MODERNITY, SUFFERING AND PSYCHOPATHOLOGY

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OUTLINE

Modernity, Suffering and Psychopathology

OUTLINING OUR PERSPECTIVE.

• Suffering, distress and pain experienced by persons, families and groups today, are largely linked to the conditions of life associated with modernity.

• We are concerned with the ways in which a wide range of suffering, distress and illness comes to be identified, in the scientific and clinical literature, as diseases characteristic of modernity.

• We have two primary goals
  – study the scientific process through which major psychosocial problems come to be defined either as psycho-pathology or socio-pathology;
  – document the impact of the lay systems of knowledge and practices on the interpretation of suffering and on the development of coping strategies.

• We intend to move beyond old territorialisms that foster opposition and endless debates between disciplinary postures, and build on the co-operative work jointly undertaken by biomedical experts and social scientists and existing partnerships between professionals, clinicians and community-based practitioners in the mental illness-mental health domains.

INTERROGATING SCIENCES AND MODERNITIES

• Science is a key characteristic of modernity.

• Medicalization and psychiatrization of emotional and social issues is increasing.

• Transdisciplinarity in the practice of contemporary health sciences has developed in a number of fields but fragmentation of knowledge is still pervasive. This is especially true in the process of structuring mental health services.

• Community-based lay knowledge hold a greater chance to match the needs and actual problems as experienced by individuals and groups.

A BLUEPRINT FOR STRUCTURING THE HEALTH INSTITUTES

• Creating a structural linkage between the researchers and the practice milieu is of key importance for maximising the operationalization of research results and to connect the research milieu with the intervention and thus provoke new questions, necessarily interdisciplinary.

• Homogenising theories, methods and research instruments may result in monolithic, rigid research organisational structures.

• Health Institutes should be constituted as dynamic "spaces" where we could create, promote, maintain and cultivate heterogeneity in the production of knowledge. This should facilitate the emergence and on interaction of creative tensions, favouring the constant questioning of the foundations of scientific culture instead of tending to self-confirmation.

• We think that a veritable integration is not made at the level of grand structures, but instead beginning with experiences first of all within the boundaries and framework of teams and meetings which permit researchers to broaden their specific field.

• The conception of Health Institutes must thus pay particular attention to questions of integration in two principal fields: (1) the setting up of medium and long term programs of specific teams organised around research themes or perspectives; (2) the development of
transversal disciplinary mechanisms of collaboration for encouraging the co-fertilisation of activities within the ensemble of programs.

• Evaluation of integration should focus not only on short term productivity but also on partnership processes.
• Diffusion of research results should value the transfer to professionals, clinicians, administrators.
• Ethical questions the following should be explored:
  • the ethical implications of partnership: the necessary conditions for an equal-complementary partnership;
  • the ethical implications inherent in considerations for collective rights;
  • the ethical implications of the diffusion of the research results.
EXECUTIVE SUMMARY

Modernity, Suffering and Psychopathology

The elements that constitute modernity are heterogeneous. Among many factors, a strong reliance on science has been —and still is— the totem of Western modernity. The rise and dominance of new forms of science (biology, medicine, psychiatry, anthropology, psychology, and sociology) have led to the pre-eminence of certain models in the ways people's suffering, pain and distress are commonly constructed by researchers and clinicians.

We are concerned with the ways in which a wide range of suffering, distress and illness comes to be identified in the scientific and clinical literature, as diseases characteristic of modernity. Why, for instance, does epidemiological research conclude that Attention Deficit Disorder (ADD) is on the rise in North America, while in other countries like Japan, it is a seldom recognised condition? Other mental health problems: self-inflicted injuries and self-destructive behaviours; trauma-related disorders; dissociative disorders; drug addiction, etc. that are often considered to emerge as a direct result of our contemporary collective ways of life and value system raise similar questions.

Our first goal is to study the scientific process through which major psychosocial problems come to be defined either as psycho-pathology or socio-pathology by bio-medical and health professionals as well as by social scientists. Our second goal is to examine and better understand the systems of knowledge and practices developed by individuals, families and communities in order to manage, cope with, assign meaning to, and interpret mental health problems.

We think it is mandatory to continue building an interdisciplinary framework —between medicine and psychiatry, medical anthropology, the history of medicine and sociology of science— in order to investigate how prevalent scientific categories used by bio-medical and health social scientists are constructed. Concurrently, it is essential to assess local systems of knowledge in mental health and mental illness that have been developed by communities, organisations and groups. Time has come for combining contributions from the biological and the social sciences as well as for merging both "expert" and "lay" knowledge, professional ideas and practices as well as alternative popular knowledge.

We propose to rely on a three-sided analytical model consisting of: (1) an ethnographic approach to study diagnostic categories, as well as theories and ways of thinking which prevail in contemporary psychiatry and health social sciences; (2) a culturally-grounded study of the local ways (popular idioms of distress, explanatory models, semiologies, systems of meaning) through which suffering, pain and illness are expressed, interpreted, reacted to, and managed on a daily basis by individuals, families and communities; and (3) a perspective inspired by the social determinants’ approach used to understand the relationships between modern conditions of life, contemporary family patterns and social organisation, new cultural values and the prevalent disease categories defined by researchers and currently used by health professionals.
This triangular analytical model should permit to produce relevant research results which will help to: (a) lay out guidelines for addressing mental health policy issues and designing innovative models of practice at local, regional and national levels; (b) facilitate the development of socially relevant and culturally sensitive mental health services by building on both professional science and lay knowledge and practices developed by communities; (c) generate proposals for reorienting the training of mental health researchers and health workers within the framework of a genuine "bio-psycho-social-cultural" psychiatry; and (d) make acquired knowledge available to policy makers, planners, administrators and health providers in the public, private and community sectors. All this should lead to improve the present situation of mental health patients across Canada and to alleviate the burden of illness put on the shoulders of patients’ families and society.

For a few decades scientists have steadily argued against all sorts of reductionistic theories that try to model the study of persons and human cultures to an animal model. They have reminded their colleagues that the problem of signification (meaning) is tied to human beings’ self-definition and that the practice of human sciences thus necessitates the inclusion of semiology and hermeneutics. The benefits of transdisciplinary co-operation appear convincing within areas such as contemporary genetics, evolutionary biology and neurology of regulatory processes, and contribute both to consolidate the biological pole of contemporary social sciences and to open biology to the impact of the social and historical context. We have entered an era dominated by biology that links the brain-mind complex with environment and history, both at collective and individual levels. Biology is thus seen as dynamic, interpersonal, historical and evolutionary. Eisenberg (1995). Both types of research have contributed to undermine the viability of any dichotomy between biology and social environment in the modeling of child's personality and psychological characteristics (Brown, 1997).

Our research group does not consider it necessary to create an Institute which, as a mandate, would address the questions of our concern, even if these questions appear to be of major importance in the planning of multi-sectorial interventions in health, and more specifically, in mental health. If an Institute for "mental health" or one in the area of the "determinants of health" were to be put in place, the perspectives proposed herein could be effectively incorporated into and constituted as a nucleus from which the research process could eventually diffuse towards other Health Institutes.

Our reflections within the team, our personal experience of collaboration within diverse research groups, and an analysis of existing interdisciplinary networks and partnerships have led us to formulate several recommendations which apply both specifically to our field of interest as well as to a more general range. Here are a series of ideas which may help structuring the CIHR:

- The idea of creating a structural linkage between the researchers and the practice milieu is of key importance not only for the purpose of maximising the operationalization of research results, but also and above all, in order to connect the research milieu with the complexities of intervention and thus provoke new questions, necessarily interdisciplinary.
- The integration of multiple disciplines and actors across networks and organisations is not, however, without risk. We may anticipate the effects of standardisation, which would
eventually lead to the homogenisation of theories, methods and research instruments, resulting in monolithic, rigid research organisational structures.

- Our research group is inclined towards an approach in which Health Institutes should be constituted as dynamic "spaces" where we could create, promote, maintain and cultivate heterogeneity in the production of knowledge. This could facilitate the emergence and parallel development and interaction of creative tensions, favouring the constant questioning of the foundations of scientific culture instead of tending to self-confirmation.

- In creating Health Institutes, it seems preferable not to arbitrarily multiply the number of Institutes according to a given number of disease categories and age groups, but to give them, an identity of their own with relatively permeable boundaries, consolidating existing alliances and networking researchers who are already engaged in research domains and themes in which they already excel. Health institutes should be conceived from the bottom-up, as dynamic spaces that favour dialogue between current thinking, fostering heterogeneity and the co-existence of diverse disciplinary approaches.
Introduction: Outlining our perspective

In this position paper, we focus on the complex pathways that connect the key characteristics of contemporary Western societies (such as Canada) and dominant reconfigurations of psycho- and socio-pathology. We consider that suffering, distress and pain experienced by persons, families and groups today, are largely linked to the conditions of life associated with modernity. In making this connection, we do not start out from the usual —and often trivial — assumption that modernity leads to a specific set of "pathologies". Rather, we are concerned primarily with the ways in which a wide range of suffering, distress and illness comes to be identified, in the scientific and clinical literature, as diseases characteristic of modernity. Why, for instance, does epidemiological research conclude that Attention Deficit Disorder (ADD) is on the rise in North America, while in other countries like Japan, it is a seldom recognised condition? Other mental health problems: self-inflicted injuries and self-destructive behaviours; trauma-related disorders; dissociative disorders; drug addiction, etc. that are often considered to emerge as a direct result of our contemporary collective ways of life and value system raise similar questions.

Our first of two primary goals is to study the scientific process (concepts, theories, methods, tools, etc.) through which major psychosocial problems (including suffering and pain) come to be defined either as psycho-pathology or socio-pathology by bio-medical and health professionals as well as by social scientists. There is no reason to assume that the conditions associated with modernity have intensified particular forms of distress and propagated new models to express and experience diverse mental health problems. The increasing prevalence of certain problems such as Post-traumatic stress disorder (PTSD), may simply reflect the high sensitivity and specificity of existing diagnostic instruments and/or the rise of interpretive theories to identify conditions that were previously undetected. In this case, these findings would represent "discoveries" rather than "products" of modernity. Alternatively, the "new" mental health problems (or an increase in their magnitude) may actually represent epi-phenomena of modernity rather than discoveries. That is to say: the dramatic increase in certain diagnostic categories may actually reflect the emergence of a new (modern) idiom of distress used by people to express their emotional problems.

Our second goal is to examine and better understand the systems of knowledge and practices developed by individuals, families and communities in order to manage, cope with, assign meaning to, and interpret mental health problems. In developed countries such as Canada, one finds progressive mental health care policies such as partnership between health care services and community resources, de-institutionalisation of care, attention to the patients’ rights. In reality, planners, administrators, health providers and local community groups do not always know how to implement community-oriented policies because there is a lack of adequate information that would facilitate the establishment of a fair partnership between the official services and the community resources, or there is insufficient knowledge about how families and communities actually deal, on a daily basis, with mental health problems. In Canada, there exists in that area of research lacunae in relevant knowledge, the filling of which could help developing bridges between communities, patients’ groups and mental health workers, and building alternative models of prevention, care and rehabilitation. In particular, mental health services do
not yet sufficiently take advantage of local lay knowledge and often do not consider the potential
of non-professional (non-formal) resources for the development of mental health interventions.

We propose to rely on a three-sided analytical model consisting of:

1) an ethnographic approach to study diagnostic categories, as well as theories and ways of
thinking which prevail in contemporary psychiatry and health social sciences;

2) a culturally-grounded study of the local ways (popular idioms of distress, explanatory models,
semiotics, systems of meaning) through which suffering, pain and illness are expressed,
interpreted, reacted to, and managed on a daily basis by individuals, families and
communities; and

3) a perspective inspired by the social determinants’ approach used to understand the
relationships between modern conditions of life, contemporary family patterns and social
organisation, new cultural values and the prevalent disease categories defined by researchers
and currently used by health professionals.

This triangular analytical model should permit to produce relevant research results which will
help to: (a) lay out guidelines for addressing mental health policy issues and designing innovative
models of practice at local, regional and national levels; (b) facilitate the development of socially
relevant and culturally sensitive mental health services by building on both professional science
and lay knowledge and practices developed by communities; (c) generate proposals for
reorienting the training of mental health researchers and health workers within the framework of a
genuine "bio-psycho-social-cultural" psychiatry; and (d) make acquired knowledge available to
policy makers, planners, administrators and health providers in the public, private and community
sectors. All this should lead to improve the present situation of mental health patients across
Canada and to alleviate the burden of illness put on the shoulders of patients’ families and
society.

We intend to move beyond old territorialisms that foster opposition and endless debates
between disciplinary postures, and build on the co-operative work jointly undertaken by
biomedical experts and social scientists in the study of the mental health-disease continuum; and
existing partnerships between professionals, clinicians and community-based practitioners in the
mental illness-mental health domains.

It is mandatory to continue building an interdisciplinary framework —between medicine and
psychiatry, medical anthropology, the history of medicine and sociology of science— in order to
investigate how prevalent scientific categories used by bio-medical and health social scientists are
constructed. Concurrently, it is essential to assess local systems of knowledge in mental health
and mental illness that have been developed by communities, organisations and groups. Time has
come for combining contributions from the biological and the social sciences as well as for
merging both "expert" and "lay" knowledge, professional ideas and practices as well as alternative
popular knowledge. In short, we are asking for the reinsertion of the imagination in the
advancement of science, an imagination to be guided by scholars, researchers and professionals as well as by lay popular knowledge about psycho- and socio-pathology.

We have divided our position paper into three parts:

Part 1. Interrogating sciences and modernities
   a) Science as a key characteristic of modernity
   b) Transdisciplinarity in the practice of contemporary science
   c) Medicalization and psychiatrization of social and emotional issues
   d) Community-based lay knowledge

Part 2. Enlarging clinical perspectives in mental health
   a) Leading trends in professional responses to psychological distress
   b) Alternative resources and the empowerment movement
   c) Case studies

Part 3. A blueprint for structuring the Health Institutes
   a) Roles of Health Institutes: opening new perspectives and avoiding possible pitfalls.
   b) Integration: towards the evaluation process
   c) Diffusion of research results
   d) The ethics at the heart of research questions and processes
PART 1: INTERROGATING SCIENCES AND MODERNITIES

The elements that constitute modernity are heterogeneous. Among many factors, a strong reliance on science has been—and still is—the totem of Western modernity. The rise and dominance of new forms of science (biology, medicine, psychiatry, anthropology, psychology, and sociology) have led to the pre-eminence of certain models in the ways people's suffering, pain and distress are commonly constructed by researchers and clinicians.

a) Science as a key characteristic of modernity

Modernity is usually associated with secularisation, the idea of progress, the rise of "science" as we know it today, and the systematisation of knowledge in general (Max Weber referred to the trajectory of modern thought as the "disenchantment of the world."). We take the position that although these trends characterise modernity everywhere, there are, nevertheless, a number of "modernities." The institutional changes and the transformation of knowledge and practices over the past century and a half in Japan, for example (and more recently in other parts of south-east Asia, South Africa, and certain regions of Latin America), have taken place in significantly different social and cultural milieus and have led to different expressions of modernity. An embrace of the idea of ‘progress’ and its effects on the practices of contemporary medical sciences is evident throughout, while subject to varying arguments and discussion. In this respect, modern medical science is responsible for the creation of taxonomies of disease that are assumed universal, value-free and autonomous from history and culture.

Medical historians and anthropologists argue, however, that both the subjective experience and subsequent recognition, labelling and treatment of distress and disease are socially and culturally produced (Young 1995; Lock 1993; Good 1994; Kleinman 1988; Foucault 1966). These researchers do not deny the materiality of the body nor the reality of suffering, but argue that values are inevitably created within a context of medical knowledge that in turn affects the way in which the life-worlds of patients are created and transformed. In other words, following Hacking (1995), "styles of reasoning" are integral to medical discourse, and these styles may vary in important ways according to different social and cultural settings. One of our principal aims is to invite to investigate such "styles of reasoning" with the intent of formulating the groundwork for a critical epistemology of contemporary medical science.

b) Transdisciplinarity in the practice of contemporary health sciences.

Linkages and connections between the biomedical and the social sciences have begun to provide new conceptual frameworks for assessing human phenomena and particularly health problems. In recent years, the biological revolution has reshaped the issue of the mind-body dualism so profoundly, that the borders between the disciplines of biology, anthropology, sociology and psychology are dissolving and new forms of transdisciplinary conceptual frames are beginning to emerge. The benefits of transdisciplinary co-operation appear convincing within areas such as contemporary genetics, evolutionary biology and neurology of regulatory processes, and contribute both to consolidate the biological pole of contemporary social sciences (particularly anthropology) and to open biology to the impact of the social and historical context.
However, the time for celebrating the achievements of transdisciplinary collaboration has not yet come. There is still much fragmentation in the production of knowledge and transdisciplinarity remains as a potential proposition, far from being implemented in reality.

**Biology as historical script**

We have entered an era dominated by biology that links the brain-mind complex with environment and history, both at collective and individual levels. The schism introduced in modern biology by Descartes’ dualism of mind and brain has been thrown to the wind: new ways to perceive the body, the mind, the emotions and the health-disease complex are emerging. The mechanistic philosophy which used to see the body as a machine is visibly dead (or dying): contemporary (neuro) biology is based on the unbreakable relationship between the person’s life experience and the modelling of his/her biological memory, the historical shaping of individual neurological architecture, the coding of neural networks along the history of persons, and the bio-psycho-social dynamics of higher consciousness (Dongier 1996). Biology is thus seen as dynamic, interpersonal, historical and evolutionary. Eisenberg (1977) translates the new ethos well when he talks about "the social construction of the human brain", equally acknowledged in Hartmann’s statement that "social change alters brain cells." (1992: 1137).

(See APPENDIX 1: Beyond the brain-mind divide).

**Persons as social beings**

For over half a century, psychologists and anthropologists have observed parents and children in different settings, with renewed attention given to the "nurture assumption". Results of many studies consistently demonstrate, for instance, that parents represent a very important modelling force in the child's environment; it is, nevertheless, still difficult to pinpoint the exact effects parents have on their children, even in cases of most extreme experiences such as sexual abuse, neglect, rape, crime, etc. Developmental biologists, behavioural geneticists and evolutionary psychologists have consistently expanded our understanding of the genetic, neurological and psychological processes that are initiated or intensified by changes in the social environment. Both types of research have contributed to undermine the viability of any dichotomy between biology and social environment in the modelling of child's personality and psychological characteristics.

(See APPENDIX 2: Assessing the influence of the family environment).

**Humans as producers of language and meaning.**

Human beings build diverse and sophisticated cultures. Contrary to non-human primates, human beings are not only equipped to produce language: they actually speak one (or many) language(s) and assign meanings, generating multiple narratives and stories on the basis of the grammar(s) they master. Human groups invent, besides languages, myths and cosmologies which provide blueprints to interpret the world in which they live, ideologies, belief systems and moral norms which tend to vary (probably around a universal core) from society to society as well as
particular social rules (family patterns, inter-groups relations) which serve as a ground for constructing the ways "to be a person" in a given society. All these ingredients compose what anthropologists name "a culture". Our modernity is constituted, as any other culture, as the ensemble of narratives, stories and experiences that people generate on the basis of the values, norms, symbols and myths which are shaping the contemporary world.

In their study of narratives and experiences produced by individuals, a large number of social scientists (particularly among medical anthropologists and ethno-psychiatrists) have recently adopted an interpretative and phenomenological stance which borrows much from semiology, literary criticism and European existential phenomenology. Among others, Merleau-Ponty was one of the leaders, in the industrial world of the post-war era, of a movement to renew philosophy—initiated by Husserl with phenomenology—that involved a new relationship between body and mind, a topics that had been left unchallenged since Descartes. Merleau-Ponty's phenomenology does not envision the body-mind as a duality, nor as a dichotomy, but rather as the translation (expression) of a "double nature": corporality comes back here in the form of a vehicle, leaving room for meaningful experiences that persons are able both to live and to put in words. Discourses, narratives and complaints that persons phrase in order to express their emotions are inevitably shaped by the idioms provided by the culture(s) to which they belong.

For a few decades scientists have steadily argued against all sorts of reductionistic theories that try to model the study of persons and human cultures to an animal model. They have reminded their colleagues that the problem of signification (meaning) is tied to human beings’ self-definition and that the practice of human sciences thus necessitates the inclusion of semiology and hermeneutics. Human beings are ontological beings who cannot avoid interpreting themselves, others and the world. "Human beings are self-interpreting animals", wrote Montreal-philosopher Charles Taylor (1985: 45), echoing a central theme in contemporary social sciences.

We firmly believe it is important to examine specific interrelations between collective meaning systems, local idioms of distress and individual discourses of pain, that is, to know among other things, how people experience and express emotions and how they connect somatic symptoms with their inner psychological states. This requires a critical review of past and current hypotheses of how symptoms are produced, constructed and experienced by different peoples or cultures under varying social, material, political, and psychological conditions.

To date, research on idioms of distress has emphasised the ways such idioms are shaped by cultural taxonomies, explanatory models and popular semiologies, at times neglecting the social context in which the person lives and the person’s spatial position—in many cases—at the boundaries between multiple cultural worlds. Anthropologically-minded psychiatrists and psychologists also favour elements within a person that can be connected with categories such as 'symptom schemes', 'illness schemes' and 'idioms of distress'.

(See APPENDIX 3: The interpretive turn in medical social sciences).
c) Medicalization and psychiatrization of emotional and social issues.

Under the influence of modernisation and globalisation of the economy, current trends in medicine, psychiatry and health social sciences tend to reinforce the perception that one's life and health status could be improved through the increased availability of medical technologies. Availability of drugs and pharmaceuticals are seen to be a visible and tangible proof of increased well-being. This image is deeply rooted in the biomedical model of health, which some authors have identified as "commodified health" (Nichter, 1989). The export of the Western model of health care, presenting health as a commodity, plays an important role in reinforcing biological reductionism and medicalising emotional and social issues on a global scale.

However, medicalisation is not solely a product of modernity, but is largely influenced by: (a) the appearance of new classification and medical devices for diagnosis (e.g. DSM-IV) and treatment (e.g. the discovery of new molecules and psychotropic drugs); (b) the "health transition" characterised by increased occurrence of mental disorders resulting in a growing burden of mental illness, along with the re-emergence of "old" diseases (tuberculosis, cholera, etc.) and emergence of relatively "new" pathologies (e.g. AIDS); and finally by (c) age and gender differentials, a dual class structure, increasing social inequalities, and the unfolding multiplicity of ethnic groups and cultures. These factors all contribute increasingly to the emergence of very diverse health and social needs, demands and expectations, and clearly influence access to and use of medical technologies.

In short, globalisation and the corporatisation of the health care industry in its various organisational forms (de-institutionalisation, privatisation, evidence-based medicine, etc.) and the ongoing reform of the health sector, have radically altered conventional forms of medico-psychiatric knowledge and practice. In the area of mental health, Western countries are progressively moving toward the configuration of vast and highly complex health care "supermarkets" which mobilise significant capital investment and create a ready-made market of medical responses. Ongoing health sector reform seems, in that context, unavoidable and irreversible, subordinated both to the global economic and financial imperatives and to the endogenous development of contemporary scientific medicine. The managerial class, including health economists and market experts, investors and shareholders, have all assumed a prominent role in defining the mediating functions of the State, the financial strategies to be adopted for the reformulation of the health sector and, most importantly, the structure and composition of an increasingly medicalised clinical services package. This is reduplicated in the medicalisation of "public health" services which are considered essential (e.g. environmental protection, food control, quality of the water supply, etc.).

As society becomes increasingly medicalised, biomedical constructions of risk have begun to infiltrate traditional cultural constructions. In parallel, many social problems are examined under the aegis of biology and medicine by "experts" who read these issues primarily as abnormal disease conditions. The medicalisation of emotions and of social issues follows the path opened earlier by the medicalisation of reproduction (e.g. pregnancy and birth) and of many other problem-areas such as infectious diseases (e.g. tuberculosis, AIDS, malaria, etc.).
Conventional epidemiology often explains infection by assigning primary importance to inter-individual variations in risk and exposure and also by "blaming the victim": late attendance, poor compliance with medical treatment, superstition, lack of education, poor lifestyle, etc. Rarely does the analysis focus on the underlying social and historical forces that influence behavioural choices or on the effects of modernity or social and economic inequalities or the constraints in resource allocation enforced by international financial institutions or government corruption, which are assigned an implicit marginal value.

The "well-being complex" has been installed as a key symbol in Western culture: techniques of all sorts and a rhetoric of persuasion (e.g. from body massage to religious enrolment) are used to discipline the body and regulate the person. In certain contexts, the therapist-patient relationship has also been transformed into a continuous and long-term relationship for body management (clinical surveillance or regular check-ups to verify the results of treatment), giving rise to a growing research industry which has medicalised social and psychological conditions. All this reinforces people’s dependence on "experts" of various vintages and on the multiplication of medical techniques geared to re-establish the balance and repair the body-mind complex. Such heavy reliance on healing techniques for the body and mind reflects one of the central concerns of our era: the achievement of a "perfect health" status. The pharmaceutical industry is spending billions on research into treatments for such problems as fat and excessive weight, baldness, wrinkles and acne, depression and sexual impotence, leading to a "lifestyles’ drug market."

Medicine’s role has been, in the past, to heal the human body from sickness. In our age, medical technologies aim to do much more: modern medicine is therapy and total recovery, organ transplants, cosmetics and self-help rehabilitation. While modern medical technologies can effectively cure the sick body, it also claims to alter the body and mind in such ways as to improve performance, preserve youth, achieve immortality, reduce or eliminate gender differentials, and eventually reach the utopia of "perfect health" (Pedersen, 1995). Based on these premises, prevention will become a massive technological enterprise, possibly involving sophisticated and costly genetic prediction procedures, reinforcing dependence on scientific technologies but also creating more ethical dilemmas and growing contradictions.

(See APPENDIX 4: A critical epistemology in health research)

d) Community-based lay knowledge.

In order to be effective, workable and comprehensive, appropriate collective responses to people’s suffering and distress have to be based on an approach that includes social and cultural traditions as well as local systems of knowledge. We know that indicators (markers, signs, symptoms) used by people for identifying actual mental health problems as well as lay explanatory systems do not exist as explicitly conceptualised bodies of knowledge that can be easily reconstituted and transformed into a sort of textbook of "popular psychopathology". Such knowledge is rather enacted and manifested in actual behaviours of people (patients, families, community groups) when they are faced with concrete cases.
We think important to build on a research paradigm that considers at least the following three factors: (a) the local representations, attitudes and practices developed to see the world, to be a person, to conduct a valuable life, to organise time and space, and to relate to material progress; (b) the indigenous values related to the use of natural resources, to the body-mind and to the spiritual aspects of human life; and (c) the knowledge regarding the natural, physical, social as well as the psychological, spiritual and cultural dimensions of the world in which individuals and groups have to live.

People are not passive actors when they face situations of distress, trauma and dislocation. Individuals and groups often generate various forms of socially-based and culturally-grounded solutions in which families and communities take active part. People have learned that responses provided by health professionals and "experts" cannot suffice to alleviate their problems. Sustainable solutions require alliances between locally based interventions and professional actions and, more globally, true integration between the values and practices of people and formal professional practices. Locally produced, collective healing responses hold a greater chance to match the needs and actual problems as experienced by individuals and groups. As a note of caution, however, while we acknowledge the relevance of such community-based lay knowledge, we should also recognise its own constraints and limitations.

(See APPENDIX 5: The social and individual production of suffering)
PART 2: FROM CONCEPTUAL FRAMES TO CLINICAL PRACTICES IN MENTAL HEALTH

If mental diseases cannot be discussed in isolation from the biological approach that is ascendant in psychiatry (Andreasen, 1997), our conceptualisation of them is increasingly reduced to an individual focus which highlights the importance of genetic and early development determinants and downplays the role of social and political factors. Current clinical practices accurately reflect this shifting conceptual framework and the dominance of the medical model in the configuration of mental health services.

To demonstrate the need for a hybridisation of medical and social sciences models in the elaboration of new intervention perspectives, we will first briefly survey some of the changes that psychiatric clinical practices have undergone in the last decades and the divergent community responses to these changes. We will then propose a few areas of research where an integration of interdisciplinary perspectives could significantly modify the focus of service delivery, prevention and rehabilitation programs.

a) Leading trends in professional responses to psychological distress

In this section we limit ourselves to an overview of three elements which characterize the universe of mental health professionals, namely the psychopharmacology revolution, the psychiatric diagnosis and classifications, and the psycho-education philosophy.

The psychopharmacology revolution

Clinical practices in psychiatry have been radically transformed by the development of psychopharmacology. Breaking through the traditional stigma of mental illness, the discovery of the new SSRI (Selective Serotonin Reuptake Inhibitors) has transformed the public discourse on psychotropic medication, incorporating for example, the "Prozac miracle" into jokes and daily references to well being. The increasing use of methylphenidate by university students to face the challenges of academic success represents a shift that can also be understood as a sign of the strength of prevailing myths about psychopharmacology. Seemingly much more cost-effective than other approaches in an over-burdened health care system, use of medication is also supported by the enormous corporate enterprises of the pharmacological industry and a powerful lobby.

On the other hand, the "myth of stabilisation of mental disorders" through medication alone, does not appear to be a final solution and often, the results shown by patients are undesirable and frustrating. In spite of psychotropic medication, there are still side-effects, still the "negative" symptoms, still the suffering, but this time distress has been suppressed or silenced, in such a way that it does not disturb the social immediate environment.

Psychiatric diagnosis and classifications

The rise of biological psychiatry is parallel to the adoption of a nosology aimed to be of a universal application, which incorporates operational, exclusion and inclusion criteria,
emphasising the imperative of reliability of diagnosis. The Diagnostic Statistical Manual (DSM-
version IV) and the International Classification of Diseases (ICD-version 10) are essentially
categorical approaches to diagnosis, permitting a research-oriented operationalization of different
disorders to which correspond different psycho-pharmacological approaches. Within this context,
the multi-axial system corresponds to the intent to incorporate the diverse aspects of patient’s
existence in the psychiatric evaluation and acknowledges their importance in the clinical context
(Klerman 1984). It provides the basis for clinical decision: that is to say, for prescribing,
monitoring and evaluating treatment plans in individual cases. Such a multi-axial system remains,
however, very crude and quite incomplete for assessing the personal, social and cultural
dimensions evoked in the first section of this paper.

However, 15 years after the publication of DSM-III, Andreasen, one of the leading
figures in contemporary psychiatric research, has warned the psychiatric professions that the
development of diagnostic criteria holds both advantages and disadvantages. She argued
that "…they [the DSMs] provide an oversimplified and incomplete view of the clinical
picture, discourage clinical sensitivity to individual patients and comprehensive history
taking, lead students and even clinicians that ‘knowing the criteria is enough’, reify an
agreement that was only intended to be provisional, and discourage creative and innovative
thinking about the psychological and neural mechanisms of schizophrenia." (Andreasen,
1997: 108). Her claim to see things within a broader context was well received. She
pointed out to the faulty assumptions on which the DSM is based, in what she calls "the
Ahistorical Fallacy" in thinking that a proposition is true because: (a) it is what the
"experts" are teaching; (b) it is the most recent fashion to be put forth; and (c) the naïve
notion that "if information increases, knowledge increases" (1994: 1405).

In addition, there is no such thing as a culturally neutral classification of disorders and the
limitations of the nosography become particularly apparent in the pluralistic cultural context of
modern Western societies such as Canada. "Under the circumstances, — writes the Indian
psychiatrist Ravi Kapur —, one would take into account the various kinds of bias which enter
into different models of psychiatric illness, rather than enforce a conceptual uniformity. Such an
exercise would start with the examination of the classificatory process itself." (Kapur, 1987).

Teaching to detect and treat disorder: psycho-education for patients and families.

The interest in biological factors in psychiatry has relocated the focus of therapies: mental
health workers have shifted from a psychoanalytical framework to an educational perspective
which emphasises the necessity to inform and educate patients and families about the
manifestations, course and management of the disease. The importance of psycho-educative
perspective in contemporary psychiatry permeates both prevention and treatment/rehabilitation
programs.

On the side of prevention, the postulate is that early detection and referral to specialised
care will facilitate treatment and are associated with a better prognosis for the identified patients.
In the area of schizophrenia, for example, several researchers are insisting on an early
identification of potential patients long before onset, on the basis of "vulnerability markers."
Some of them propose for these potential patients, low-dosed neuroleptic medication while others emphasise psycho-educative intervention. Ethical issues associated with early detection are nevertheless numerous, including the risk of stigmatisation due to identification of false positive individuals, often creating a sense of demoralisation and inducing a self-stigmatising process (McGlasan, 1996). These issues are still poorly understood and illustrate the necessity to better grasp the complex set of reactions elicted by symptoms and diagnosis in particular social and cultural environments.

On the side of treatment and rehabilitation, psycho-educative approaches build on the premises that teaching the patient about his/her illness will convince him/her to adhere to medical norms of treatment and that one has to target patients’ skills to allow them to adjust socially and emotionally and to be functional in society. Relying in "needs assessment" scales for planning mental health services follows a parallel logic. However, while these scales were initially developed to support global administrative decisions and fund allocation, they tend to be used as an instrument for case management and individual treatment plans.

There is no doubt that such an approach has permitted to transform the clinical services in psychiatry and to disseminate current knowledge to the users and their family. As such, it is an important accomplishment. On the other hand, the notions of insight, compliance and information, remain formulated from an unidirectional, professional perspective at the expense of a closer attention to the personal and social significance of psychiatric symptoms; they also ignore the very meaning of social integration from the standpoint of persons and communities (Kirmayer and Corin 1998; Corin and Lauzon 1992). Community groups have denounced the standardisation of this approach as limiting the capacity of patients and families to reconstruct meaning and to invent creative strategies that may be considered marginal, including the right to deny illness and to choose non-medical treatment alternatives.

b) Alternative resources and the empowerment movement.

Parallel to the development of new psychiatry by scientists and health institutions, community resources for persons suffering from mental health problems have multiplied. Created first as a critical reaction toward the perceived hegemony of the official system, over time they have gained recognition. Institutions like the National Institute for Health have underlined the importance of strong representation for groups such as patients and their families, who are directly involved in mental health problems. In some Canadian provinces alternative resources, community groups and non-medical practitioners have been actively involved in the discussion surrounding mental health services planning and evaluation. They have gained political recognition and are now central players in the mental health care system. They introduce non-medical types of knowledge and at the same time create alternative healing spaces, both in opposition to and complementary to the medical and psychiatric systems. They permit and actualise a resistance to the medicalisation of daily life, reinvesting patients, families and their communities with a sense of control over their own lives. In spite of their importance, very little research has been done on their role in the mental health care system's provision of service.
c) Case studies

In order to illustrate the rapid transformation in the field of psychiatry and the effect of the polarisation of knowledge around a predominantly biomedical model we will present vignettes in three different psycho-social pathologies: Attention Deficit Hyperactivity Disorder, Youth and Violence, and Trauma and PTSD.

Attention Deficit Hyperactivity Disorder (ADHD)

Attention Deficit Hyperactivity Disorder, (ADHD), has become one of the most common psychiatric disorders in school-aged children and accounts for the majority of all child referrals to mental health services. It has been estimated that the prevalence of ADHD is between 5-10% and that it is closely associated with social, emotional and academic problems (Schneider & Tan, 1997). ADHD is more common in males than in females and is characterised by inattentiveness, impulsiveness and hyperactivity. The latter defining features of ADHD can be detected at a very early age but the disorder is usually diagnosed in the early school years and includes inappropriate activity levels, low frustration tolerance, impulsiveness, poor organisation of behaviour, distraction and inability to sustain attention and concentration (Pelham, 1982).

Although the aetiology of ADHD is not yet clear, the role of the brain, specifically the frontal lobes, has been widely studied in relation to this disorder (Cantwell, 1996; Castellanos, 1997). Most children with ADHD may also experience other difficulties including academic problems, peer rejection, low self-esteem and repeated failure. The latter, as well as the core features of ADHD, may persist into adolescence and adulthood and is considered to be quite debilitating to the individual (Gittelman et al, 1985; Weiss & Hechtman, 1986). Literature on the disorder reports that a large proportion of adolescents with ADHD suffers serious discipline problems at school and this may result in high rates of suspension and expulsion (Mendelson et al., 1971). Furthermore, ADHD commonly coexists or is associated with other co-morbid conditions. The latter includes oppositional defiant disorder (ODD), conduct disorder (CD), mood disorders (i.e., depression), anxiety disorders (i.e., obsessive-compulsive disorder) as well as tic disorders (Ingersoll, 1998).

Due to the prevalence of ADHD and the potential for further severe problems in affected individuals (Mannuzza et al, 1989), this area has been studied intensively during the last 3 decades and has received unprecedented attention in scientific journals, at professional conferences and by the media. However, while the number of children diagnosed with or treated for ADHD in North America can be counted in millions, only 60,000 cases have been identified in Europe. Although scant, research in other cultural environments suggests that the definition of and attitudes toward children’s learning and behaviour difficulties are greatly affected by cultural variations (Tao, 1992). These epidemiological differences, which are often interpreted as underdetection, raise an important question: to what degree are societies responsible for the labelling of behaviour and learning difficulties of ADHD and/or for the production of such difficulties?
Some researchers have begun to make hypotheses in response to this last question. Anderson (1996), for example, suggests that the more "permissive" nature of Western child rearing may be involved in the production of ADHD. Permissiveness, however, is a characteristic of the private sphere and the family environment; societal demands on the other hand can be seen as becoming increasingly rigid for children and youth who cannot envision earning themselves a decent position in the future if they cannot withstand the pressure of competition. Research should focus on a number of social and family issues possibly related to: (a) the production of the ADHD phenomena: the implicit exclusion of non-achievers; the disqualification of "real boys" values by the ideology of social correctness; the structural violence of schools which marginalize children who do not respond to the norm, rather than "correcting" them as was the rule in the past; the long term effects of intensive stimulation of young children; (b) the positive and harmful effects of the medicalisation process on the future development of these children.

Youth and Violence

Research done on youth violence in North America reveals the local, "American" characteristics of violence among minors in the United States: younger and younger aggressors, incidents which, though no more frequent than those in the past, are increasingly tragic and more often fatal (Steiner and Stone, 1999). The association of this violence with poverty and racial minorities has lead to an extreme sensitivity in those studies which examine the profile of young aggressors while trying to remain politically correct in order to avoid accusations of racism.

The dominant explanatory theories stress the complex relationship between physical and genetic inheritance and the influence of environment on genetic make-up. This influence is understood primarily in terms of parental and family influence and early childhood experiences. In this context culture, taken in a narrow sense to mean various forms of media and new communication and entertainment technology (the Internet, Hollywood, video games and media), is put on trial for providing youth with fantasy scenarios to be acted out in real life situations. The structural violence of social inequalities and exclusion of those persons unable to handle the pressures of a competitive society is sometimes mentioned as a basic fact, but rarely if ever considered as a factor which might be modified, except in its most peripheral manifestations (gun control, for example).

The American Academy of Child and Adolescent Psychiatry considers the epidemiological knowledge in the area of violence to be sufficient, but believes more biological research is necessary, the principal weakness still being at the level of intervention. The GAP (Group for the Advancement of Psychiatry, Committee on Preventive Psychiatry, 1999) admits that individual interventions of all kinds have thus far proved to be partially or entirely ineffective. More systemic models of interaction which incorporate diverse methods of treatment and aim to act on the individual, family and community levels simultaneously have met with more success (Borduin, 1999). A rare large-scale example, the Boston Œmiracle¹ has demonstrated the significant effect that coordinating community, religious, and sports resources in a clearly defined support network can have on children.

Despite this, academic efforts and public opinion continue to focus on identification of dangerous individuals, a trend which, in the absence of effective solutions, only serves to
aggravate the phenomenon of exclusion and provoke further violence (Montgomery, 1997). Moreover, theories of vulnerability suggest the necessity for a reinterpretation of the social in light of hard data on the private or individual sphere: when, within a group of individuals subject to the same stress, only certain individuals among them cannot handle such stress, it is these individuals who are perceived as the origin of the problem.

The discourse of youths who commit acts of violence makes frequent reference to the feeling of exclusion and non-existence. Identification which takes as its starting point the phrase "born to be a killer" reflects the genetic theses of a society which seeks to control youth while feeding bulimically on their acts in voyeuristic fashion. In reaction to the growing pressure of "politically correct" censure, a resurgence of fascination with evil has occurred, sometimes channeled into phenomena like satanic cults. And while daily life becomes more sterile following the logic that any word spoken in anger is a violent act, virtual space continues to expand in order to accommodate increasingly realistic representations of raw violence which are less and less symbolic.

In this context it is essential that we reconceptualize intervention and prevention in more complex and dynamic terms which focus on interaction between youth and society, without singling out the former as the sole instigators of violence, while questioning the paradoxical effects of past approaches. To some extent this means using the mandate of medicalisation of violence to re-examine the social origins of the problem and, more importantly, to conceive new methods of prevention.

**Trauma and PTSD**

"Trauma" is an area of increasing concern in psychiatry and among the general public, and the wider issue of violence —accidental, interpersonal, or collective— is an enormous social and public health problem, in Canada and around the world. An increased risk of adverse experiences and events, which include deprivation but overlap with traumatic events, is thought to be one of the ways in which the negative effects of inequality become biologically embedded over the life-course (Hertzman, 1998). Trauma exposure and PTSD have been associated with worse physical health, but the relative roles of trauma exposure, PTSD, and context are still contested (Gorst-Unsworth and Goldemberg, 1998; Friedman and Schnurr, 1995). Current trauma research ranges from the clinical to neurophysiology to anthropology, political science and history, but the vast majority of published studies focus on one possible outcome of trauma: Post-Traumatic Stress Disorder (PTSD).

While social support is a variable of concern to many researchers, contextualized studies of trauma or of experienced violence are rare, to the point that "trauma" as the occurrence of an extraordinary event has almost become synonymous with "PTSD" in both popular and academic thought. However, recent studies suggest that PTSD symptoms do not represent the continuation of the initial responses to trauma, and recent epidemiologic research indicates that the incidence of PTSD may be lower and more variable than previously thought (Breslau et al, 1998; O’Brien, 1998). In fact a meta-analysis of all trauma studies in North America indicates that only 20% of the persons who undergo a traumatic event do eventually develop PTSD (Yehuda, 1995).
Furthermore, trauma may not have only psychopathological effects and may permits the
development of new capacities or strengths (Macksoud, 1993; Punamaki, 1996). This research
indicates a need for closer examination of: first, the differences and interactions between different
type of events like: a) chronic adversity, stressful life events, and the excess morbidity caused by
structural inequalities (structural violence); b) loss; and c) extreme events perceived as accidental
vs. deliberate. Second, a wide range of responses to trauma, including adaptive and strategic
responses at the individual and at the collective level. Third, circumstances in which medical or
psychological interventions help or hinder long-term recovery from traumatic experiences, and
fourth, non-Western patterns of cultural meaning and social organisation, to question psychiatric
models who posit the existence of universal biological, psychological and social mechanisms and
use instruments which are based on these assumptions of universality (Young, 1995).

Approaches to trauma based on the diagnosis of PTSD are centred on the individual. The
trauma or PTSD model has been and continues to be of value in the understanding and healing of
distress caused by violence, terror, and dislocation. For therapists who are sensitive to cultural
difference, history, politics, and the presence and effects of inequality, PTSD can be a useful tool,
which does not preclude attention to the social, the cultural, the historical, and the political. Such
sensitivity and openness, however, entails a constant working against the grain of a way of
thinking which privileges the individual and the biological over the social and cultural. As a
general model, however, a highly individualising view of trauma that emphasises catharsis and
healing of ethically and politically neutralised "memories" and "emotions" is essentially
ideological and not really based on empirical research. Such model is often also therapeutically
inadequate, because it assumes that disclosure should be systematically favoured against
avoidance and it risks missing the key themes that converge in the experience of trauma,
especially collective trauma. Individuals are always part of multiple overlapping social networks.

These social and cultural matrixes are not identical around the world or throughout
history. Although culture contact and social change have always occurred and are in many ways
accelerated in a globalized economy, nevertheless not all notions of the suffering self and of the
links among loss, distress, illness, and healing are reducible even to the range of "Western"
models, let alone to DSM-IV categories. Indeed, the experience of trauma, war, and loss can play
a critical role in mobilising social cohesion and demonstrating resistance as well as resilience.

Finally, collective trauma, where the experience of an individual is explicitly connected to
that of a group, has been and continues to be the norm rather than the exception. This is the case
not only for obviously collective violence, such as genocide, but also, more insidiously, in most
instances of disasters such as famine or industrial accidents, which usually occur not at random,
but rather in contexts of structural poverty and inequality.

How, then, might clinical and epidemiological research and clinical practice arising out of
psychiatric models speak to the social, political, cultural and economic dimensions of human
experience? How might prevailing models be influenced by the knowledge in the social sciences,
especially with respect to different cultural and social systems? How might we link research
exploring the ways in which individual experience over the life course becomes biologically
embedded with the more social and political perspectives emphasised in this critique, and vice
versa? What are the implications at various levels, from neuroendocrine structures to Third World refugees to economic or human rights or health policy, of the different approaches to trauma?

Material, social and cultural environments both shape and are shaped by the risk as well as the meaning and outcome of violence and inequality. We consider "trauma" to represent a challenge or threat to personal and collective systems of meaning and the patterns of social organisation and interaction through which meaning and health are created and maintained. This challenge can lead to divergent outcomes, from the rupture of social networks and personal life-worlds, to incorporation of an event or ongoing adversity into locally constructed versions of the normal vicissitudes of life, to the mobilisation and reinforcement of individual and collective identities and effective social support. Medical and public health interventions are one of many components of the environment and one way of understanding the significance of and responding to trauma from human origins. In order to maximise the benefits that such interventions can offer, we must examine them in light of other ways of understanding trauma. This requires not only more careful study of trauma and PTSD, but also research which de-centers medicine, trauma, and PTSD and thus offers the possibility of looking at these pressing social and health issues in new ways.
PART 3. A BLUEPRINT FOR STRUCTURING THE INSTITUTES

Our research group does not consider it necessary to create an Institute whose mandate would be to address only our questions of concern, even if these questions appear to be of major importance in the planning of multi-sectorial interventions in health, and more specifically, in mental health. If an Institute for "mental health" or one in the area of the "determinants of health" were to be put in place, the perspectives proposed herein could be effectively incorporated into and constituted as a nucleus from which the research process would eventually diffuse towards other Health Institutes.

Our reflections within the team, our personal experience of collaboration within diverse research groups, and an analysis of existing interdisciplinary networks and partnerships have led us to formulate several recommendations which apply both to our specific field of interest and to a broader range of inquiry. We are concerned primarily with quality of research and how it could be attained.

a) Role of Institutes: opening new perspectives and avoiding possible pitfalls

The challenge generated by the establishment of Health Institutes across Canada opens the door to an in-depth reshaping of the interactions between disciplines and categories of actors, and invites a re-examination of the priorities in the health research domain. By devoting themselves to the rapid and efficient conveyance of research results, with the goal of exercising more influence on the decision makers in the health area, the Institutes could help bring about the necessary changes which are hoped for by many of us. The idea of creating a structural link between researchers and the practical milieu is of key importance not only for the purpose of maximising the operationalization of research results, but more importantly, in order to connect the research milieu with the complexities of intervention and thus provoke new questions, necessarily interdisciplinary.

The integration of multiple disciplines and actors across networks and organisations is not, however, without risk. We still believe it is important to be cautious. Private enterprises are swept up by the insidious power of standardisation and normalisation, which tend to homogenise ways of thinking and doing in order to maximise administrative or managerial efficiency. We may anticipate the effects of standardisation, which would eventually lead to the homogenisation of theories, methods and research instruments, resulting in monolithic, rigid research organizational structures. Experience has shown that a simple multiplication of contacts transforms the management of research but not the content. Paradoxically, it is even possible that it renders researchers more impermeable to the basic questions because of saturation, the mind holding only to the logic and presuppositions of a particular field of scientific interest.

Our research group is inclined instead towards an approach in which Health Institutes be constituted as dynamic "spaces" where we could cultivate and maintain heterogeneity in the production of knowledge. This would facilitate the emergence and interaction of creative tensions, favoring the constant questioning of the foundations of scientific culture instead of tending toward self-confirmation. It seems to us absolutely essential to insure the construction of
solid spaces of critical thought at all levels, although we are aware that we should avoid the paralysis that may emerge with the pure and simple deconstruction of science.

In creating Health Institutes, it seems preferable not to arbitrarily multiply the number of Institutes according to a given number of disease categories and age groups, but to give them, in the first place, an identity of their own with relatively permeable boundaries, consolidating existing alliances and bringing together researchers who are already engaged in research domains and themes in which they excel. Health institutes should be conceived from the bottom up, as dynamic spaces that favor dialogue between divergent lines of thinking, thus fostering heterogeneity and the co-existence of diverse disciplinary approaches.

During the first years of their existence, it would be advisable to create Health Institutes from a few, well-conceived health research domains defined according to specific criteria, with a periodic redefinition of the Institutes’ borders and their relation to cross-disciplinary themes. Health Institutes should be built around "matricial structures", where research themes are intersected by disciplines and actors, and whose organisation allows flexibility, cross-fertilization of ideas and transdisciplinarity.

**b. Integration: towards the evaluation process**

The discourse promoting collaboration between different disciplines and milieus in health research has given birth, in recent years, to multiple structures: research teams, partnership projects, research networks and centers of excellence. The daily activities of research practice and the diffusion of results, in different groupings, have increased exponentially the integrated use of various communication technologies (e.g., multiplication of Internet sites, video and telephone conferences). Likewise, it is the circulation of information which is at the base of those "mega-structures" which now monopolize more and more time in the lives of researchers. Moreover, networking relies most often on the simple juxtaposition of information from teams and researchers in different milieus without always allowing for heterogeneity in theories and methodology. With the tendency to favor the quantitative, and thus essentially summative, evaluation of these structures, too often little room is accorded to reflection on the non-instrumental mechanisms for generating collaborative work across disciplines and conceptual models.

Nowadays, two main models of partnership prevail in the groupings of researchers:

1. horizontal partnership where researchers of different disciplines associate to obtain funds by juxtaposing their work and creating a "quasi-fictional" referential model to which each of the partners seems to adhere;

2. vertical partnership where, for example, the academic researchers persuade a partner from the practical milieu to take part in a research project without, however, allowing this partner to question the theoretical and methodological foundations of the project.
The capacity of seasoned researchers to adapt to the discourse and objectives of funding bodies need not be demonstrated: it is a condition sine qua non for survival. Researchers are quick to adopt the rhetoric of the time, as they are concerned with putting forward their ideas in the most palatable form. But this practice is not without consequences. That great strength underpins both the capacity to survive and the subversion of research. To influence the content and process of research, the reformulation of philosophies in granting agencies (as is the case with the creation of Health Institutes) will not in itself suffice.

The analysis of diverse models of partnership and varied funding programs aiming at integration, leads us to think that a veritable integration is not made at the level of grand structures, but instead by beginning with experiences first of all within the boundaries and framework of teams and meetings which permit researchers to broaden their specific field. In order to formulate indicators and guidelines which establish a solid base of co-operation between disciplines and partnership between researchers, we believe it important to identify certain aspects of integration practice at both the knowledge and team levels which appear particularly promising to us. We have limited ourselves to three major principles:

1. Sustainable and effective collaboration lies in the medium and long term. In reality, solid partnerships can only be constructed with ample time. An accelerated process (forced upon researchers) frequently results in opportunistic, superficial and short-lived alliances, lacking serious impact.

2. Sustainable and effective collaboration is founded in process. We should pay attention not only to project implementation but, equally important, to the internal process of building strong links, identifying convergences and complements, divergences and tensions. The process of sustained collaboration then becomes an instrument of transformation of the conceptual bases and the methodological approaches of the partners. It follows therefore, that the institutional and social power between different partners is particularly noteworthy. A complementary partnership demands equality and a certain transparency at the level of decisional processes, particularly with respect to budgetary decisions.

3. Sustainable and effective collaboration is characterized by meaningful and timely communication. A true integration of knowledge lies generally in the framework of more timely meetings which allow real debates around precise themes which approach a question from different perspectives. The conception of Institutes must thus pay particular attention to questions of integration in two principal fields: (1) the setting up of teams organized around specific research themes or perspectives and (2) the development of transversal disciplinary mechanisms of collaboration to encourage the co-fertilization of activities within the ensemble of programs.

The programs of interdisciplinary teams and of collaboration between the professional, managerial and academic milieus must be conceived in a manner which permits work over the medium and long term, evaluated regularly (every three years, for example) beginning with three types of indicators:
- productivity, in the specific field of the researchers;

- transformation, of paradigms and/or approaches in different disciplines or domains of related practice, including criteria documenting how processes have led to transformations (role and contribution of partners, consensus, tensions and negotiations of differences);

- interdisciplinarity, productivity and diffusion in the academic, clinical, administrative, and political milieus.

These considerations apply on a general level but are of particular importance in the field of mental health because of the multiple levels of variables at work, an idea that is supported by the popular bio-psycho-social model of health. In the case of mental health, interdisciplinarity constitutes an incontestable priority. Thus, it goes without saying that the structures of research in mental health serve a critical function. They must promote the development of interactions between diverse disciplines. Above all, they must help sustain the researchers in the social and human sciences interested in this field of inquiry by sending them a clear message with respect to the pertinence of their contribution, and by reassuring them that their research protocols will be evaluated with criteria pertinent to their discipline. More specifically, it is important to promote the co-operation between different actors from different academic and practical milieus in order to:

a) put in place models which permit the study of the collective dimensions (social, political, and cultural) underlying the experience of people identified as having certain (mental) health problems and more broadly the experiences of suffering and well-being,

b) examine specifically the influence of the social inequalities in this domain,

c) evaluate the impact of dominant classification models for certain (mental) health problems and the interventions and programs, reimbursement and proposed prevention within that framework,

d) propose models of programs, services, and interventions in (mental) health which integrate the collective dimensions of the experience of suffering and which take root in non-dominant knowledge, and

e) evaluate the impact of new models and their transferability.

In the field of mental health, interdisciplinarity should be founded on a restructuring of the respective weights of the biological, psychological, and social components of the dominant model, so that the importance accorded to each of these three dimensions is manifest at the level of the importance of programs, the distribution of funds and the modes of evaluating projects.
c. Diffusion of research results: to value the transfer to professionals, clinicians, administrators

Methods of evaluating the productivity of researchers are increasingly demanding and precise. They demand publications in leading specialized international journals, in order to assure that researchers are at the leading edge of world knowledge in their domain. The translation of research results at the political level is also considered, despite its lesser importance. Certain funding agencies encourage and even demand the diffusion and discussion of research results within the practical milieu, even though these activities are hardly considered, if at all, when the researcher is evaluated by peers.

This paradox frequently translates into a gap between the good intentions put down on paper at the time a protocol is submitted and the real time the researcher and research team can dedicate to the dissemination of results within the practical milieu. A certain bitterness born in these milieus can leave a researcher "cannibalized" by the research process itself without the research actually having contributed to the tools and reflections for rethinking practices.

Dissemination in the practice milieu would benefit therefore from consideration not only of the frame of research protocol evaluation, but also, and perhaps above all, at the level of the evaluation of a researcher's performance, which is done for obtaining career bursaries and academic promotions. It goes without saying that if the financial sponsor seriously considers the diffusion in the practical milieu as a priority, that position would certainly have to influence the academic milieu. What forms could this diffusion in the practical milieu take? In order to maximize the dissemination of knowledge, all forms of diffusing research are probably to be encouraged, but it would be important to develop, in particular, the return of a permanent practice of bilateral interaction, in a process which would give a voice to practitioners in order, not to censor, but to multiply the possible interpretations of results.

d. The ethics at the heart of research questions and processes

Within the frame of this current exercise of reflection, two propositions of ethical concern, regarding the Health Institute’s initiative, are submitted. Our research team is of the opinion that the ethical questions must occupy a central place in all the Health Institutes, and address not only the protection of research subjects but as well all the relations which are involved in research and in particular those between partners, and between social groups and communities which are less often mentioned. The ethic of health research, which is too often interpreted uniquely within the framework of medicalization focused on individuals, must thus also be rethought in those collective dimensions: historical, social, economic, cultural, and political.

Specifically, we believe it is of high priority that the following be explored:

a) the ethical implications of partnership: the necessary conditions for an equal-complementary partnership; relations of power and decisional processes between partners; representativeness, individual and collective speech,
b) the ethical implications of research: starting with the presupposition that research is necessarily an intervention and that it modifies certain aspects of the subject’s life, such an effect must be recognized and explored instead of constantly minimized in order to obtain protocol approval,

c) the ethical implications inherent in considerations for collective rights: to examine the question of the collective subject, to reflect on the question of the entitlement to speak in the name of a particular group, and

d) the ethical implications of the diffusion of the research results: to whom do the research results belong? Should everything be disseminated? To question the supposed “neutrality” of the researcher in the diffusion process, while favouring the emergence of a critical thinking and speech.
CONCLUDING REMARKS

Philosophers and historians of science have amply demonstrated in recent decades that scientific facts, theories and techno-cultures are value-laden and that medical, psychological as much as sociological knowledge is culturally and historically constructed. Experts in the ethnography of science have shown, for their part, that all forms of knowledge are largely context-dependent products rather than transcendent realities; they have also designed methods, concepts and tools for understanding why the prevalent contemporary Western literature in biology, medicine, psychiatry and health social sciences tend, on one hand, to bring to the forefront particular theoretical frameworks, categories and models and, on the other hand, to suppress or silence alternative ways to assess, interpret, name and manage mental disorders. The perspective we have favored borrows much from the work in anthropology of science produced by Latour (1999) and Latour and Woolgar (1979).

We have argued that it is through the evaluation of frames, models and practices commonly used in medicine, psychiatry, psychology and health social sciences that we will eventually better understand how suffering, distress and pain are transformed into nosographic categories and eventually absorbed into the psychiatric domain. We have also demonstrated how the medico-psychiatric science and medical technologies are used both in the medicalization of the "problem" and as a form of social control. One may easily find numerous examples in industrial nations as well as in the developing world of medical technologies aimed at controlling deviant behaviour (hyperactive children, drug addictions, etc.), as well as plagues, diseases and even natural life cycle events (childbirth, menopause, etc.).

We believe it essential to promote a greater heterogeneity of models, theories and concepts as a counterweight to the increasing homogenisation of medico-psychiatric knowledge and practice. The critical perspective that we have been exploring with respect to psycho- and socio-pathology is also relevant to a broader range of disease conditions, thus cutting across all areas pertaining to the health and well-being of populations
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APPENDIX 1: Beyond the brain-mind divide

It is today commonly acknowledged by scientists that there exist three master codes: the Quantum (the realization of one possibility out of infinite probabilities); the Genetic (DNA) and the Synaptic, the last two codes being particularly relevant to biology. The genetic code presents a fairly stable and predictable structure that lasts a lifetime; its evolutionary adjustments take many generations in establishing themselves. The synaptic codes, however, present a less stable long-term structure because the brain is continuously reshaped by the dynamics of the genic structure (DNA) and the environment in which the person lives. Individual experiences constantly inform the biological networks and often provoke rapid and ever-changing patterns in the neurological codes. Individual histories shape brain and mind simultaneously; the brain and mind are indissolubly linked to one another and to the actual history of the person.

Neuroscientists, evolutionary psychologists and biological anthropologists generally agree that individual neurological maps are both historically and environmentally produced. Jean-Pierre Changeux writes that each individual develops a highly personalised version of the brain due to a selective process of neuronal networking acquired: "au cours de l'expérience épigénétique de l'enfant sur le monde extérieur et de l'adulte lorsqu'il communique avec ses semblables "(1998: 113). Neural codes are thus formed through: "une mise en correspondance entre, d'une part, un état de choses extérieur, un objet, une situation, et d'autre part une organisation neuronale et l'état d'activité qui l'investit" (Changeux 1998: 113). Thus, differences in the epigenetic development of persons (particularly in the family environment) contribute to differences in the coding of each individual’s neuronal architecture.

Biological anthropologists, primatologists and palaeontologists refer generally to the so-called "epigenetic rules" when they study, particularly over long-term periods, the complex patterns which interconnect built-in genetic programs and differential environments. "From diverse vantage points in biology, psychology, and anthropology, researchers have conceived a process called gene-culture co-evolution. Genes prescribe epigenetic rules, which are the neural pathways and regularities in cognitive development by which the individual mind assembles
itself. The mind grows from birth to death by absorbing parts of the existing culture available to it, with selection guided through epigenetic rules inherited by the individual brain " (1998: 85, 126). It is not necessary to share all of Edward Wilson’s sociobiological views to accept what is now common knowledge: "By environment I do not mean merely the immediate circumstances in which people find themselves. (...) It is nothing less than the myriad influences that shape body and mind step by step throughout every stage of life" (1998:139). It has become clear that we are as much a product of our genes as of our actual experiences in a given environment.

Stephen Pinker, a specialist in cognitive neuroscience, has likewise insisted on the differential mapping, across human groups, of basic universal genetic and synaptic (cognitive) codes. Pinker presents views which borrow much from the "epigenetic rules" that Edward Wilson and Noam Chomsky have posited in their respective domains of specialisation, the former in evolutionary biology and the latter in linguistics. Here again there is no need to share all of Pinker’s views on language to accept the following: " The Babel of languages no longer appears to vary in arbitrary ways and without limit. One now sees a common design to the machinery underlying the world’s languages, a Universal Grammar. Unless this basic design is built in to mechanisms that learn a particular grammar, learning will be impossible. (...) There are important roles for both heredity and environment: a child brought up in Japan ends up speaking Japanese; the same child, if brought up in [the] United States, would end up speaking English. So we know that the environment also plays a role" (1997: 408-9). Thousands of different grammars are produced out of the same universal ‘epigenetic rules’ that are specifically designed for producing language. Gene-culture co-evolutionary explanations have also been proposed, by Pinker and other neuroscientists, for understanding the differential patterning of all kinds of human phenomena besides language: emotions, avoidance, mate preferences, fondness for gossip and psychological disfunctioning. Nevertheless, research results in these areas are often less than convincing.

It must be noted that the epigenetic approach limits itself to the hardcore wiring of the brain and tends to overemphasise the built-in genetic programs by which human beings are formed. Critiques affirm, with good reason, that such an approach often downplays the formative
role of environment. The proposed model pretends nevertheless to be totally interactive: "innate mechanisms inscribed in genetic codes are differently rearranged in the context of different environments and end up producing variations". But what can actually be put under the umbrella of environment? The physical world, the family setting, economic distress: probably all of these and more. Scholars such as Edward Wilson, Noam Chomsky, Jean-Pierre Changeux and Steve Pinker are not, in reality, always convincing when they talk about environment. Current biological research has nonetheless defeated simplistic explanations based exclusively on either biological fatalism or environmental determinism.

Though much work remains to be done, we are well aware of the direction our efforts must take. It is true that the more we know about the interactions between genetic and non-genetic factors the more complicated these interactions appear to be: the ways in which 'causation' functions are often far from self-evident and a number of feedback loops, both positive and negative, are constantly at work. All serious behavioural specialists now acknowledge the interdependence between heredity and environment: no longer does one speak of a gene or a series of genes "causing" a particular behaviour. Such a statement is no more valid than the idea of behaviour arising from culture without the intervention of brain activity. The accepted explanation of 'causation' from genes to culture, as from genes to any other human phenomenon, is neither heredity alone nor environment alone: it is interaction between the two.

The 'epigenetic model' has other weaknesses: it discards what people do with what they produce, the meanings they attach to their local productions and the experiences they construct. It is not surprising that scholars who examine human phenomena from the perspective of persons consider the epigenetic model to be reductionistic and animal-driven and still too deterministic despite its effort to overcome past dualisms, as the one proposed by Descartes. Undoubtedly, there is still significant misunderstanding between genetically minded scholars and social scientists but much has been done to narrow the past gaps. It is now possible to move beyond the past opposition to establish a solid and balanced co-operation between the socio-cultural and bio-genetic paradigms, in a partnership in which both perspectives are equally valued and respected.
What we need is precise data about actual gene-environment interactions, preferably in natural settings: we have to better identify, for example, the series of associations which lead, in certain environments, to the ‘production’ of more fragile individuals, or “abnormal behaviours”. This is precisely the type of work we intend to do.
APPENDIX 2: Assessing the influence of the family environment

Behavioural geneticists have determined that genes account for about fifty percent of the personality differences among people; they have also concluded that where there is no genetic inheritance in children and there is no resemblance because the action of the social and cultural environment tends to produce a very large spectrum of variations. Psychologists and child development–oriented anthropologists have, for their part, attempted to locate the precise source of the environmental influence that must account for the other fifty percent, by focusing mainly on life in the parents' home during early infancy. Although the influence of family context and education patterns on the child's brain connectivity and psychological development is most evident in childhood and adolescence, it has become clear that the influence of the environment is by no means limited to early life.

No serious scholar goes on, in these days, opposing 'nurturists' who emphasise the contributions of the environment to the shaping of individual psychological profiles in contraposition to 'hereditarians' who rather emphasise the genes. Edward Wilson wrote the following about this irrelevant opposition: "Redefined with the more precise concepts of genetics, nurturists can now be seen to believe that human behavioural genes have very broad norms of reaction, while hereditarians think the norms are relatively narrow. In this sense the difference between the two opinions is thus one of degree, not of kind. It becomes a matter that can be settled and agreed upon empirically, should the adversaries agree to take an objective approach" (1998: 142). But which are the key components of the environment, which ones contribute and in what proportion to shape the psychological profile, character and behaviours of individuals? The intra-family dynamic and the first years of the child's life have traditionally been seen as forming the key spatio-temporal environment in which the psychological and emotional development of the person/individual takes place.

In reality, all researchers do not share exactly the same position about the actual role the family environment plays in modelling children. Three main positions are worthwhile to be discussed because they allow us to consolidate our conceptual framework:
i) Robert Plomin, a behavioural geneticist, has just completed (with colleagues) a ten-year study of 720 American families. Results support the classic view about the influence of parents: differential parental treatment relates to differences in child psychological profile and adolescent adjustment; the sibling who got the better microenvironment does better, is less depressed and less antisocial; parents’ negative attitudes are the strongest predictors of negative adjustment of the siblings. This study was also designed to look at genetic influences: it was here discovered that the link between negative parenting and problems in adolescence almost entirely disappears when genetic factors are taken into consideration. Plomin affirms that "...the parents' negativity isn't causing the negative adjustment of the kids but is rather reflecting it" (The New Yorker 1998: 58). The notion of "reflexivity" translates here the idea that parents realign (and eventually correct) the genetic program transmitted to their children. For Plomin et al. (1996) it is clear that we have to take both nurture, namely the family environment, and nature, specifically the genes, seriously. "It is likely that genetic research will ultimately tell as much about nurture as it has about nature. Moreover, some of the most interesting questions for genetics involve the environment, and some of the most interesting questions for environmental research involve genetics." (1996: 602).

ii) Judith R.Harris (1998) has recently tried to demolish the basic "nurture assumption" which states that what shapes children, apart from their genes, is the way their parents treat them. In her daring assault on consistent evidence collected over the years by behavioural psychologists, sociologists and anthropologists, Harris maintains that parents have little or no long-term influence on their child's personality and psychological profile, and that a child's peer group, more than his or her parents, are responsible for shaping personality.

It is in their own age group that children learn, according to Harris, what sort of people they are and how they are expected to behave. Harris goes as far as contending that parenting style does not model, but rather reflects (adjusts to), the child's personality, character and behaviour. Harris's position challenges decades of psychological thinking about child
development and relegates Freudian-inspired emphasis on parenting to the margins while placing peers squarely at the centre of the child's universe.

Howard Gardner, a widely-read psychologist, has stated that: "Harris’s thesis is overstated, misleading and potentially harmful. Overstated in the sense that she highlights evidence consistent with her thesis and understates evidence that undermines it. Misleading because she treats as 'natural' and 'universal' what is really a characterisation of contemporary American culture. Potentially harmful in that it may, if inadvertently, discourage parents from promoting their own beliefs and values, and from becoming models of behaviours, at a time when such values and models should be clearly and continually conveyed to children." (1998: 19). Gardner goes on to remind Harris that children are not only born into a family or a peer group: they are also born, he notes, into an entire culture that they learn through interactions with many individuals; they also experience conditions of daily life (such as peaceful communities or situations of war) which inevitably have an impact on their entire psychological development. The whole contextual fabric, insists Gardner, must be taken into account and not only the exclusive influence of peers, as in Harris’s work. Peers probably play a more important role in the horizontal American society than is the case elsewhere, but it would be blindness to limit the child's significant environment to their peer group. Comparative intercultural studies in children from different societies around the world (such as those done by the Whitings, 1975) point consistently to the importance of the entire family (mother, father, grand-parents, siblings), of age groups (same-sex peers, opposite-sex peers), and of other meaningful figures (initiators, teachers, other adults) in the framing of the child's personality.

iii) We still find "hereditarians" who continue to emphasise the epigenetic codes as the key factors in the development of certain psychological profiles and behaviours. Such is the case with Sandra Scarr, who argued recently that genetic factors dominate the process of child development, and that parental influences and the family environment have only a limited effect, except in supposedly extreme cases which fall "outside the normal species range." Moreover, Scarr maintains that the ways in which people are influenced by their environment are considerably less important than the process by which "people construct their own experiences"
and select their "environmental opportunities", a process which in Scarr’s view ultimately reflects the genotypes of individuals (1992: 4). According to Scarr the genetic heritage overrides the role of the family environment. Scarr believes that through advances in science it may one day be possible to predict the relative importance of each factor, genetic and environmental, in the development of the child's personality. In contrast, we believe that the variables involved are so numerous that something largely unpredictable will come out in the majority of cases.

The most adequate method for estimating the fractions of variation due respectively to gene and environment is by studies of twins. In these research designs identical twins, who have exactly the same genes, are generally compared with fraternal twins, who on average share only the same number of genes as the number shared by other siblings in the family. "Studies of siblings, fraternal twins, identical twins reared together, and identical twins reared apart all point to the same conclusion: about half of one's intellect and personality results from one's genes. That is, in any group of people drawn from a particular population, about one half of the variations in an observed trait (for instance, IQ or aggressiveness) is owing to one's genetic contribution. The other half is, of course, the result of one's environment." (Gardner, 1998:19). Studies have consistently demonstrated that few non-genetic variations can be attributed to the 'shared environment' and that the inter-child variations are principally due to what is called the 'nonshared environment' — for example, the fact that children are treated differently by parents.

The main problem with these studies is that we simply do not know with accuracy what makes up the 'nonshared environment' in the case of a particular child. It is quite evident that such environment is made out of many things which vary from one child to the next (number of siblings, peers, order of birth, other adults, school experience, etc.) and which form a complex series of interactions. This again leads us to the necessity of favouring natural settings and preferably inter-group comparative designs in any relevant study of human processes. Another problem we encounter in such studies is the fact that domains are not as clear-cut in the natural environment of children as researchers imagine when distinguishing between the 'shared' and 'nonshared' environments.
APPENDIX 3: The interpretive turn in medical social sciences

In their comments about the interpretive turn that human sciences have taken since the mid-seventies, Rabinow and Sullivan wrote: "Common meanings are the basis of community. Intersubjective meaning gives a people a common language to talk about social reality and a common understanding of certain norms, but only with common meanings does this common reference world contain significant common actions, celebrations and feelings. These are objects in the world that everybody shares. This is what makes community" (1985: 35). Intersubjective meanings are not only located in the minds of people, but are also incorporated and expressed in their collective practices and constituted as social actions. Only a direct experience of the world of others provides a sense of pre-comprehension about the meanings people attach to their behaviours and actions; this implies that researchers have to become familiar with the world of others (natural settings) and experience it at least partially if they want to be able to grasp something of the world in which people live.

Besides meaning, two other important notions, namely narrativity and experience, are attached to the perspective opened by the phenomenological and interpretive turn of medical social sciences. It is not enough to say that people act towards things in at least partial congruence with the meanings that these things hold for them. People also produce discourses, commentaries and narratives in which they tell, via complex rhetorical strategies, the meanings associated with their behaviours. Their idioms of distress and their illness explanatory models and schemes are also largely dependent on their systems of meaning. To be properly understood the various narratives and idioms have to be inserted within a series of other discourses, and ultimately placed in the larger context of the culture which supports these texts. We must take into account the fact that human speakers incorporate in their narratives cultural presuppositions, that the blank spaces of discourses are overloaded with meanings, and that any reading limited to the surface runs the risk of missing the cultural dimension. The stress put on narrativity is sometimes so strong in contemporary human sciences that some scholars, particularly medical anthropologists, have come to see culture as nothing more than a mega-text.
One finds in almost all modern countries the co-existence of multiple languages, religions and cultures. The dialectic notions of centre and periphery, inclusion and exclusion, majority and minority, are commonly used by social scientists to study the dynamics of cultural power, cultural pluralism, hegemony and dominance, control and submission, and the relations that either oppose or link together the various social groups in one given society. Most people today live on the boundaries between groups and define themselves as persons with multiple affiliations. It appears particularly urgent to tackle the challenges created by the impact of such pluralistic societies (many religions, languages and cultures) on both individuals and families. Cognitive maps, values and systems of meaning are reorganised to fit the pluralist context, with vacuums and cracks in their midst.

Past studies in social sciences most often focused on well-bounded groups which were in many cases trapped within their own boundaries and disconnected from their regional network, on domestic economies that largely ignored the external macroscopic constraints, and on marginal populations that were often detached from their global context. More recent research frameworks take into account the contradictions and tensions emerging from the pluralistic situations in which individuals and groups live: scholars today insist on the fact that tribal affiliation, religious membership and shared indigenous culture, which have constituted powerful symbols, are reshaped when people want to translate their collective identity in the contemporary world. They also indicate that such collective symbols often fuel, under certain circumstances, inter-group conflicts, either within particular countries (Yugoslavia is a paramount case) or between nations. Common notions about culture have also changed. Creolized versions of cultural systems have emerged on all continents, citizens of most countries are therefore torn between multiple parallel attachments, and people are everywhere trapped between the fidelity to one’s cultural identity and the need to assume a more flexible pluralist frame of reference (Bibeau, 1997). The ethnic, linguistic, religious and cultural pluralism which was already present in the vast majority of countries is greatly accelerated by migration, displacement and refugee movements across national borders and by the fact that countries are more and more permeable to influences from abroad. In most countries, people have to confront themselves with more and more ambiguity, with multiple group affiliations, and with hybrid identification models at the edges of their
cultural worlds. The dominant challenge in all pluralist societies is to build collective cultural systems of reference that combine the local with the global, community-grounded values with a common sense of belonging.
APPENDIX 4: Toward a critical epistemology in contemporary medical science

"Once medicine is established as anthropology, and once the interests of the privileged no longer determine the course of public events, the physiologist and the practitioner will be counted among the elder statesmen who support the social structure. Medicine is a social science in its very bone and marrow."

Rudolph Virchow
Die Einheitsbestrebungen, 1849

To contribute to a critical epistemology of medical science, we should begin to examine the conventional epidemiological model of disease causation. The "holy epidemiological trinity"—agent, host and environment—has been extensively applied to infectious diseases, as well as a wide range of other conditions (from coronary artery disease to suicide to traffic accidents), tend to ignore or marginalize the social system’s influences on the distribution of illness and disease in the population (McKinlay, 1995). Among others, we have argued elsewhere, that it is imperative to enlarge the conventional epidemiological model of disease causation and incorporate the social system in the analysis and better understanding of disease occurrence and its distribution (Bibeau, in press; Pedersen, 1996).

There is enough data being reported in the epidemiological literature referred above to suggest that there must be other factors beyond the introduction of medical technologies (i.e. vaccines or drugs) to explain why certain diseases have experienced a substantive decline. A classical example is the historical decline of death rates for tuberculosis in England and Wales, which has been attributed more to changes in industrialization and working conditions, housing and nutritional status, rather than to the introduction of the BCG vaccine and streptomycin or a better understanding about the disease causation (McKeown, 1979). Fifty years after the introduction of a highly effective combination therapy, tuberculosis still remains the world’s leading infectious cause of preventable deaths. Nevertheless, there still is a stubborn tendency in
national programs to rely mainly in vaccines, drugs and medication for the control of tuberculosis.

Another prime example is malaria. In the last 50 years, malaria rates in the US have been steadily declining largely because ecological changes, agricultural development and a range of other poorly understood factors (Levine, 1964). In Southern US, the use of antimalarial drugs and DDT have been rather limited in the last few decades, which means that there are other factors at play in the reduction and maintenance of low attack rates for malaria beyond medical technologies and vector control measures.

HIV infection and the AIDS epidemic seem to be following a similar pattern, when trying to explain the rise and decline in the number of cases among certain risk segments of the population. For instance, a wave of optimism recently displayed with regards to the AIDS epidemic have been created by the illusion of having "conquered" the disease and raised life expectancy with a new generation of drugs. Media coverage of scientific conventions and international conferences have focused on the appearance of new "revolutionary antiviral agents", capturing the imagination of the public at large, as well as raising expectations of patients, medical practitioners and the pharmaceutical industry. However, differentials in access to these new drugs and ability to pay are still determining the outcome of AIDS among the peoples from rich countries such as the US and Canada. Even though randomized clinical trials are showing a clear advantage with antiviral agents when compared with placebos, the overall impact of treatment in mortality due to AIDS may show a limited effect since the population under treatment represents only a fraction of the total population already infected with the disease. Virtually no AIDS patients in the low-income countries are receiving protease inhibitors and, given the high numbers of people infected with HIV in these regions, the likelihood of this happening within this generation is remote.

HIV transmission is another example of how medical and social scientists can be caught barking up the wrong tree. While clinical epidemiologists study inter-individual variations in risk and explore in detail the range of behaviors allowing for blood-to-blood contact, anthropologists
investigate sexuality and stigma in "exotic subcultures", ritual scarification or risk behavior in long-distance truck drivers. But after more than a decade of such studies on HIV transmission, few have explored the "precise mechanisms by which such forces as racism, gender inequality, poverty, war, migration, colonial heritage, coups d'état, and even structural adjustment programs become embodied as increased risk" (Farmer, 1999). On the other hand, the development of effective interventions are also dependent on the social, economic and political context within which policy makers, bankers, investors and scientists reach their decisions. For instance, the development of an AIDS vaccine will largely depend on the investors’ confidence in profit margins and return of their investment, which may explain why there is little effort in developing an AIDS vaccine in spite of the massive (and growing) potential demand in low-income countries.

Likewise, in psycho-pathological conditions, some of which we have presented in this position paper (e.g. Attention Deficit Hyperactive Disorder, self-inflicted injuries and suicide, PTSD, youth violent behaviour, alcohol and drug abuse, etc.), the same principle applies. To further understand the epistemological origins of mental illness and explain the varying levels of mental health and differential rates of psycho-social distress and illness in a given population, we must raise similar questions as with other illnesses, such as:

• Who becomes sick, and why?
• What contributes, beyond current biological or genetic explanatory models, to these differential rates?
• What is the relative weight of each of the environmental factors involved (for some are more important than others); and finally,
• What are the areas or factors amenable to change and potentially responsive to individual and public health interventions?

No single model accounts for the role of social, environmental, and biological factors causing mental illness. Current research provides strong evidence that all mental disorders are biosocial and that whatever physiological processes are involved the quality of a person’s social
environment influences both vulnerability to mental illness and the course (and possibly the outcome) of that illness (Desjarlais et al, 1995). Schizophrenia is a prime example of an illness with no known social etiology but where social and cultural factors strongly influence the likelihood of recovery and prognosis, independently from the degree of medicalisation in the provision of care for these patients. Indeed, the well-known WHO comparative study of Schizophrenia in countries with different levels of care for the mentally ill, seem to suggest that those patients coming from less-developed countries such as Colombia or Nigeria, showed a better prognosis when compared with homologous schizophrenia cases in Denmark or England.

But to advocate for a critical epistemology and interrogate science and the medicalisation of psychosocial problems does not mean we neglect medicine and psychiatry as a science and a legitimate clinical practice. By questioning the impact of medical technologies in health and disease as a failed strategy, we intend to adopt a critical stance in front of the development of pseudo-scientific solutions as "magic bullets" to solve the health-related problems engendered by social inequalities. While we censure the abuses of medicalisation, we acknowledge that there is nothing wrong with using effective therapies and appropriate interventions. As has been pointed out by Eisenberg and Kleinman (1981): "The key task for medicine is not to diminish the role of biomedical sciences in the theory and practice of medicine but to supplement them with an equal application of the social sciences in order to provide both a more comprehensive understanding of disease and better care of the patient. The problem is not ‘too much science’, but to narrow a view of the sciences relevant to medicine."
APPENDIX 5 : The social production of collective and individual suffering.

Public health has since its inception stressed the social and ecological determinants of health. Each new version of public health provides a specific model for linking the macro context (ecological, economic, political, social and cultural) in which communities, families and persons live, with the differential distribution of health outcomes, both at the individual and collective levels. In recent decades we have seen the emergence of "community health", "health promotion" and "population health". However, most community-based studies (particularly epidemiological surveys) still produce probabilistic relationships between variables while generally bracketing many elements which are part of the macroscopic context and also bracketing the subjective experience and distress of individuals.

Critical social theorists believe that not being explicit about the social sources of disparity contributes, in most public health studies, to an inadequate reading of the collective context in which suffering and disease are produced and ultimately leads to the maintenance of social inequality. As a counter-position to the emphasis placed on "neutrality" and "objectivity" by conventional community medicine approaches, some health and social scientists insist on the social sources of injustice in all societies, including Western societies, as the key factor involved in the production of suffering, pain and illness. While functionalist models still view society as being held together by common values and institutions, critical social sciences see social organisations in human groups as the historical results of socio-economic relations and as stemming from the power exerted by certain groups over others.

Critical theorists stress the role of power in the shaping of societies, drawing on insights provided by Marx and Gramsci or, more recently through approaches connected to Foucault, Bourdieu and others. These thinkers have reminded their fellow social scientists that power is generally divisive, produces a context of conflicting interests, and pushes hegemonic social groups to maintain the status quo. Critical theories consider that all social arrangements have political and economic bases and that health scientists have to analyse situations of suffering and pain resulting from such factors as class, gender, and race. In this approach, understanding
conflictual situations serves as the main entry door for deconstructing the processes at work in societies. More recently, such research has focused less on formal class struggle and other divisions, and has emphasised instead the implications of Michel Foucault’s insight that power in society relies not only on control, repression and submission of others, but also expresses itself—perhaps primarily—in its ability to define what is acceptable, appropriate and normal.

The above approaches have been criticised by other social scientists, particularly by some anthropologists, for paying insufficient attention to the lived experience of distress or suffering. In order to recapture this experiential dimension while avoiding the highly individualised perspectives of psychology and psychiatry (which were seen as contributing to structural inequalities by their silence on political, cultural and social issues and on power in general), the notion of social suffering was developed. The leader in this move has been Arthur Kleinman, himself a psychiatrist and anthropologist. The notion of social suffering evokes an assemblage of human problems that have their origins and consequences in the devastating injuries that the existing macroscopic social order of the world inflicts, in variable degrees according to local situations, on the experience of individuals and entire communities. A. Kleinman, V. Das and M. Lock have defined the terrain of this notion as follows: "Social suffering results from what political, economic, and institutional power does to people, and, reciprocally, from how these forms of power themselves influence responses to social problems. Included under the category of social suffering are conditions that are usually divided among separate fields: health, welfare, and legal, moral and religious issues. (...) For example, the trauma, pain, and disorders to which atrocity gives rise are health conditions, yet they are also political and cultural matters. Similarly, to say that poverty is the major risk factor for ill health and death is only another way of saying that health is a social indicator and indeed a social process" (Kleinman et al, 1997).

The notion of "social suffering" carries the idea that it is essential to address both individual and social levels of analysis; experience of persons and politico-economic context; local problems and their relation to global issues; community-grounded solutions and professional responses; health problems and social problems. This perspective holds that the significance of the inter-linkages between these various domains is generally underestimated. It
stresses the need for a clearer understanding of the ways in which macro-social dimensions interact with the micro-social (the community, the family and the person), in attempting to explain both the construction of suffering and its opposite, the production of health.

Finally, critical social sciences insist that knowledge production is never neutral, that there is no such thing as a "mere fact", and that scholars and researchers themselves are inevitably linked to a particular social group. While critical theory and the social suffering perspective serve as an important and productive counterpoint to the studied neutrality of traditional science and public health, these views must themselves be subjected to the same scrutiny that they bring to bear on medicine and science, including the criticism that they themselves silence dissent - in this case through claiming a morally rather than scientifically unassailable position. Epidemiology and critical theory converge in arguing that structural inequalities are the most important determinants of population health. Interpretive anthropology and cultural psychiatry converge in insisting on the importance of lived experience. Knowledge production may never be neutral, but it is possible to aim at understanding and acting on the determinants of health, disease, and suffering, while maintaining awareness of the particular stakes and interests of a given perspective and the particular social arrangements through which it is expressed.