Social Psychiatry Inside-OUT

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Response

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A heartfelt thanks to all commentators on this trio of papers. The idea that animates these papers is that placing modern psychiatry in a comparative perspective lays bare its weaknesses, for it shows that some of the problems that dominate our contemporary discussions in journals such as *Philosophy, Psychiatry & Psychology* (e.g., the problem of diagnostic validity, the demarcation challenge, stigma on mental illness), do not actually exist elsewhere, at least not to the same degree or in the same form. I believe this should raise the question of why certain healthcare systems manage so differently and what, if anything, might modern psychiatry learn from them. My proposed answer is externalism: the development of a set of conditions that allow people to place the causes and treatment of psychiatric illness out of the psyche and into the social world. The contributors offer important insights and critiques regarding these conditions.

Derek Bolton's (2024) commentary is a good place to start since his focus on the biopsychosocial (BPS) model is also the starting point of the tryptic. I began with it because, I felt, previous attempts at externalism (I am thinking here of the cluster of approaches often referred to as 'anti-psychiatry') were skewed precisely by the absence of a model of BPS interaction. This has led to a lot of binary thinking between biological and social explanations of illness (Aftab, 2020) that fly in the face of the "interacting causal pathways, including feedback and feedforward mechanisms, within and between [bio, psycho and social systems]" (Bolton, 2024, p. 321), which frameworks such as enactivism and predictive processing bring to light. So, when Bolton says that there need to be no deep cuts in the BPS model, I agree entirely. The vignette he presents from Morocco shows that, when the will to recover trumps any ideological commitment, people act pragmatically, and tend to flexibly move across different kinds of therapeutic resources in a way that is compatible with our picture of BPS integration.

Nothing in all this is at variance with what I describe in Ongaro (2024b). As I note, pragmatism and pluralism are the norm among the Akha as well. Akha shamans might encourage sick people to visit the hospital if they feel there are no more spiritual causes to address. I should have mentioned that the relatives of the young man with psychotic symptoms that I discussed on p. 13 (Ongaro, 2024b) even asked me if I have medicine 'for his brain,' much like Bolton's Moroccan acquaintances did to him.

But although I agree we should posit no deep cuts in the *use* of therapeutic resources, there are

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clear cuts between the *types* of resources people can flexibly avail of. The therapeutic effects of cognitive-behavioral therapy—psychological, internalizing—are different in kind from those of finding meaningful work or housing security—social, externalizing. In Ongaro (2024b), I argue that Akha rituals are more similar to the latter than to the former, and that Akha society is structured in such a way that social affordances can be easily mobilized. There is a resourceful externalist framework in place. When viewing modern psychiatry from a broad anthropological perspective, it is the absence of anything like this externalist system that stands out, at the detriment of therapeutic efficacy. If anything, Bolton's incisive point that even our 'social determinants of health' tend to be psychologized underscores this contrast.

In the end, I resist the dichotomy Bolton draws between 'small' and 'homogeneous' societies and 'large,' 'diverse,' and 'complex' societies, along with the implicit suggestion that one cannot speak to the other. The Akha carve their own community within a rather complex and ethnically diverse environment in the Lao highlands. In turn, Akha shamans carve their own within Akha society. Conversely, I discussed in Ongaro (2024c) examples of therapeutic movements that achieve 'collective effervescence' in modern 'complex' contexts. Evidence of superior recovery rates in spiritually treated psychosis comes from megacities like Chennai. The challenge of developing an externalist framework for psychiatry is, therefore, cultural and political. A tall order, no doubt, but there is nothing about 'modernity,' 'scale,' or 'complexity' that inherently prevents that.

The suggestion that externalism comes with 'collective effervescence' was made by George Ikkos and Giovanni Stanghellini (2024). Ikkos and Stanghellini fully capture the spirit of the first two papers Ongaro (2024a, 2024b), while contributing interesting perspectives of their own. The gist of their commentary is that social psychiatric treatment requires an 'understanding' of the social conditions in which it takes place. The example of anorexia nervosa is effective in conveying their message. This condition seems to arise out of a process of objectification of the body that is magnified in the image-saturated environment of late Western modernity. Indeed, it has often been described as a 'culture-bound syndrome.' Although Ikkos and Stanghellini do not say much about what the therapeutic implications of this understanding should be, they imply that successful treatment must engage with the ideology that exacerbates the disorder. Presumably, because that very ideology is psychologizing, involves forms of psychological and embodied therapy aimed at redressing imbalances in culturally specific forms of bodily self-perception (see Osler, 2021, pp. 54–55, for leads). Echoing my response to Bolton, I see no issue with this. My sole objection is to the mainstream dismissal of externalist treatments that could complement the current psychobiological focus, particularly when they tally with patients' frequent encoding of anorexia nervosa with spiritual idioms (Banks, 1992) and have shown some remarkable success (Richards et al., 2007). What, I ask, could a mainstream theoretical and institutional legitimization of these approaches look like?

Walter Benjamin's work is as ever fascinating, and I look forward to seeing how Ikkos and Stanghellini's future writings illuminate its value. Myself, I feel that its ultimate value in this area should be judged in terms of therapeutic implications. This was the concern of the third paper (Ongaro 2024c), where I pointed to a disconnect between a naturalistic social understanding of mental illness and its treatment: biological science gave us biological treatments; psychological science gave us psychological treatments; social science, by contrast, has gave us nothing remotely comparable in terms of social treatments. Durkheim might well have captured the phenomenon of 'collective effervescence' but there is hardly a historical case of collective effervescence that has been inspired by Durkheim. At fault, I suggested, are the limitations of naturalism in making social reality actionable.[1] Hence the importance of social constructivism in psychiatry.

In focusing on fictionalism, Sam Wilkinson's (2024) commentary touches on the most important dimension of constructivism and the most important aspect of the third paper (Ongaro 2024c). Central to this idea is that the constructs we use to discuss health and illness are intrinsically

bound to culturally specific and collectively imagined institutional structures and courses of action. Wilkinson explains, more thoroughly than I did, the thrust and virtues of fictionalism. Like him, I believe that developing a case for fictionalism is a way forward in psychiatry.

However, Wilkinson marshals the fictionalist argument into a somewhat different debate from the one I engaged with: not on the challenge of capturing the etiology of an objective phenomenon called 'illness' but on the evaluative dimension of the category of 'illness,' which, insofar as it defines certain courses of action instead of describing the world, can be said to have a fictional nature. From this viewpoint, he suggests that my fictionalist sympathies sit at odds with an implicit realist take on 'illness.'

This might look that way, but Wilkinson also admits to the usefulness of using broad etic anthropological categories like 'healing' as analytical tools that differ from emic categories. I should have made these conceptual caveats at the outset: it is precisely these etic categories that I am wielding in the three papers. I have treated 'illness,' 'medical,' and 'therapeutic' within the same semantic domain as the anthropological concepts of 'sickness' and 'healing' (Hahn, 1995). On these, I am very much a realist. I think there are phenomena called sickness and healing that exist universally with varying combinations of bio-psycho-social causes but that are managed differently in different places. Being a realist about these phenomena also allows you to avoid extreme cultural relativism in cross-cultural comparison. The point of Ongaro (2024b) is to argue that the Akha system of social treatments fares much better than that available to modern psychiatry.

The debate Wilkinson engages with is undoubtedly important and, in fairness, it has been the conventional ground where the word 'fictionalism' has been employed in the literature. It is important because the label of 'mentally ill' comes with society-specific practical consequences (e.g., receiving benefits). What strikes me when looking at this from the Akha perspective is that, precisely due to a different institutional structure, it is the very framing of this debate that differs. Modern psychiatry's 'demarcation challenge' is not much of an issue among the Akha. When someone suffers, attention is directed at the causes of suffering rather than at the classification of suffering (e.g., deciding whether someone is 'sad' or has 'dysthymia'). Beside a handful of disorders whose symptomatic profile is so reliably stable to merit their own category, like 'epilepsy,' I noted that nosology folds into etiology. An Akha DSM would be three pages long at most. The pantheon of spiritual forces that make up their social aetiology, by contrast, would fill a book at least as long as the American DSM-5. Among the Akha, the culturally salient demarcation is not so much between mental 'health' and 'illness,' but between 'normality' and 'abnormality.' For example, twin birth is abnormal and justifies a certain course of action: until recently, the killing of twins (Wang, 2023). Could we then think of the demarcation problem itself as in a certain sense fictional while we stay realists about the (etic) category of 'illness'? A lot more can surely be said on all this – Wilkinson has drawn out further aspects in his commentary – though I believe it is a somewhat separate, if related, discussion.[2]

Ultimately, I agree that fictionalism is incompatible with externalism, but only if the latter is understood in a metaphysical sense, one that preoccupies a fairly narrow circle of philosophers engaged in the 'extended mind debate' (e.g., Adams & Aizawa, 2008). I was never very inspired by that side of the debate. I cannot see how it could ever be progressed and, if it were, what difference it would make to most of us ordinary mortals (Ongaro et al., 2022, pp. 3-4). The debate becomes interesting, it seems to me, once we anchor it to real-world scenarios that show us the possibility of casting causes and treatment of illness onto the social environment (Wilkinson, 2023, p. 301, appears to agree here), to the point where, if the only way to redress illness is to act on the environment, one can say that the latter is *constitutive* of the illness. Within this framing, I argued in Ongaro (2024c) that fictionalism can be an important dimension of externalism rather than the other way around.

If Wilkinson is enthusiastic about fictionalism, Laurence Kirmayer (2024) remains skeptical, at least about my own way of handling the term. Be-

fore getting to the gist of it, let me address a couple of areas I feel I have been slightly misunderstood in his commentary. First, I do not take enactivism as a replacement of earlier psychosomatic theories, but as something that built on them, making a philosophically sound synthesis of BPS integration that has emerged from earlier empirical research (as I say in Ongaro, 2024a, p. 271). Second, I do not endorse enactivism wholesale, but as far as BPS integration goes. The point of the Ongaro (2024a) is to highlight its weakness in dealing with the social. Enactive psychiatry has no solution to the semantic void about social causation that I believe to be one of the central problems in modern psychiatry.

So, I disagree with Kirmayer's assertion that the main problem of BPS psychiatry is "more a failure of medical education, psychiatric training, and clinical practice than of conceptual resources and empirical research" (p. 316). I think it is absolutely also a problem of conceptual resources, along with the systemic conditions that psychiatry finds itself in. Although Kirmayer did not comment on it, my lengthy discussion of functional neurological disorders (FNDs) was aimed at bringing this out.

FNDs, so I argued, reveal to us that the social causes of mental disorders can remain indeterminate; to a degree, they fail to be captured naturalistically. I suggested that for treatment to work we must construct explanations that resonate meaningfully with patients. Kirmayer's own work on the healing power of metaphor is illuminating to this end. Metaphors, which are fictional constructs with "little regard for truth" (Kirmayer, 1993, p. 174), build a bridge between the incoherent and causally indeterminate experience of the body in pain and culturally broad symbols, thereby opening the possibility for transformation. This transformation will be much more profound when collective social consensus around the patient legitimates these constructs, so that they become part of cultural myth (Lévi-Strauss, 1963) or social ontology. Studies on observational learning and placebo effects give us indirect evidence of the mechanisms at play (Bajcar & Bąbel, 2018).

Kirmayer's point about the darker side of social consensus is well taken. I do acknowledge this (Ongaro, 2024c, pp. 309) but more can be said. Medical systems are always embedded in local worlds of power and ideology. Evans-Pritchard's classic *Witchcraft, Oracles and Magic among the Azande* (1937), a study of causal thinking around illness, notably doubled up as one the best accounts of ideology ever written. Still, there is a lot of cultural variation on the insidiousness of ideology, and if this dimension has not stood out in my Akha ethnography, and in the dozen written by other anthropologists who lived among them (e.g., Tooker, 2012), it is because it is less conspicuous in such anti-authoritarian society.

Equally, a lot more can be see about how spirits 'maps onto' social relationships, though my point was that these spiritual relationships are *social in themselves*, and it is far from obvious that they all map onto 'real' social relationships, or, even, that, to have therapeutic power, they must do so.

This brings me to Michelle Maiese's (2024) commentary. After carefully summing up the three papers (Ongaro, 2024a, 2024b, 2024c), Maiese argues that an externalist psychiatry would do better building on scientific evidence on the social determinants of mental health, which do so much to mindshape people into distress. I am in complete agreement. Theoretical aspects of psychiatry should not distract us from the fact that, epidemiologically speaking, it is systemic injustice in its various forms that lies at the root of most mental health problems (Kirkbride et al., 2024).

Political action represents the only way to deal with this devastating scenario, *up to the extent in which it proves effective*. In bringing up FNDs, I cast doubt on whether a focus on systemic forces should be all that there is in social psychiatry. There are disorders whose social cause remains indeterminate. Furthermore, there are cases (of trauma, in particular) in which the patient struggles to confront what psychiatrists consider the 'real,' 'objective' root of their illness. Constructing causal narratives around it—above all, laying the ground for their social legitimacy—is the way to offsets these limits and add therapeutic potential. This is what I meant by the 'tension' between naturalism and social constructivism: each approach should compensate for the limits of the other.

Also, it is an open question whether approaches aligned with liberation psychiatry can do away

with the transcendental aspects of mental illness that so many people end up grappling with, even in largely secular societies (interestingly, 'liberation psychiatry' in South America was influenced by 'liberation theology'). In Ongaro (2024a, 2024b, 2024c), I pointed to a need to deal with 'belief,' broadly construed, in psychiatry, because naturalism has always had a hard time doing so. A fully fledged externalist system should accommodate non-naturalistic orientations.

The Akha system was insightful to me not only for the nature of their spiritual treatments, but also the way in which these were integrated into their overall medical system. While in the United States the 'master narrative' about mental illness is bio-psychological, it would be wrong to say that among the Akha it is 'social' or 'spiritual.' The 'master narrative' among them is inherently pluralistic: illness is understood in causal terms with varying combinations of bio-psycho-social causal forces that are case-specific. Externalist (social) spiritual treatments represent the area Akha are most resourceful in, but these are integrated into a BPS model of health.

It seems clear that any progress towards a developed externalist system in modern psychiatry demands cultural and above all political change, like Maiese contends. In this outline, I have tried to see the implications of theoretical debate into real-world scenarios, much in the tradition of anthropology, which, as Tim Ingold once quipped, is essentially "philosophy with the people in" (Ingold, 1992, p. 696). To be meaningful at all, a philosophical commitment to externalism must be a political commitment.

Notes

1. My own perspective here has been influenced critics of naturalism in the social sciences as diverse as Bhaskar (2000) and Milbank (2005).

2. I should note here that, writing in different styles and vocabulary, anthropologists in the past have advanced arguments that, translated into contemporary analytic philosophical parlance, could be considered as straight up defenses of fictionalism (Benedict, 1934; Devereux, 1980).

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