The Appropriation of Suffering
Psychiatric Practice in the Post-Soviet Clinic

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IN THIS article I revisit the clinic both as a major social actor and as the site of intimate and painful exchanges. The clinic makes it possible to document how socio-economic events and conditions become registered at the level of normal and abnormal selfhood. This article draws on ethnographic work conducted in Latvia in 2001 to show how the customary divide between society and culture breaks down in particular ethnographic contexts. What my research sought to do quite specifically was to outline the semantic domain in which problems in the economic sphere are seen as the consequences of individual deficits in the shape of depression and anxiety disorders. Strikingly, identifications and categories unmistakeably bore the stamp of transitions to market orders.

The argument of this article has evolved through an exploration of psychiatric consultations that owes much to the ideas of Canguilhem. In particular, his reading of early theories of physiology and pathology uncovers 'the identity of the normal and the pathological' (1991: 44). Physiology does not support the view that health and disease are opposites. Indeed, for Canguilhem pathology is merely an intensification and extension of health. He quotes Claude Bernard: 'At every moment there lie within us many more physiological possibilities than physiology would tell us about. But it takes disease to reveal them to us' (1991: 100). His views also support Virchow's ideas that pathology is: 'physiology with obstacles' (1991: 41). In other words, we see the full repertoire of human physiological functioning precisely at the point where the organism is most fully stretched. 'Disease reveals normal functions to us at the precise moment when it deprives us of their exercise' (1991: 101). These theories of physiology accord with Soviet and post-Soviet ideas about health and illness in Latvia, where illness was seen as a normal state of affairs by both doctors and patients alike. By contrast, Western conceptualizations rest upon a more

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localized ontology where in Canguilhem's inimitable words: 'Disease enters and leaves man as through a door' (1991: 39). In this theoretical framework health and illness are discrete and mutually exclusive categories. I suspect that these two ways of envisaging human physiology owe much to social context. They remind me of Bloch's discussion of internal and external ways of living in history (1996). So too, some Westerners can afford utopian ideals in which discrete healthy bodies are defended against illness, whereas those with a less favourable set of social and historical experiences see pathology as a normal part of the life course. Thus many conditions in Latvia such as 'damaged nerves' were thought to be universally distributed throughout the population. This is no longer so.

This study of Latvian psychiatry deals with the reconfiguration and reframing of languages of the self, emerging in tandem with new market forces and social inequalities. It maps the social and historical connections encoded in these languages and, in so doing, examines the extent to which psychiatric explanations align themselves with the individual's experience of market forces. In order to delineate these cross-cutting links more clearly, I will use transcripts of my interviews with psychiatrists and of consultations between psychiatrists and their patients. These transcripts show the very rapid changes in ideas about individual and national health, and of normality and abnormality. Through what Parker et al. have described as 'a strange, pathologically curious attention to language and practice' changing metaphors of the self are made visible (1995: 4). I will argue that the mismatch between the rhetoric of democracy and the reality of market forces manifests itself in contradictory articulations of illness and the self. Thus psychiatric transformations have reflected market transformations. However, these conceptual connections and arguments can only be constructed by grounding them in ethnographic work in the clinic. The commitment of successive governments to shock treatment of the economy, coupled with equally sudden changes in therapeutic practice, make Latvia an ideal social laboratory. The language of the clinic has changed swiftly and dramatically.

The idea that the self has a history is, of course, not new. Neither is the idea that the experience of illness is shaped by social and cultural forces. These ideas have been thoroughly mined by anthropologists, sociologists, historians and philosophers. Unlike broader theories of social change, in which change is gradual, incremental and misleadingly superficial, change in ideas about mental health and illness, and its associated behaviours, has come about in sudden spurts. In the Baltic states we find that the dominant narratives of suffering have changed rapidly. The early 1990s saw the publication of huge numbers of memoirs describing the impact of Soviet crimes in all three Baltic countries. These memoirs gave emotional impetus to the drive for independence and backing for nation-building. But now other louder narratives of economic suffering and social injustice have pushed these earlier narratives into the background. Arenas in which this shift is particularly noticeable are the *poliklinik* and the psychiatrist's consulting room. These stories from the clinic have shifted

from the political injustices and expulsions of the past shared by doctor and patient alike to the differentially distributed economic injustices and exclusions of the present. The brunt of economic injustice and social exclusion are experienced as very personal forms of pain, but in the clinic they are registered as various forms of disorder: depression, panic disorder, social anxiety disorder and obsessive compulsive disorder to name a few. In effect these terms are markers for social failure.

The sudden appearance of new psychiatric categories has been aided by the arrival of Western pharmaceutical companies with their persuasive literature and conferences, and by the World Health Organization (WHO) funded translation of the *International Classification of Diseases and Related Health Disorders* (*ICD*) manual into Latvian in 1997. These two institutions have combined to introduce new diagnostic categories – such as depression, panic disorder and anxiety – to psychiatric practice. These have replaced the old Soviet taxonomies of functional neurological disorders influenced by Pavlov's theories of the conditioned reflex (Joravsky, 1988: 386–7). However, unlike the historical examples cited by Hacking (1995, 1998) on, for example the fugue and multiple personality disorder, the psychiatric changes in the Baltic states, and their full meaning can be examined by talking directly to psychiatrists, neurologists and their patients. Observations from my own ethnographic work suggest that the new diagnoses involve a taxonomic reordering of existing symptoms rather than the discovery of new symptoms (Skultans, 2003, 2004, 2005). Nevertheless there is still something importantly new in this process: namely, the reconfiguration of the individual's relationship to others and the reallocation of the responsibility for illness. My study fits with Crawford's writings on Western meanings of health: his study found that what he called the moral discourse of health provided people with 'an opportunity to reaffirm the shared values of a culture, a way to express what it means to be a moral person' (1984: 76). These values revolved around, 'self-control, self-denial and will-power' (1984: 77). So too the advent of a market economy in Latvia has made prominent the idea of the self-propelled individual, both in economic and health discourses.

Psychiatric Transformations in Latvia

We might suppose that the abrupt arrival of the new taxonomies of illness would threaten not only the old taxonomies but also existing narratives of identity. As my case study will show, the transformation of shyness into panic disorder has implications for the patient's self image. On the one hand he becomes a disfigured individual with a quasi-physical and unpleasant condition: he has a mental abscess. But, on the other hand, he is also attributed a negative personality: he does not try hard enough to deal with his condition. I turn now to examine the palimpsest upon which contemporary psychiatric practice in Latvia has been built. The medical historian, Henry Sigerist, writing some 70 years ago, claimed that of all social institutions medicine is most influenced by the entire culture: 'Every

transformation in medical conceptions being conditioned by transformations in the ideas of the epoch' (1932: 42). And I would add that of all the subdisciplines of medicine, psychiatry is the most influenced by culture. The speed and manner in which these psychiatric changes have been articulated and implemented encourage a reappraisal of the vexed question of the relationship between psychiatric discourse and the experience of distress.

The anthropologist Verdery has astutely written that, 'the nature of a system often appears most clearly with its decomposition' (1991: 420). Applied to my area of interest this means that the recent reconstitution of psychiatric theory and practice according to a Western paradigm also throws light on its Soviet predecessors. So let me first take a look backwards. Latvian, like Russian psychiatry, has been developed in the German psychiatric tradition. Indeed, Emil Kraepelin, who perhaps more than anyone else has promoted the importance of psychiatric classification, worked for five years between 1886 and 1891 in Dorpat, which was situated in what was, at that time, Livonia. Soviet psychiatry incorporated wholesale the German passion for taxonomies and also broadened the social mission of psychiatry but, at the same time, retained a firm hold on the biological basis of mental illness. Indeed, this biological framework makes it difficult for any meaningful distinction to be drawn between psychiatrists and neurologists. The dispensary for nervous and alcoholic patients became the model for promoting the mental health of the population (Sirotkina, 2002: 156). In their emphasis on mental hygiene and practice, the dispensaries had as much an educational as a clinical role:

> We are talking about the healthification of labour. But the first word in the matter should be given to the neuropathologist. The problems of optimisation of work, which preoccupy our workers' state so much at the moment, cannot be solved without the neuropathologist and psychiatrist. We are talking about our archaic, barbarian everyday life, but in this matter as well one should listen to the neuropathologist with special attention. We are talking about the proper education of the younger generation. But who is the best pedagogue . . . if not the neuropathologist and psychiatrist! (Semashko, 1924, quoted in Sirotkina, 2002: 160)

Thus the template for the Soviet mental health clinic was laid down in the 1920s. A widespread malady that acquired the name 'Soviet exhaustion' following the losses of the First World War made the case for community mental health more urgent.

> In part the psychohygiene movement was a reaction to a peculiarly Soviet problem. Eight years of war, social upheaval, economic collapse, and famine, 1914–1922, had done enormous damage to mental health. Psychiatrists used various terms to describe what they saw in their clinics and heard from their colleagues. Some spoke of mass neurasthenia, others of mass schizoidization, or the widespread appearance of autistic symptoms, or simply of '*Soviet iznoshennost*' (exhaustion or premature ageing). (Joravsky, 1978: 113)

The problems of exhaustion perhaps also explain the focus on occupational and educational psychology. For example, the psychiatrist Segalin received his training in Germany and there learnt about the cult of genius and ideas of racial hygiene. Racial hygiene did not travel well to post-revolutionary Russia but theories of genius did. Arguing against the association of illness and genius, Segalin extended his argument to challenge the division between the normal and the abnormal. Instead, the distinction should be made between productive and unproductive illness: 'Nature . . . knows only one division – between repetitive and creative work' (quoted in Sirotkina, 2002: 166).

However, these kinds of culturally embedded theories were at odds with the prevailing physiological psychology associated with Pavlov. Joravsky describes Pavlov's mechanistic doctrines as 'the natural ally of Marxist-Leninist social science and revolutionary politics' (1988: 53). After the relatively free and experimental ideas of the 1920s, Stalin's support of Pavlov elevated him to the status of a national icon. His brand of neurophysiology was, however, far removed from Marx's theories of the self as made and remade through historical processes. For psychologists and psychiatrists to embrace Marx would have meant recognizing the connection between exhaustion and the social conditions through which it was engendered.

After the Second World War and the annexation of the Baltic states Soviet psychiatric theory and practice was exported to Latvia. However, as Kleinman among others has pointed out, once relocated, psychiatric ideas acquire different meanings and overtones: they became indigenized. The diagnosis of neurasthenia came to dominate the practice of what was called 'little psychiatry' in Soviet societies and is a good example of this translation process. The ready acceptance of neurasthenia by Soviet psychiatrists in itself requires some explanation, since so much of Western psychiatry was rejected solely on account of its provenance. Neurasthenia first appeared in the medical arena in 1869 when Beard and his colleague Van Deusen distinguished it from the term asthenia (Bynum, 2003: 1753). Neurasthenia was at one and the same time an organic disorder and strongly connected to social circumstances. Roelcke describes the 'ongoing debate about the relation between the supposed increase in "functional nervous disorders" (or "functional psychoses" and the conditions of life in modern civilization. Neurasthenia was the prime example of these disorders' (1997: 384).

The diagnosis of neurasthenia pulled together a number of ill-defined symptoms, such as exhaustion, weakness, irritability, lowness of spirits and inability to concentrate. It spoke of a disjuncture between the relentless demands of a speeded up bureaucratic society and individual resources, particularly female resources. The much-quoted cure was a good diet, rest and sleep. However, by the 1920s the symptoms of neurasthenia had been parcelled out among a number of other diagnostic categories. Neurasthenia disappeared because, as Wessely comments, 'It has ceased to be useful to

the doctor' (1994: 194). Whereas during its early history it had provided a way of avoiding the stigma of psychiatric illness, with the growth of psychosomatic medicine this was no longer possible. Thus its social tasks had been completed. So why then did Soviet society, otherwise in rivalry and reluctant to borrow from the West, take on board a diagnosis that had long passed its sell-by date in North America and western Europe? The answer, I believe, lies in the Janus-faced nature of neurasthenia, being configured as both an organic disorder of the nervous system and as the inevitable outcome of excessive societal demands upon the individual. Thus neurasthenia satisfied both the ideological needs of a dogmatic mechanistic physiology and implicitly suggested the experiences of oppressed peoples. This was particularly true for Latvia.

Soviet exhaustion acquired an anti-Soviet tinge in the Baltic states. It did so at both the collective and the individual level. Nerve exhaustion was used to weave together a medical model of political oppression. Individuals were described as damaged by a terrible collective history and national identity itself was seen as damaged. Medical metaphors have been used at other periods to emphasize social and cultural decline. 'If medicine has a political and cultural history, as is now widely acknowledged, so do politics and culture have a medical history' (Nye, 1982: 20). Indeed, Nye describes the ways in which 'medical judgements were capable of expressing the consensual norms, prejudices and salient anxieties of French [*fin-de-siècle*] society' (1982: 21). So too the anxieties of Soviet and post-Soviet Latvian society are expressed in medical terms. National identity under Soviet rule was seen as being endangered by a low birth rate, a high rate of birth abnormalities, high rates of alcoholism and suicide, and a population that envisages the damage to its nervous system as a collective experience. Thus ill health was seen as a collective rather than an individual problem.

Thus the network of mental health dispensaries established throughout Latvia was a response to the requirements for Soviet surveillance as well as corresponding to the needs of Latvians who saw themselves as a damaged people. Soviet psychiatry aimed to have both a prophylactic and a pedagogical function. However, this kind of practice was labour intensive. As a result, during the decades of Western psychiatric de-institutionalization, the Soviet Union tripled the number of psychiatric beds and quadrupled the number of psychiatrists (Joravsky, 1988: 432). This generous provision of psychiatrists and neurologists at the primary care level extended to Latvia and the other two Baltic states. Here the corrective and pedagogic role of psychiatrists and psycho-neurologists was particularly important because the Soviet Union could not count upon the political allegiance of the Balts. However, the majority of psychiatrists were local Latvian women and there was a large degree of identification with and sympathy for their patients. For example, rather like the early writers on neurasthenia, many Latvian clinicians admitted that they too suffered from neurasthenia, which they attributed to the difficult social circumstances of their lives. Inevitably this created bonds between doctor and patient. There was, of course,

surveillance, but also considerable solidarity. Doctors frequently spoke of their patients', and indeed their own, impossible living conditions.

Thus whereas the history of 'Soviet exhaustion' is confined to the years after the First and Second World Wars, the history of neurasthenic exhaustion in Latvia extends throughout the years of Soviet occupation. Exhaustion is the ultimate form of individual resistance against society. 'Fatigue potentially subverts the utopian belief in the myth of universal energy and a universe subject to physical laws' (Rabinbach, 1982: 58). But clinical histories of exhaustion soon became intertwined with collective history. The emphasis on exhaustion may account for the importance placed on the personality of the doctor, who counteracts the patient's weakness with his strength: 'The authority of the personality of the doctor giving the treatment, and his educative influence both in work-therapy and in culture-therapy, are decisive' (Snezhnevskii, quoted in Joravsky, 1988: 422). The authority of psychiatrists was, of course, reinforced by the fact that their activities were carried out with virtually no legal restrictions: psychiatric practice had no legal framework. But the converse of that was that psychiatrists could prescribe prophylactic rest or convalescence for patients in one of the many well-equipped spas in Latvia. However, the authority and pedagogic role of the psychiatrist was potentially threatened by subversive conceptualizations of normality and abnormality. In Soviet Latvia illness and disease were accepted as the norm. These ideas about health and illness were articulated against broader taken-for-granted assumptions about the nature of normality to which I shall return later.

Thus the medical legitimacy of exhaustion was one way in which Soviet society sought to contain individual resistance and discontent. These ideas about fatigue and the 'normality of abnormality' informed clinical practice in Latvia during the early 1990s. During the summer of 1992, I spoke to many clinicians, mostly psychiatrists and neurologists. Among them was, Dr Ieva Alka, the director of the central emergency ambulance service of Riga, which, at that time, was located in Brunenieka iela. Her pragmatic approach to the inevitability of illness unwittingly draws upon ideas about the nature of physiology similar to those of Canguilhem. Unlike Western emergency medical services, Latvian emergency services had a wide remit. First, what constituted a medical crisis was generously interpreted. Since primary care was delivered through the polyclinics, whose doctors worked office hours, most medical problems outside these times were handled by the emergency 'brigades'. These brigades were organized along the lines of medical specialties, so that, for example, there would be a cardiovascular brigade, a neurological brigade, a psychiatric brigade and so on. Each brigade would include a doctor, a medical assistant and a driver who usually also had some sort of intermediate medical training. In other words, Dr Alka's experience of the perception and treatment of medical problems troubling the inhabitants of Riga was extensive. Moreover, during the period of transition in the early 1990s, the emergency ambulance service was free while charges were being instituted for polyclinic consultations and hospital

stays. Dr Alka was well aware of the financial constraints under which her patients operated.

Essentially Dr Alka had a cautious attitude to illness, preferring to err on the side of over-diagnosis rather than under-diagnosis. 'We are afraid to overlook organic illness.' But her caution is prompted by a theory in which the very process of living brings about pathological changes of function that eventually result in organic disease. Various medical terms capture the idea that living itself produces functional disorders, such as, for example, neuro-circulatory dystonia, cardiac dystonia and vegetative dystonia. These produce symptoms such as chest pains, variations in blood pressure, dizziness and weakness. As Canguilhem points out, any medical term that starts with the preface *dys-* indicates that a dynamic, functional rather than an ontological theory of health is in operation (1991: 41). The generic Soviet term for these conditions was 'vegetative autonomic nervous system patterns'. This kind of physiological lability, while perfectly normal, is of serious medical consequence because of the cumulative imprint that it leaves on the internal organs. Bukharin's metaphor of a person as 'a sausage skin stuffed by environmental influences' provides an apt visual description of this approach (quoted in Joravsky, 1978: 125). Thus the question is not whether a person will fall ill, but when they will do so. According to Dr Alka, some degree of organic pathology was to be expected from the mid-30s onwards. Thus the assumptions of Soviet medicine conform perfectly with Canguilhem's identification of the normal and the pathological (1991: 44). Indeed, pathology is primary, it is physiology in action. It is 'an extended or broadened physiology' (1991: 57).

Normality and Abnormality

This clinical framework accorded well with popular views of normality and abnormality in Soviet and transition Latvia. The Russian term *normal* does not translate precisely as normal in English. Neither does the Latvian term *normali*. Rather, in Soviet societies, the reply *normal* to the question 'How are you?' is often accompanied by a shrug and suggests something along the lines of 'Bad, but not too bad, taking into account everything we have to put up with.' In other words, normal is nearer to meaning not normal. This ties in with the findings of other anthropologists working in post-Soviet societies. For example, Rausing, who studied the dismantling of a collective farm, has this to say about normality:

> The entire settlement, and, by implication, Soviet Estonia, was not normal in comparison to [the] imagined construction of the normal. . . . The normal was rather associated with the solid ordinary comforts of Northern Europe, which, of course, were anything but ordinary on the collective farm. (2004: 36)

> Wanner, studying national identity in Ukraine, describes how 'Abrasive intrusions into everyday life in post-Soviet society were so abrasive that they had ceased to be remarkable' (1998: 5). Wanner recounts her attempts to pass as a Lithuanian on a train journey through the Ukraine. Her fellow passengers

> ask her about the price of food in Lithuania but she answers that her nerves are in such a state that she cannot manage the shopping. This immediately confirms her authenticity as a Soviet citizen: A woman who admitted to them that she is so strung out that she can no longer cope with the not-so-basic task of buying bread: that's a woman whose psyche has been mangled by the Soviet system. Of course, she's *nasha*. (Wanner, 1998: 9)

Stukuls-Eglitis describes how the imaginings of Latvian nationhood imply 'that a state of normality was something that needed to be consciously (re)created (2002: 71). Fehervary notes that luxury goods rarely seen in Hungary are described as 'normal' (2002: 369).

Thus we find ourselves in a semantic domain in which normality belongs elsewhere, in another time and another place. However, these ideas of abnormality and normality are not stand-alone concepts. They are linked to a focus on the aetiology of abnormality and illness that points to its roots in history and social circumstances. However, the idea that one is living in abnormal times that exact a toll from one's health, both mental and physical, is not linked to self-deprecation or stigmatization. The network of ideas around shared abnormal circumstances and damage to individual nerves preserves, indeed, it may even enhance, individual dignity. This semiotic system is radically different from that described in the more recent sociological literature. There is a substantial amount of writing that describes post-communist societies in negative, even pathological terms. Sztompka writes about the distrust of the public realm under communism and its subsequent reinforcement by the uncertainties of life under post-communist society (1999: 151–90). In describing the absence of traditions of civil society, he also uses the ambiguous and somewhat unfortunate term 'civilizational incompetence' (1993). Verdery draws an analogy between the role of Western advisers in post-communist Europe and that of doctors. She describes a narrative which 'compares the former socialist bloc with a person suffering from mental illness – that is, socialism drove them crazy, and our job is to restore their sanity' (1996: 205). However, lay people also have views similar to those of the social scientists. Older *émigré* Latvians use similar derogatory terms to describe the Latvian character. The verb used most frequently – *sabojats* – can be translated as 'damaged', but has more negative connotations. It can also be used for food that has gone off and of computer files that have been corrupted. In this context the phrase used is *Mes esam sabojata tauta* ('We are a damaged nation'). The other descriptive term that is used is *degenerets* which translates as 'degenerated'. When Latvians from Latvia use these terms, there is a note of defiance and triumph over adversity. Petryna in her book *Life Exposed: Biological Citizens after Chernobyl* writes of the very tangible advantages that the recognition of invalidity can confer: 'How biology, scientific knowledge and suffering have become cultural resources through which citizens stake their claims for social equity in a harsh market transition' (2002: 4). In Latvia, neurasthenia conferred some advantages for the patient, such as so many free

weeks a year in one of the many spas and health resorts. However, beyond the material advantages there was a kind of spiritual belonging to a community of sufferers. The boundaries of this community do not extend to *émigré* Latvians, who are often perceived by Latvia's Latvians as having an instrumental and materialistic approach to their country (Herloff Mortensen, 1999).

The language of nerves encompassed both the history of the body and the history of the nation. The language of nerves also enabled doctors to identify with their patients, to admit their own suffering, by virtue of a shared national history. The processes of identification are rather akin to what Rabinow, writing about a later period of genome research, describes as biosociality (1996: 99). Nerves described as *cietusi*, as having suffered, recalled Leonardo's anatomical drawings of walking and crying skeletons. Mind–body dualisms reduce not only the mind but also the body. My position was reinforced by reading Elizabeth A. Wilson, who argues that: 'what is "reduced" in biological reductionist theories of psychology is not only the psychological phenomena involved but also biology itself' (Wilson, 1998: 96, in Fraser, 2001: 72). Latvian doctors and their patients operated with an expanded notion of biology. Ironically, the expansion of psychological medicine has produced an emaciated understanding of human biology.

Drug Companies and Changing Psychiatric Language and Practice

The collapse of communism in Latvia has required an unprecedented refashioning of consciousness. The rapid and convulsive nature of changes has meant that transformation has relied more upon language than upon tradition or practice. Verdery (1991) makes this point with regard to socialist societies generally. She writes:

> While one could argue that all regimes are concerned with language to some extent, I would hold that socialist ones lie at an extreme on this dimension. For unlike the western European societies that benefited from several centuries of slow evolution in which consciousness came to be formed through practice than through discourse (Bourdieu 1997), eastern European communists came to power with the intention of rapidly revolutionizing consciousness and with precious few means of doing so. Popular resistance to many imposed practices made language the principal arena for achieving this end. The social power deriving from control of representations of reality became truly vital for rulers who disposed of relatively few such means . . . language and discourse are among the ultimate means of production. (1991: 430)

The newly rediscovered independence of the Baltic states, has found expression in a rejection of all things Soviet. This has led, among other things, to the well-documented practice of renaming streets, the rejection of Moscow time as well as the rejection of Soviet psychiatric diagnostic

categories. Language changes have occurred in all spheres: political and economic no less than psychological and psychiatric. The psychiatric revolution has been as sudden and as unexpected as the other more visible and talked-about revolution.

Soon after independence, market principles affected psychiatric practice. Major pharmacological companies such as Lundbeck, Solvay Pharma and Wyeth Lederle distributed large quantities of their drugs to psychiatrists and neurologists. This kind of strategy showed a sensitivity and awareness of the earlier mechanics of Soviet bureaucracy, where 'there [was] a rampant competition to increase one's budget at the expense of those roughly equivalent to one on a horizontal scale, so as to have potentially more to disburse to claimants below' (Verdery, 1991: 424). Of course, it also showed a keen awareness of the market potential of the Baltic states. Although these 'charitable' donations fitted the public image that drug companies wanted to project, by the mid 1990s this form of charity had dried up. In its mission statement, Lundbeck states: 'Sometimes effective treatments exist but only a fraction of those suffering are diagnosed and treated correctly', and that their overall goal 'is to improve the quality of life for people with psychiatric and neurological disorders' (Lunbeck, n.d.).

Most doctors and patients accept the humanitarian statements of the pharmaceutical companies at face value, especially since the quality of drug treatment during the Soviet period was poor. Verdery's astute article, reflecting on the nature of socialism, explains why this had to be so (1991). Drawing upon East European theorists of socialism, she argues that the goal of socialism is to maximize 'allocative power' in contrast to the goal of capitalist societies, which is the maximization of surplus value. 'The capacity to allocate is buttressed by its obverse, which is the destruction of resources outside the apparatus' (1991: 421). Thus it is not in the interests of socialist societies to produce desired and saleable goods but rather to amass inferior goods and create shortages. This applied to treatments for suffering nerves, often labelled neurasthenia. People who sought medical treatment, would be treated by chemical compounds whose primary purpose was sedative. From the 1960s onwards, tricyclic drugs were developed in the Soviet Union to treat depression. However, these could only be obtained if one had the right connections. Thus the switch to a market economy held out the promise of more sophisticated and effective treatment for a range of psychiatric problems.

However, in addition to the widening range of available drug treatments, there were also major changes in diagnostic language. These changes were initiated largely by the drug companies, but also by the WHO-sponsored translation of *ICD-10* into Latvian (*SSK-10*). This was first published in 1997, although the work of translation had been initiated in 1990. However, the prohibitively high price of the volume meant that very few doctors would have access to it, let alone own a copy. By contrast, the drug companies distributed free literature and organized day conferences at no cost to participants. These conferences focused on depression, anxiety,

including social anxiety disorder and panic disorders. The ostensible aims were to familiarize psychiatrists and family practitioners with a new set of diagnoses, to facilitate the recognition of these disorders but also to persuade clinicians to use their drugs for these conditions. Training courses to promote the identification of these new disorders were also given by visiting Western psychotherapists, mostly coming from Sweden and Denmark. We see in this historical development a good illustration of Hacking's looping effect (1995: 21, 61). New categories bring into being new classes: diagnoses of panic disorder come into being at the same time as individuals come to reinterpret their behaviour and give their symptoms a new name.

The emphasis of these imported disease categories differed from those of Soviet disease categories. The primary emphasis of Western psychiatric categories was on emotional states and behaviour rather than bodily feelings. A characteristic of these classifications, especially since *Diagnostic and Statistical Manual of Mental Disorders-III* (*DSM-III*), is that they aspire to be purely descriptive and a-theoretical, and that they eschew any speculation about aetiology (Cooper, 2004; Sabshin, 1990; Wilson, 1993). However, the exclusion of aetiology and the dynamic processes of mental illness is associated with the dominance of the biomedical model and what Wilson describes as 'a significant narrowing of Psychiatry's clinical gaze' (1993: 399). Implied in this view is that psychiatric classifications are able to capture the patterned clustering together of symptoms as they occur in individuals. They claim to 'carve nature at the joint' and in so doing demote earlier systems. These are seen as having less of a purchase on the reality of mental illness and as being less discriminating. But, as Cooper points out, psychiatric observation is not theory-free (2004). Moreover, the categories of the *DSM* have financial implications in terms of what insurance companies are and are not prepared to pay for. Similarly, in Latvia diagnoses are important because some entitle the patient to free drugs while others do not.

Given the radical nature of social change in Latvia, we would expect psychiatric theory also to change. Psychiatry in Latvia provides support for Hacking's claim: 'If my ecological approach is correct we should expect a disorder to mutate or disappear if its habitat is destroyed' (1998: 56). As with many earlier disorders, such as hysteria and fugues, 'The miscellany of symptoms was redistributed among a new set of illnesses' (1998: 72). Similarly, the symptoms of neurasthenia have been shared out among the taxonomies of *DSM-IV* and *ICD-10*. A well-tried way of challenging and replacing the authority of earlier diagnoses is by introducing the concepts of latency and masked illnesses. Thus, in the early 20th century, hysteria came to be seen as a latent form of epilepsy. In the same way, the psychopharmacology companies urge doctors to see neurasthenia 'for what it is', namely, a masked form of depression. This type of argument rests upon naïve realist assumptions that present depression in a highly decontextualized form and as being a natural kind existing independently of the language that describes it.

However, the symptoms of depression (*ICD-10*: section F32) are very similar to those of neurasthenia: low mood, decreased energy, decreased concentration, sleep and eating disturbance, often accompanied by anxiety. But, unlike neurasthenia, depression is not necessarily seen as brought about by circumstances. Ironically, although neurasthenia is primarily articulated in terms of nerves and depression in terms of feelings, neurasthenia was linked to a shared past and circumstances whereas depression is represented as a disorder that bears little relationship to the circumstances of life. Thus, although the syndromes are similar, the mutation from neurasthenia into depression has very different meanings for the patient. Neurasthenia connects to others, whereas depression isolates. Thus Rose's (1998) triad linking liberal democracy with self-governance and 'psy' technologies illuminates, but does not fit perfectly onto Latvian psychiatry. The new psychiatric diagnoses reflect a certain degree of cognitive dissonance in psychiatric thinking: they are simultaneously treated both as indicators of personal failure and of organic disorder.

Kramer writing about the uses of Prozac has this to say: 'All men are created equal – at least in our political and moral ideal but they are created biologically heterogeneous' (1994: 298). If we accept the arguments of Kramer, namely that Prozac is the great leveller, overcoming the inequalities created by different neural architectures of the brain, then psychopharmacology has a contribution to make to 'the democratic project' (Fraser, 2001: 63). However, my argument is that, in Latvia, psychiatric language has both a part to play in making those neural inequalities seem real and then offering ways of overcoming those inequalities that are beyond the reach of most patients. Thus psychiatry constructs and reinforces biological, psychological and social and economic inequalities.

A 'Case' of Panic Disorder

I will focus on a single case study that illustrates several of these themes. My fieldwork was carried out over a period of six months in 2001. During this time I spent around three days a week sitting in on and tape-recording psychiatric consultations. In this way I observed the practice of six clinics, four of them provincial and two in Riga. I also talked to psychiatrists and their patients. However, I have chosen to focus on a single patient because the psychiatric transformation of his problems is typical of what I observed time and again in other consultations. My description of this 'case' is based on a consultation between Dr H, a psychiatrist working in a private clinic in central Riga, and her patient of two months Maris. He is 45 years old and works as a sound technician. I had spent several days sitting in on Dr H's consultations and tape-recording them. My presence and the tape-recorder were negotiated with the agreement of each patient. Before this particular consultation began, Dr H left the room to collect some medicines from the chemist. Her invitation to Maris to recount his *anamneze* or clinical history to me in her absence gives some indication of Dr H's enormous generosity and the trust she placed in me. The trust that patients placed in

Dr H is evidenced in Maris's willingness to talk without any prompting from me:

> *Maris*: In other words, my problem is . . . well, let's say, although it may seem strange to you, maybe because from the outside I seem an outgoing individual (*komunikabls cilveks*). And yes, I could be outgoing as far as my character goes. But it's precisely my illness that prevents me from being like that. And what is the illness that I've only recently begun to regard as an illness? Because for a long time I didn't understand that it was an illness.
>
> *Vieda*: Did you suffer for a long time?
>
> *Maris*: As a matter of fact I suffered from my early years, well from about [the age of] 20, when I became an adult. Because while one is a child or an adolescent, the psyche is different.
>
> *Vieda*: How old are you?
>
> *Maris*: I'm 45. The problem is that I have, as I would describe it, a pathological shyness about myself, about contact with other people, about finding myself sharing a space either in a tram or a train or a shop. Well and that's why I call it a pathological shyness, because although I know that everyone is shy about some things, for me this shyness doesn't have an intelligible basis. In other words, I'm not shy about my appearance. I could understand it if there was something in my appearance or my behaviour to be shy about. I'm shy for reasons that I don't understand, and that creates a whole string of problems and side effects. For example, one side effect is that if I'm travelling by tram, I'm too shy to read. If I'm reading a newspaper I'm less shy, but if I have a foreign journal in English, then I feel very shy, because those standing round me can see that I am reading a foreign language and that makes me stand out. It's linked to the thought that I am somehow attracting attention. And then as a result of this shyness I start feeling hot, terribly hot, waves of heat sweep over me and that brings on a sweat and I break out sweating. But otherwise I'm lean and never sweat. On the contrary I suffer from cold hands.

But Maris says he only came to the conclusion that his problems amounted to an illness about five years ago and he first sought medical help by consulting Dr H. about two months ago. His search for medical help was precipitated by the problems his shyness caused for his work, which requires him to be sociable. Maris's problems illustrate the way in which certain personality traits come to be seen as incompatible with working in a market economy and are, therefore, given a medical gloss.

On her return from the chemist Dr H sums up the situation as follows:

> *Dr H*: The problem has tormented him for several decades. And it's only two months ago that the poor man took any practical action. Two months ago we started moving this problem forward, tackling it and looking for medical solutions. Well then, [turning to Maris] how would you compare your state since the first visit and your state now? How has the condition changed and in which direction? For example, has it improved roughly by half or more? Or by half, or by a bit less?

Maris: I'd say it's improved by about half, because by and large the medications remove the stress. I've already told you that there is a side effect of sleepiness, but I manage to grapple with that somehow or other.

Having discussed Maris's occasional appetite for beer and wine Dr H moves on to ways of tackling his symptoms.

Dr H: The main thing is that . . . the most important victory is what you do yourself, how you yourself cope with the symptoms or with the illness, not with the help of some sort of cider, because that's cider – that's not a medicine. For example, Fluanxol that's a medicine. Does it do anything for you? In the case of systems that result in this kind of tension, Fluanxol stabilizes these systems. And it's not wine or beer that stabilizes these systems. They only have an effect for a moment. But you yourself can create the same sort of effect if you practise simple relaxation exercises. In which case, I'd take my hat off to you, if you started to practise these instead of having a glass of wine. If you replaced wine with another therapy. Because, and I have to repeat, that's such a slippery path, that God help us if you slip. It's so slippery, especially with these kinds of conditions. And thank God that you are a person that can stand his ground, but you are vulnerable. And so compare Ivars [a relative of Maris], why does he drink? I can tell you why he drinks. He drinks simply because he feels better. It's easier for him to drink alcohol and to skip taking two or three medications for his phobias. He feels the effect more. But he went down that path in gradual stages. The only difference is that you have a different personality, you stand on your own feet, others are weaker.

Maris: Everything is going well at the moment – my work, my wife, my family, everything. In actual fact, there shouldn't be a problem, no problem at all. But at the same time I'm in a complete depression and fed up with life because this illness is . . .

Dr H: You have everything except one thing. And that's enough for a person to be ground into the dust. Yes and no, Maris. We've already talked about how that's one of the stages and you have to put up with that until the medication takes effect. Because this problem is very long-standing, it's chronic and we can't deal with it without medication. And, as a matter of fact, there is no psychological dependency, but it's just the same as, for example, excising some suppurating boil and in just the same way you need this medication at this stage, it's the essential therapeutic moment and it's quite simply necessary for you. Because you can't substitute or slow down those substances that are in your organism. You can't do that.

Maris: I have no objection to taking the medication.

Dr H: It's necessary to balance the system, the biochemical system. In principle they are disturbances of the central hormonal system. And show me any hormonal disturbances that can be eliminated without the help of medication. I don't know of any such. And these illnesses are treated and the treatment is not dependency. But just see, as soon as people have taken the idea of dependency into their little heads (*galvina*), everybody has read about dependency. Dependency, dependency – I have to ask you what you

understand by dependency. In that case, I doubt whether you understand what dependency is.

And I really believe that anyone who takes an interest, who is interested in their illness and who is educated has particular privileges. You have all the weapons in your hands; you can start to look and start to do something. And you can consult me whenever you need and ask whether something is appropriate or not. And I'll give you my opinion, but meanwhile you can be active and strengthen yourself.

Maris: Then does that mean that my attitude is too passive?

Dr H: To a certain extent, yes. It's begging, and asking: 'Why do I have this and why do I have that?'

Maris: What exactly should I be doing? Should I be searching the literature?

Dr H: Yes you should search the literature. Because with this thing, it's become an abscess. And the most important strategy with obsession is counter-obsession. You need counter-obsession. And if, say, it's at the level of mood, then you must search for counter-obsession at the thinking level, so that you can stop or exclude the obsession as you said yourself. You simply need concrete exercises, concrete exercises and nothing else. You simply have to search yourself. There is a whole string of books on these relaxation techniques. You should search yourself and see what suits you best.

Maris: I've found one such for myself. It's Carnegie's *Stop Worrying and Start Living* [Latvian translation: *Jasak Dzivot*].

Dr H: Listen, don't mention Carnegie to me.

Maris: But that book suits me like a Bible. I've used a highlighter to underline the parts that apply to me 100 percent.

Dr H: But don't you understand that Carnegie, that's just his approach and it may be totally unsuited to your inner world. One person advertises his opinions and the whole world runs after them like crazy. But humans are individual beings.

Maris: It seems to me that these ideas are similar to mathematical or physics formulations, akin to some sort of law of omega, that really corresponds to my feelings.

Dr H: And that's how he deceives the public.

Maris: Well, let's say with regard to thoughts and feelings. If you feel sad then think happy thoughts. You can change your feelings by trying to create a bright mood with happy thoughts.

Maris is afraid that if he reads too many books on the subject he will become confused.

Maris: If I start to read more I'll be going deeper into the forest, because in this realm the jungles are vast and there are so many points of view

Dr H: You must understand, the jungles are not in the literature, the jungle is in yourself.

Now, let's get back to the base-line therapy. I'm writing out the prescription for Fluanxol and . . .

Maris: Cypramil and Dematimark.

Dr H: Yes, 100 mg. And have you got enough Phenazepam?

The entire consultation lasts some 30 minutes and my transcripts of the recording cover 10 single-spaced sheets of A4. I have extracted fragments of the dialogue that connect with and illustrate the theoretical issues I have already raised. Much of the rest of the consultation revolves around a discussion of appropriate and inappropriate uses of alcohol and these issues merit a separate article.

Discussion

First, it is worth noting that Maris has accommodated the experience of shyness throughout the 25 years of his adult life. He has only come to see it as pathology since about 1997 and sought treatment from Dr H two months ago. A visit to any clinic in Latvia would have afforded him the possibility of reading about panic disorders and social anxiety disorders. Maris's contextualization of his shyness requires some unpacking. The mention of an English-language newspaper is not fortuitous. During the Soviet period this would, indeed, have attracted attention, including possibly the unwelcome attention of the KGB. Such shyness and fear would have made sense against a background of Soviet distrust of Western influence and the attendant surveillance imposed upon citizens. With the arrival of the psycho-pharmaceutical companies, shyness and distrust have become transmogrified into an illness, namely, social anxiety disorder. This disorder has extended the market for a whole range of medications. However, the pathologization of shyness has not simply come about as a result of new taxonomies introduced by the drug companies. The ground for this kind of disorder has been prepared by the introduction of a more extrovert business culture epitomized in Dale Carnegie's popular psychology handbooks. A number of translations into Latvian have appeared since 1990 at low prices. Over the same period, unemployment has increased, conditions of employment have become more precarious and anxieties about work and performance have increased. Maris's concern with his outward appearance in his work role reflects a business culture in which age, appearance, dress and social ease have become ever more important. Thus, the ecological niche for social anxiety disorder has been shaped by vectors from both above and below (Hacking, 1986: 234).

Dr H has a seemingly contradictory dual perspective on Maris's problems. She conveys to Maris in no uncertain terms that his illness has a biological basis and that it requires intensive and extensive drug therapy.

Indeed, she evokes its physical reality by comparing it to an abscess. However, at the same time as emphasizing the organic basis of the disorder, Dr H insists on the seemingly contradictory need for Maris to be more active in combating shyness and anxiety, and to search the literature on relaxation for personal solutions. Education gives Maris an advantage she claims. In her dual allegiance to organic determinism and the importance of individual striving Dr H is echoing the contradictoriness of a market economy that excludes vulnerable individuals and yet appears to offer unlimited possibilities to all. When Maris points out that he has already found Dale Carnegie's books extremely helpful, Dr H dismisses the suggestion that they could be useful, perhaps because Carnegie represents individuals as enjoying too much sway over their circumstances and thus challenging the organic basis of problems, or perhaps because his enthusiasm threatens her authority. It is significant, however, that Maris has singled out an iconic publication of the American dream as being of relevance to what he has now been taught to see as illness.

The consultation between Dr H and Maris demonstrates that Western psychiatric taxonomies, psychotherapies and drug treatments have arrived in Latvia. If Rose's arguments about the inevitable dependency of democracy upon the psychologization of the self are correct, then we might have expected this kind of rapid conversion. Rose writes: 'To rule citizens democratically means ruling them through their freedoms, their choices, and their solidarities rather than despite these' (1998: 117). These democratic selves do not come into being of and by themselves. They are, according to Rose, brought into being through professional discourse and dialogue with psychologists, psychotherapists and psychiatrists. But, as Kleinman (1980) reminds us, Western psychiatry becomes indigenized when exported to other cultural settings. Psychiatric dialogues in Latvia reflect not only a new democracy's demands for active and self-regulating individuals, but also the mismatch between the rhetoric and reality of the market economy. As Waitzkin has argued for a Western capitalist context, 'social reality contains structural contradictions' (1983) and these in turn are reflected in medical structures of oppression. Verges has described a displacement that, 'instead of looking at socio-economic and historical reasons to explain the island's situation [La Réunion], authorities concentrate instead on the "Creole self" and its symptoms. "Creole pathology" has become a familiar referent in Réunion's public discourse' (1999: 192). So too psychiatric experts, and indeed sociologists, reflect upon the post-Soviet self and see it in terms of pathological deficits. These examples from diverse social contexts demonstrate the ease with which a language of individual psychiatric pathology can adapt and lend itself to disguising the sources of social oppression and overriding popular memory.

Kolakowski writes of the need 'to convince oneself that those communist decades were a kind of unnatural hole in the historical process, an empty time, a total break in continuity, a sheer waste' (1992: 56). But Maris's history speaks to us of a Soviet legacy of fear and anxiety, now dressed up

in Western garb. Part of Dr H's solution to this problem lies in the use of medicines. She would, I feel, agree with the following characterization of psychopharmacology as 'promis[ing] to be the great democratizer for people made vulnerable by trauma or by innate neural chemistry' (Giggers, 1997: 129, quoted in (Fraser, 2001: 63). But, for many patients, psychopharmacology does not provide an easy solution. In the first place, most patients do not have the money to be able to afford Western medicines. Although, these medicines may hold out the promise of an equal share of mental health and happiness for all, the economic realities are such as to make these rewards inaccessible to most people. For this reason, there is a frequent slippage in psychiatric discourse between the determinism of the organic and the persuasive rhetoric of personal effort. Thus a visit to the psychiatrist may reaffirm, rather than loosen, 'the relation between an individual and biology' (Fraser, 2001: 65). Second, those who can afford the medicines are worried by dependency. Latvian psychiatrists have not renounced their earlier pedagogic role and they urge their patients to take a more pro-active role in the management of their illness. But when this activity extends to questioning the dangers of dependency, they are rebuked.

In several ways the contradictions of psychiatric practice reflect the contradictions of a neoliberal economy. The philosophy of the market suggests that everything is possible to the individual with enterprise. Similarly, psychiatry and its handmaiden psychopharmacology suggest that individuals with mental disorders can be fully restored to their former selves through a combination of Western drug regimes, medical compliance, and individual effort and searching. The reality is somewhat different, however. A market economy is weighted against certain individuals and not all circumstances are of one's own making. Similarly, not all psychiatric disorders can be overcome by individual effort, and some have emerged as disorders with the advent of a new type of society and economy. Rose has argued that, 'In advanced liberal democracies, biological identity becomes bound up with more general norms of enterprising, self-actualizing, responsible personhood' (2001: 18; see also Novas and Rose, 2000: 488). Under these circumstances, biology links individuals to a community. Whereas there was what might be described as bio-sociality in Soviet Latvia, economic inequalities are now reflected in biological inequalities. Psychiatrists play a key role in translating patients' acutely experienced feelings of insecurity and social injustice into medical categories that consolidate a sense of individual failure.

It will be interesting to see how changes in psychiatric theory and practice relate to the stigmatization of mental illness. A number of theorists of cross-cultural psychiatry, among them Kleinman (1977), have argued that the somatic presentation of emotional distress is one way of avoiding the stigma of mental disorders. However, major psychotic disorders continued to be stigmatized throughout the Soviet Union and in Soviet Latvia. Indeed, the terms marking subdivisions within psychiatric practice in use throughout the Soviet Union, namely, *liela psihatrija*, translated literally as big

psychiatry, and *maza psihatrija*, small psychiatry, map the boundaries between those conditions that are, and those that are not stigmatized. Thus we can see that the biological understanding of the major psychoses did not prevent their stigmatization. In Latvia there were two quite distinct discourses: one that used the idiom of damaged and suffering nerves and the other relating to mental or spiritual illness. The first idiom left the self, suffering but intact, the second had a more penetrating and corrosive force undermining the very sense of self. However, as I have argued, it would be naïve and wrong to assume that the language of nerves was in any sense reductionist. By contrast, Western psychiatric languages of depression and anxiety aim to be more tightly bound and organic. However, in the course of consultations these strictly defined taxonomies unravel as troublesome circumstances create a seepage between psychiatric texts and social contexts. Psychiatrists frequently use unflattering metaphors, such as that of the abscess, to impress upon patients the seriousness of their disorder and the urgency of treatment. But, although such metaphors may contribute to a disfigured identity, they do little to smooth the relationship between the individual and the social environment. Thus, while the disease category may have found its social niche, the person most certainly has not. Let me return to Canguilhem's configuration of ideas about the normality of pathology and the importance of obstacles for understanding health. We can see how this configuration maps onto a society that recognizes the common impact of social experience. But it does not readily map onto a society that rests on assumptions about the unequal distribution of resources be they biological or economic.

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