not to be in immediate danger of self-destruction or existential retreat into insanity and to value engagement with life, the ever-present possibility of returning to the hospital symbolizes both short-term horror and long-term setback. At the same time, the possibility of true cure and the promise of a truly mundane quotidian life without feeling different and being stigmatized by self and others is a hope that is not offered along with treatment. Patients want their antipsychotic medication to be like a penicillin (or at least like an effective chemotherapy) that will eradicate their disease and not like an insulin that must be taken indefinitely to counter a permanent deficiency, promising only a future as a pharmaceutical self medicated for life.

The second existential polarity is predicated on the fact that the target or destination of antipsychotic medication is the brain. Talking about their medication, patients are just as apt to say that it works on "the brain" rather than on "my brain." In its purest form the brain becomes the fulcrum in a polarity between alterity and identity. Experienced as other, the brain is alienated and passive; experienced as self, it is ego-syntonic and active. In an illness where dissolution of the self is a constantly looming abyss, it can hardly help to entertain the notion of one's brain as a kind of machine or even an autonomic organ that is "not me." It is not difficult to see how the dynamic of alterity could develop into an unbearable alternative in Binswanger's sense. It is one thing to say that the brain is experienced as other in the sense that one is alienated from it. It is yet another to experience the brain as other in an uncanny or spooky sense. It is yet a third for the brain to be experienced as other insofar as it is defined as a supernatural entity or power.

Short of such potentially frightening possibilities, whether the brain is experienced as self or other has pragmatic consequences for whether medicine is experienced actively as a tool one uses or passively as a controlling substance. My research participants expressed both attitudes, and both were consequential for their existential stance in everyday life. In a broader historical perspective, it may not simply be that thinking of the brain as an objective biological entity allowed the development of drugs targeted to that entity but reciprocally that drugs targeted to the brain have themselves encouraged us to think of "the brain" in a way that was not entertained in earlier times. This is perhaps more relevant to the brain than, for example, to the heart (which can also be targeted by specific drugs), for, at least in this ethnographic context, the brain is more intimately and literally connected with mind, self, and soul, whereas the heart is connected with emotional life in a sense that is relatively more metaphorical.

SELF AND PSYCHOPHARMACOLOGY IN POPULAR PARLANCE: CHEMICAL IMBALANCE

Before ethnographic discussion of these two dimensions of the pharmaceutical self and imaginary, I turn now to the question of how persons experience and convey a sense of self as a set of processes oriented by and toward pharmaceutical drugs. I want to begin by noting the difficulty of examining subjectivity as affected by drugs since in the present situation all are taking psychotropic medication. Are we studying processes of subjectivity formed by drugs rather than by illness, dysphoria, dysfunction, or hyperfunction? The response is that we cannot be so naive or presumptuous to pretend we are examining a "natural" phenomenon—indeed, we would be misled if imagining that even untreated and unmedicated schizophrenia is solely a natural disease. Even so, the relevant point for the present analysis is that it should be evident that a subjectivity formed by the temporal and sensory alterations of the self by virtue of psychotic (or other illness) process is inseparable from the subjectivity formed by the temporal and sensory alterations of the self by virtue of taking psychotropic drugs. This hardly exhausts the possibilities for the self as a matter of subjectivity of concern to me here but is useful to bear in mind as an analytic distinction lest these become muddled or conflated.

The thoroughly social and cultural aspects of this problem of experience are vividly evident in the core metaphor underpinning the pharmaceutical self in my ethnographic case of schizophrenia, that is, the pervasive metaphor of "chemical imbalance." To be specific, this metaphor generated in the cultural imaginary is taken up into the subjectivity of diverse actors across the social field of psychiatric treatment. That chemical imbalance is indeed a metaphor is without question: to date there are no blood tests or measurements of brain chemicals that can specify balanced proportions of such chemicals. What reveals it as metaphoric is that there are other ways to describe it, and each way has a rhetorical influence on symbolic experience and social transactions in relation to these representations. Moreover, insofar as the overwhelming majority of patients, doctors, kin, and others fully incorporate and take for granted a "biochemical imbalance" as a suffused element of pharmaceutical and psychiatric ideology, schizophrenia as a form of subjectivity can only be understood as a tightly intertwined kernel of the chemical imbalance that is the disease and the chemical effort to restore balance that is psychopharmacology. The effects of illness and the effects of medication are part of the same cultural phenomenon for us, and our question is, what can we learn of subjectivity and self-processes by examining this contemporary face of schizophrenia in the early twenty-first century? As untroubled a culturally held assumption as the trope of "biochemical imbalance" ostensibly appears, I argue here and elsewhere that this representation not only obviously oversimplifies the neuroscientific basis upon which it draws, but also that it falls flat as an existential and cultural matter of subjectivity.

Now, in what sense is the statement "I have a biochemical imbalance" ideological? It becomes evident as soon as one recognizes that the statement is not grounded in biochemistry but in the pharmaceutical imaginary. The speaker does not understand biochemistry (necessarily) and cannot explain the physiology of imbalance (necessarily). The statement is instead a key symbol, an invocation of an existential state where "biochemical" means it is deeply embedded in the person, and "imbalance" means that one is reeling with instability through everyday life. The fact that "biochemical imbalance" is the default phrase instead of, say, "existential instability" strongly suggests that discourse privileges and is thus formulated by pharmaceutical intervention. And, as we know, the metaphor of biochemical imbalance is not limited in application to schizophrenia but is pervasive across psychiatry and even in everyday life. The social and cultural allure of defining a problem as a biochemical imbalance is also intended to provide a kind of "fault-free" insurance for patients and family alike. The goal is to alleviate the culturally specific personal blame that is often associated with mental illness in North America and Europe, as well as other parts of the world. The objective of a widespread collaborative of psychiatric treatment and family advocacy groups is to reject several decades of psychiatry from the twentieth century that ideologically located psychopathology in family relations, with deficient mothers invariably the culprits. Such views are now widely held not only as offensive by families but also in scientific disrepute in academic psychiatry. Despite the good intentions and popularity of this social movement to reposition the site of psychopathological production, I regard this recent iteration of an enlightenment narrative through appeals to the rationality of medicine and hygiene as largely a failed project. The biomedical account, when invoked as a cultural model, falls short. In eschewing existential and social concerns surrounding the illness, an (unsuccessful) attempt is made to bypass what matters most to people: agency, morality, and kin attachments.

This is so in everyday realities because the clinical gloss for the problem as a "biochemical imbalance" does often not confer sustained relief or alleviation of culpability but instead is invoked as a prelude to the primary clinical tasks of (1) prescribing psychopharmacological agents to alter brain chemistry, and (2) instructing patients on the absolute necessity of taking them as prescribed. Not to do so, patients are told, is to risk recurrence and intensification of psychotic symptoms and rehospitalization. To be sure, the immediacy of suffering and survival are urgent matters for patients and families. However, as an anthropological matter of subjectivity in my analysis, it also remains true that "biochemical imbalance" as the stand-in diagnostic term for laypersons affords little in terms of "the work of culture" (Obeyesekere 1990) in symbolically transforming previous cultural accounts that can re-create personal subjectivity in terms of therapeutic potency or offer a compelling explanatory model of the ailment. Rather than infusing patient subjectivity with therapeutic power tendered by the scientific knowledge of a "biochemical balance," over time patients come to feel existentially and culturally bereft at having been handed an empty sack. Indeed, in my years working ethnographically on this topic, not only is "biochemical imbalance" a dead metaphor that can provide only fleeting and superficial succor, but it also wreaks havoc with the very problems of subjectivity that concern me here.

The metaphor has no staying power because it fails as a cultural process that transforms and re-creates symbolic forms in the minds of people (Obeyesekere 1990). On the contrary, talking about the problem as one of "biochemical imbalance" produces instability with respect to agency and choice, improvement and cure, responsibility and blame, shame and social exclusion. In one respect, one could anthropologically imagine that the clinical vagueness and diffuse scope of the term might do cultural work parallel to that done by other popular terms such as "neurasthenia" (Kleinman 1986), "nervous breakdown," or "*nervios*" (Jenkins 1988). But often this is not how it goes because, unlike these conditions, a "biochemical imbalance" is a brain deficit over which a person has little control and that requires lifelong medication seemingly without possibility of definitive recovery or cure. If this was imbalance in the sense of "I lost my balance," then there could be a medicine that would help one regain one's balance and henceforth stand upright on one's own. In fact, the implicit sense of imbalance is that of a deficiency that is permanent and must be constantly corrected by indefinite reliance on medication.

My ethnographic subjects clamor to know: what can *I* do to get better? How can others help me to be cured? What choice do I have to be or not be psychotic, to take or not take medications, when I could wind up in the hospital (again)? What did I do to myself to bring this on? What have others done to me to cause this? If I have a "biochemical imbalance" that is not my fault or my family's fault, why do I feel such crushing shame and humiliation? Why have I been left behind and abandoned while others go on with their lives?

MATTERS OF PHARMACEUTICAL SELF

I conclude by invoking Arthur Kleinman's (2006) central anthropological question, that is, what is "at stake" for an understanding of suffering framed by the pharmaceutical self and the pharmaceutical imaginary within the social field of psychiatric treatment? To answer this question we must bring ethnographic methods to bear and occupy ourselves simultaneously with two tasks. First is careful theoretical and empirical consideration of desire (Jenkins and Carpenter-Song 2005; Biehl 2005) and open-ended subjunctivity (B. Good 1994) in patient experience. Second is the sociocultural and psychopolitical constitution of psychiatric disorders and their treatment (M. Good 2007).

I have emphasized the importance of mutually informed understanding of institutional forces and the pharmaceutical imaginary, on the one hand, and the experience of actors and the pharmaceutical self, on the other. I have tried to show that the images of chemical imbalance and normality pertain simultaneously to self and imaginary. At the same time, I have attempted to show that the notions of pharmaceutical self and imaginary are relevant to all of us, to the extent we are all pharmaceutical selves, and we are all immersed in the pharmaceutical imaginary. It is in this context that I have focused on a small subgroup, that is, schizophrenia patients, among whom the phenomena of interest are shown to good advantage insofar as they are amplified and intensified in lives and subjectivities. I demonstrated in particular how this is the case with respect to communication about ideology and intimacy of medicated selves, gender identity, and existential dilemmas of unattainable cure and the deficient brain.

Pharmaceutical self and pharmaceutical imaginary are in fact reciprocal sides of actors' subjectivities. The orienting activity of the self both draws on and constitutes the pharmaceutical imaginary, and the creative activity of the pharmaceutical imaginary both institutes and is reformulated through the experience of consumers. When a person is acting as a member of the public, in the institutional dimension, she is engaging the pharmaceutical imaginary. When she is taking the psychotropic medication, in the experiential dimension, she is engaging the pharmaceutical self. Thus these reciprocal sides of subjectivity cannot be reduced to a simple distinction between the levels of individual and of society. Far more than this, they are constituted by the relation between narrative and institutional form, consumer and producer, experience and ideology, existential meaning and political economy.

Elaborating these relationships poses a challenge from which we cannot shy away, and here I have traced the range of the social field of psychiatric treatment in an ethnographic study of subjective experience and psychopharmacological medication. While from a psychiatric point of view the problem is patient noncompliance, from an anthropological perspective the problem is that particular and enduring dimensions of subjectivity—that in the end are matters of desire—are compromised such that they breed dissatisfaction (Jenkins and Carpenter-Song 2005). The irony we are faced with is that roughly a half century after the advent of psychopharmacology, a compelling narrative for treatment satisfaction cannot be maintained among persons living with severe mental illness. Hospitalization and levels of symptomatology have been reduced, but the same existential problems in subjectivity that have always accompanied mental illness remain within the domains of self, agency, identity, social relations, and cultural and community response. Neuroscience and psychopharmacology were to have substantially altered for the better these problems of subjectivity that have historically marked mental illness.

Acknowledgments

The anthropological research upon which this chapter is based was supported by NIMH RO1 Grant MH-60232, awarded to the author as principal investigator, on "Culture, Schizophrenia, and Atypical Antipsychotics." Ethnographic data collection in clinical, home, and community settings was carried out from 1999 to 2004 by a team of researchers including Sarah Adler, Jean Berggren, Elizabeth Carpenter-Song, Jerry Floersch, Liz Ihler, Martha Sajatovic, Dawn Miller, Milton Strauss, and Holly Bowron, the latter of whom I owe the greatest debt of gratitude for data collection and analysis of the "University Clinic" setting, including the notion and description of a "hyper-femme."

Notes

1. This assertion is true even in situations in which people are not taking pharmaceuticals because they have decided against such a course of action or because they lack access to them. The point is that the existence of pharmaceuticals for ingestion on a regular if not routine basis is culturally understood as a means for constituting a "possible self" as formulated by Parish (2008, ix)—to conceptualize the "possible self" as "a venture into life, a way of endowing life with purpose and direction, for form that the human effort to live takes."

2. Psychopharmacology is broadly defined by neuroscientists as "the study of drugs that affect the brain" that can be "used by experts for therapeutic purposes" or can be "misused for nontherapeutic purposes" (Stahl 1996, 332).

3. For some years now, the problem of patients not taking medications regularly (or at all) has also been characterized as the problem of "adherence." A National

Institutes of Health (NIH) symposia series on "Adherence" in September 2009 presented perspectives for the social sciences on this topic, including sociology, economics, health services, and anthropology.

4. Although controversial during the selection process, John Nash is well known for being awarded the Nobel Prize for Economic Sciences for his contributions to game theory. His life and struggle with schizophrenia were the subjects of a book (Nasar 1998) and the Oscar-winning film *A Beautiful Mind* (2001).

5. This definition of self follows a long-standing tradition in psychological anthropology (Hallowell 1955; Csordas 1994). Joseph Dumit (2002) invoked the term "pharmaceutical self" in reference to the situation of having to take "drugs for life," Emily Martin (2006b) has referred to the "pharmaceutical person," and Nicholas Rose (2006) has used the term "neurochemical selves."

6. The term "imaginary" has entered the common vocabulary of the human sciences in large part under the influence of Lacan (1977) from an intrapsychic standpoint and Castoriadis (1987) from a social standpoint. Castoriadis is preeminently concerned with human imagination in society as a creative and instituting power—he flips Marx's materialism and economic determinism on their heads by saying human imaginary is the primary source of human society. On the other hand, he sometimes tends to conflate the imaginary with culture, whereas in my view, the social imaginary derives from *cultural* significations. Lacan's distinction among symbolic, imaginary, and real is useful in some ways, but there is too much emphasis on how the imaginary masks and distorts reality and not enough on the way it creates and produces reality.

Claudia Strauss (2006) has compared different approaches to the imaginary in a way that is useful, though somewhat problematic. She includes Benedict Anderson's (1983) notion of imagined communities as an instance of the imaginary, insofar as people can imagine they are part of the same community without sharing a geolocation. For present purposes, this might be useful in terms of asking how different national psychiatries do or don't conceive of themselves as a single professional community. Strauss also examines Charles Taylor's (2004) definition of "social imaginaries" as the ways we imagine our society, which is for Strauss equivalent to the ways we conceptualize our society and actually has little to do with imagination as such. From the standpoint of psychological anthropology, it is revealing that she rejects Castoriadis (1987) while acknowledging that his notion corresponds to that of ethos and endorses Taylor because his notion corresponds to her preferred concern with cultural models.

For purposes of the present argument I considered using the term "pharmaceutical ethos" in parallel to my earlier discussion of "political ethos" (Jenkins 1991), but the notion as it comes from Bateson is predominantly concerned with sentiment, and I needed something broader. The term "culture" is too broad, as my concern here is with the subjective and creative dimension of culture, and the notion of an imaginary suits this purpose. In related work Marcus (1995) has used the term "technoscientific imaginaries" and Mary-Jo Good (2007) has discussed the "medical imaginary."

7. A related but slightly different stance is elaborated by Mary-Jo Good (2001, 2007), who places subjective experience on one side and biomedicine along with its associated institutions on the other, bridging them by means of concepts including medical imaginary, biotechnical embrace, political economy of hope, and clinical narrative in the context of her remarkable interpretive study of oncology in the United States.

8. Considerable fanfare accompanied both the promotion of the drug in the United States and the opening of the University Clinic. An issue of *Time* magazine published in 1992 featured a cover story and photos of patients treated at this site (Wallis and Willwerth 1992).

9. My ethnographic case draws from a social situation in which access to psychopharmaceuticals was possible. Given the suffering of the persons we have worked with, I am not comfortable referring to them as "privileged elites" as members of the American middle class with (albeit limited) "access" to health services. The services they receive are not commensurate with their needs but instead are compromised by economic and political constriction. Still, as persons who have received (at the time) so-called cutting-edge medications, they are not representative of the United States, whose health care system has appalling disparities of care. For the vast majority of the world population, the problem is one of abysmal neglect and a lack of access to treatment among the poor.

10. Elsewhere I have argued (Jenkins 2004), following Harry Stack Sullivan (1962), that schizophrenia is best understood as a peculiarity of situation.