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PERSPECTIVE PIECE

Anthropological perspectives on the trajectory from institutionalisation to community care in Irish psychiatry

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The trajectory of the anthropology of Irish psychiatry, like the trajectory of Irish psychiatry itself, is indelibly shaped by the history of Ireland's mental hospitals. This paper focuses on three works concerning the anthropology of psychiatry in Ireland: Nancy Scheper-Hughes's book, *Saints Scholars and Schizophrenics: Mental Illness in Rural Ireland*, an anthropological study (1977/2001); Eileen Kane's paper, 'Stereotypes and Irish identity: mental illness as a cultural frame', from *Studies: An Irish Quarterly Review* (1986) and Michael D'Arcy's conference paper, 'The hospital and the Holy Spirit: psychotic subjectivity and institutional returns in Dublin, Ireland' (2015), based on his PhD dissertation. All three publications explore the relationship between institutional and community psychiatric care in Ireland, concluding with the work of D'Arcy which, like much good anthropology, is rooted in the lived experience of mental illness and combines deep awareness of the past with tolerance of multiple, ostensibly contradictory narratives in the present.

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Anthropology and psychiatry seem like natural partners (Sapir, 1932). Both disciplines are centrally concerned with human behaviour and, in particular, socially organised responses to illness and disease (Kleinman, 1980; Kleinman & Good, 1985; Kleinman, 1988). Most recently, research in cultural psychiatry has been described as existing at the crossroads between anthropology and epidemiology, further underlining the deep links between the two disciplines (Dein & Bhui, 2013).

The trajectory of the anthropology of Irish psychiatry, like the trajectory of Irish psychiatry itself, has been indelibly shaped by the mental hospitals that were established in the early 19th century, grew steadily for over a century and eventually declined in the latter half of the 20th century (Robins, 1986; Kelly, 2016). The story of the Irish asylums is a complex, fascinating one that richly merits anthropological exploration (Finnane, 1981; Finnane, 1985; Cox, 2012; Kelly, 2017a).

In order to explore this further, this paper focuses on three works concerning the anthropology of psychiatry in Ireland: Nancy Scheper-Hughes's book, *Saints Scholars and Schizophrenics: Mental Illness in Rural Ireland*, an anthropological study based in rural Ireland that was first published in 1977 and re-published in 2001 (Scheper-Hughes, 1977/2001); Eileen Kane's paper, 'Stereotypes and Irish identity: mental illness as a cultural frame', published in *Studies: An Irish Quarterly Review* in winter 1986 (Kane, 1986) and Michael D'Arcy's paper, 'The hospital and the Holy Spirit: psychotic subjectivity and institutional returns in Dublin, Ireland', delivered at the Society for Psychological Anthropology in Boston, Massachusetts in 2015 (D'Arcy, 2015), based on his PhD dissertation submitted to the University of California, Berkeley and San Francisco, in 2018, titled *Uncertain Adherence: Psychosis, Anti-Psychosis, and Medicated Subjectivity in Dublin, Ireland* (D'Arcy, 2018).

These three publications – a book, a journal article and a conference paper based on a PhD dissertation – were chosen purposively because, taken together, they illustrate key points about the evolution of the study of the anthropology of psychiatry in Ireland over the past half century. Before considering each of these works, however, it is necessary to provide some brief background about the history of mental hospitals in Ireland (Kelly, 2017b) and, especially, the idea that the Irish have a higher rate of mental illness than any other people – the myth of the 'mad Irish'. These key themes relate, in various different ways, to all three works of anthropology considered in this paper.

The 'mad Irish'?

The idea of the 'mad Irish' has a long history (Kelly, 2017a). Its most recent incarnation and (apparent) re-affirmation came in the 1960s when, in 1961, Seán MacEntee, Minister for Health, appointed a

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Commission of Inquiry on Mental Illness to report on the services available to the mentally ill in Ireland and to propose any improvements that the Commission felt necessary. MacEntee had previously addressed a meeting of resident medical superintendents of district mental hospitals and roundly criticised the services on offer to the mentally ill (Kelly, 2016). The Commission he established in 1961 was chaired by Mr Justice Seamus Henchy and presented its findings to Seán Flanagan, Minister for Health, in late 1966. The '1966 Report' was published in March 1967 (Commission of Inquiry on Mental Illness, 1967).

Striking a tone that was remarkably similar to the essentially endless succession of governmental reports that preceded it, the Commission's '1966 Report' pointed out that 'in Ireland, approximately 7.3 psychiatric beds were provided in 1961 per 1,000 of the population; this rate appears to be the highest in the world and compared with 4.5 in Northern Ireland, 4.6 in England and Wales, 4.3 in Scotland, 2.1 in France and 4.3 in U.S.A' (p. xiii). With this in mind, 'one of the first tasks to which the Commission addressed itself was to consider the exceptional rates of residence in the psychiatric hospitals in Ireland':

> No clear explanation has emerged. There are indications that mental illness may be more prevalent in Ireland than in other countries; however, there are many factors involved, and in the absence of more detailed research, the evidence to this effect cannot be said to be conclusive. Special demographic features, such as the high emigration rate, the low marriage rate and problems of employment, may be relevant to the unusually high rate of hospitalisation. In a largely rural country with few large centres of population, social and geographic isolations may affect both the mental health of individuals and the effectiveness of the mental health services. The public attitude towards mental illness may not be helpful to the discharge of patients and their reintegration in the community. On all these points, the Commission could do little more than ask questions. To provide answers would demand years of scientific inquiry for which neither the personnel of the Commission nor the time at its disposal would have been adequate. The Commission considers that a greatly expanded programme of research, not only into these social and epidemiological problems, but into other aspects of mental illness in Ireland, is urgently necessary (p. xiv).

In its conclusions, the Commission recommended 'radical and widespread changes' to mental health services (p. xv), as well as further research into the epidemiology of Ireland's apparently high rates of mental disorder. The call for epidemiological research was especially important and timely. Papers by the brothers Dermot and Brendan Walsh in the later 1960s duly provided important, rigorous and credible insights into hospitalised psychiatric morbidity in Ireland, as well as variations in admission rates (Walsh & Walsh, 1967, 1968; Higgins, 1968; Anonymous, 2016). Clearly, the rate of psychiatric hospitalisation in Ireland was notably high, but was the *incidence* of mental illness high too?

In 1984, Torrey *et al.* (1984) published an especially influential paper on this theme, titled 'Endemic psychosis in western Ireland' in the *American Journal of Psychiatry*. Torrey *et al.* (1980) noted that earlier studies had shown higher rates of psychiatric hospitalisation in Ireland compared to other countries and went on to report a study in a small area within county Roscommon, in which a relatively high prevalence of schizophrenia had been reported previously. Torrey *et al.* found that some 4% of the population over the age of 40 years were actively psychotic in this area and that the 6-month prevalence of schizophrenia, schizoaffective and atypical psychosis was 12.6 per 1,000 population, compared to 3.6 in parts of the USA (for broadly defined schizophrenia) and 9.1 in a comparable area of northern Sweden.

This was quite a striking finding and the authors, wisely, pointed to possible sources of error in their work, including selective migration of mentally healthy persons leading to an accumulation of mentally ill persons who either never emigrated or were sent home. While the paper generated animated discussion (Fahy, 1985; Torrey, 1985), the apparently high prevalence of schizophrenia it reported in its rural study area appeared consistent with a 1975 study of psychiatric admissions in Cork, which associated admission for schizophrenia with being reared in rural areas, at least for men (Kelleher, 1975).

The precise relevance of rural dwelling was further explored in the 1980s when a study of admissions in one rural and one urban area (between 1978 and 1980) showed that readmission rates for schizophrenia were equivalent in urban and rural areas, but that people with schizophrenia in rural areas were admitted at a later age (Keatinge, 1988). Furthermore, while incidence rates did not differ between rural counties, treated prevalence and readmission rates did, indicating that social and community variables significantly influenced psychiatric hospital utilisation (Keatinge, 1987a, 1987b). As was becoming apparent, the idea of a higher rate of incidence of mental disorder among the Irish was inseparable from the higher rate of hospitalisation, and it was not entirely clear that the two could be meaningfully separated, using available data.

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Into this mix, in 1993, a paper from the Roscommon Family Study demonstrated that, in the west of Ireland, schizophrenia was a strongly familial disorder and that diminished reproductive rates had a large impact on the pattern of risk in relatives (Kendler *et al.* 1993). That study also concluded that its results were *not* consistent with previous claims that the prevalence of schizophrenia was elevated either in Ireland as a whole or in western Ireland. Torrey (1994), in response, pointed out that earlier work had indicated increased rates of schizophrenia in persons born prior to 1940, and that the 1993 study looked at those born from 1930 onward, that is, a significantly different population. Walsh & Kendler (1994), in turn, responded that studies looking at 'first admissions' might result in overestimates, as certain hospitals used the term 'first admission' to refer to first admission *to that hospital*, rather than lifetime first admission. There were also concerns about the reliability of the application of diagnostic categories in unsupervised hospital data.

The situation was clarified significantly the following year, when Waddington et al. (1995) pointed out that a systematic catchment area study of the incidence and prevalence of schizophrenia in rural Ireland indicated unremarkable rates that were well within the mid-range of values recorded worldwide (e.g. lifetime risk of 0.7%). This finding did not out-rule the possibility of variations in rates between geographical regions within Ireland or over different time periods, but it provided convincing evidence that the overall rate of schizophrenia in Ireland in recent times was no higher than the worldwide average.

As a result, after many decades of elaborate theorising about possible causes for apparently increased rates of mental disorder in Ireland and a great deal of investigation and discussion, it finally appeared that Ireland does not, in fact, have a notably high rate of schizophrenia at all – and never had (Robins, 1986; Cabot, 1990; Holmquist, 1990; Clare, 1991; Youssef *et al.* 1991; Walsh & Kendler, 1995; Kelly, 2017a). While incidence rates of schizophrenia may well differ between different geographical locations within or between various countries (McGrath *et al.* 2008) or over time, Ireland's unremarkable rate of psychosis was consistent with a 1986 World Health Organization multi-centre study which included Ireland and demonstrated little systematic or overall difference across countries (Sartorius *et al.* 1986).

The final conclusion, then, is that, despite a high rate of psychiatric hospitalisation, there is insufficient evidence to conclude that Ireland ever had a higher rate of mental disorder than elsewhere. The reasons for variations in psychiatric hospital admissions that created the appearance of a high incidence rate appear to be attributable to social and nosocomial (i.e. hospital-related) factors rather than true variations in incidence (Walsh, 1992). As a result, Ireland had an epidemic of mental hospitals rather than an epidemic of mental illness. This remarkable phenomenon cannot be explained by any single factor but, as Brennan argues, was part of a social process driven by broader structures and systems, combined with the actions of various individuals and groups (Brennan, 2012; Brennan 2014). In other words, the story of the 'mad Irish' is one that is very well suited for the attention of anthropologists with an interest in the history of psychiatry in Ireland.

'Saints, Scholars and Schizophrenics'

Given the persistence of the myth of the 'mad Irish', the accumulated literature on the evolution of psychiatry in Ireland is predictably complex and intriguing (O'Hare & Walsh, 1981; Blake *et al.* 1984; Ní Nualláin *et al.* 1987; Webb, 1990). Perhaps, the most comprehensive anthropological exploration of these themes to date is Nancy Scheper-Hughes's book, *Saints, Scholars and Schizophrenics: Mental Illness in Rural Ireland*, an anthropological study based in rural Ireland that was first published in 1977 and re-published in 2001 (Scheper-Hughes, 1977/2001).

Scheper-Hughes is a leading anthropologist (Scheper-Hughes & Lovell, 1986; Scheper-Hughes, 1990) and *Saints, Scholars and Schizophrenics* presented an in-depth field study of the apparent social disintegration of a small village on the Dingle Peninsula that Scheper-Hughes referred to as 'Ballybran' (but that was readily identifiable to many readers). Scheper-Hughes's book explored a range of issues affecting this particular community, including emigration, unwanted celibacy, various childrearing practices, attitudes towards intimacy, suicide and schizophrenia. The 2001 edition of the book also includes an epilogue about the well-being of the community and examines Scheper-Hughes's attempts to reconcile her responsibility to honest ethnography with respect for the people whom she studied in 'Ballybran'.

It is difficult, if not impossible, to summarise Scheper-Hughes's book. There is little doubt that it presents a remarkably self-aware, vivid and intimate portrait of village life, at least as seen by an American anthropologist in the early 1970s. For that reason alone, *Saints, Scholars and Schizophrenics* richly merits a place in the canons of Irish history and anthropology. It is, however, a lot less clear what the book reveals about schizophrenia in Ireland. While Scheper-Hughes's discussion of mental illness is generally even and nuanced throughout the text, it is, today, difficult to sustain her final, tentative arguments about various alleged schizophrenia-evoking factors in rural Irish society, stemming chiefly from the apparent breakdown of

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traditional Irish familism: declining marriage and birth rates, secularism, individualism and general *anomie*.

These factors might well lead to loneliness, isolation and depression, but they seem more likely to increase hospitalisation with mental illness in general rather than increase risk of developing schizophrenia in particular. Consistent with her very considered approach to her topic, however, Scheper-Hughes is at pains not to deny the potential role of genetics and other biological factors in schizophrenia but emphasises that her key argument is that sociocultural factors should be considered when exploring both the causes and chronicity of mental illness. This is an important point that Scheper-Hughes makes beautifully throughout the book, albeit that the subsequent realisation that the rate of schizophrenia in rural Ireland is not unusually high in the first place casts doubt on the extent to which the issues she identified in 'Ballybran' truly increase risk of the disorder itself.

While *Saints, Scholars and Schizophrenics* was very well received internationally (Healy, 1996), it – perhaps predictably – generated mixed responses in Ireland. Eileen Kane, an anthropologist, reviewed the book for the *Irish Press*, noting that 'the interpretations and conclusions which Scheper-Hughes presents are based upon a year's observation of the community [in 'Ballybran'] and the administration of Thematic Appreciation [sic] Tests to thirty-six village adolescents and twenty-two hospitalised schizophrenics [sic] in the county mental hospital' (Kane, 1979). Kane outlined significant concerns about Scheper-Hughes's methodology including her 'participant observation' technique, her generalisations from 'Ballybran' to other Irish villages and her selection of psychiatry inpatients: 'the fact that her diagnosed schizophrenic population comes not from Ballybran at all but from the general catchment area of the mental hospital does not deter the author'.

Kane presented a range of other objections to Scheper-Hughes's study and pointed out that her account of the decline of rural Ireland rested uneasily with increases in the populations of counties Kerry, Cork, Galway, Mayo and Donegal, according to provisional 1979 census figures. Today, some 30 years since Kane's review of the book, and with the benefit of hindsight, we can add the fact that the 'decline of rural Ireland' has become a constant feature of national discourse over the intervening decades and was by no means limited to the time period or situations described by Scheper-Hughes and others (Brody, 1973; Hockings, 1975): a 'decline' there might or might not be, but a demise there is not.

David Nowlan reviewed Scheper-Hughes's book in the *Irish Times* in August 1979 and argued that while it was easy to question some of the inferences that Scheper-Hughes drew from her findings, it was hard to disagree with her thesis of a dying society in rural Ireland (Nowlan, 1979). In September 1980, journalist Michael Viney took to his bicycle and visited the real 'Ballybran', reporting back that the book had engendered anger and hurt in the village (Viney, 1980). In February 1981, Scheper-Hughes responded with a reflection on ethical issues in anthropology and pointed out that much of her account was subjective, that she presented herself openly and directly to the villagers as an anthropologist and writer and that she shared advance copies of the book with several people in Ireland, including a member of the village, but no one suggested any changes (Scheper-Hughes, 1981). Scheper-Hughes also wrote that her book sought to find out what might contribute to the area's high *psychiatric hospital census* (my italics) and not, interestingly, the reportedly high incidence of schizophrenia itself.

Eileen Kane, in April 1981, argued that the balance of anthropological evidence suggested that, rather than being in 'decline' or undergoing 'demoralisation', western Ireland was in a period of understandable transition but remained vital, resourceful and culturally strong (Kane, 1981). Michael Viney revisited these themes again in the *Irish Times* in August 1983 and noted, in particular, Scheper-Hughes's decision to make 'Ballybran' readily identifiable – a step that was, she said, necessary for the book (Viney, 1983). There were also letters to the editors of the *Irish Press* (O Freini, 1980) and *Irish Times* (Bradshaw, 1983; Pye 1983), and the book was invoked again when confirmatory evidence emerged that Ireland's rate of schizophrenia was not, in fact, especially high and probably never was (Holmquist, 1990; Kelly, 2016).

All told, Scheper-Hughes's book provided – and still provides – an exceptionally vivid account of life in one Irish village in the early 1970s, helped shed light on high rates of psychiatric *hospitalisation* (which was borne out by subsequent studies) and generated a fascinating discourse about the ethics and experience of anthropology in rural Ireland. Subsequent epidemiological studies disproved the reportedly high *incidence* of schizophrenia in Ireland that was largely taken as a given in the 1970s and census data cast doubt on the idea of a simple 'decline' in rural areas. Even so, discussion of these topics continues today and Scheper-Hughes's book still plays a key role in shaping many of these debates.

'Mental illness as a cultural frame'

In winter 1986, Eileen Kane, head of the Department of Anthropology in St Patrick's College, Maynooth, published a paper titled 'Stereotypes and Irish identity: mental illness as a cultural frame', in *Studies: An Irish Quarterly Review* (Kane, 1986). Kane's paper returned

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to the themes of the reportedly high rate of mental illness in Ireland and the reported 'decline' of rural areas. Or, more precisely, Kane interrogated the effects of such 'stereotypes' on their broader fields:

> Stereotypes are self-feeding, even in the 'sciences', and the persistence of certain 'facts' about Ireland, such as high incidences of mental illness or alcoholism or suicide, have a number of important consequences: an increasingly worrying one is that some research-funding agencies are now rejecting proposals for social science research on Ireland which do not accept these stereotypes as 'facts'. A national US research-funding agency, for example, recently rejected a proposal for a rural Irish research project because it did not take the 'devitalization' of the west of Ireland into account. Another was rejected as 'unrealistic' because it made no reference to the 'extraordinarily high rate' of mental illness in western communities (p. 539).

Matters become more complicated – and more interesting – when the former 'subject population' itself starts to believe the 'stereotypes':

> What is most interesting is when a group such as the Irish in Ireland is no longer a subject population, supposedly is not attempting to emulate a dominant neighbour, and yet manifests a number of negative cultural propositions about its own characteristics. Negative propositions about Irish character and behaviour accepted, and sometimes even revelled in, by many Irish people, are readily voiced and easily elicited [. . .]
>
> More serious assumptions about negative cultural attributes have passed into common belief: that the rates of alcohol consumption in Ireland are the highest or among the highest in Europe; that the suicide rate is extremely high by international standards; that western rural Ireland is dying, devitalized, demoralized, declining in population, suffering from *anomie* and that the 'cream' of its population has emigrated; that the Irish worker is lazy, troublesome, unproductive, loath to take or give direction – characteristics which are knocked out of him fast enough, people say, when he goes abroad and *has* to work; that the Irish farmer is backward, tradition-bound, greedy, inefficient and living off the rest of the nation (pp. 540–541).

Kane correctly points out that 'most of these negative cultural propositions are couched in undefined terms but those which can be tested tend not to be validated' (p. 541). Even so, 'several negative cultural assumptions have passed into some of the anthropological literature on Ireland as phenomena to be explained rather than as points to be questioned or hypotheses to be tested. The death of rural Ireland is one of these and the sexual repression of the Irish another. A third, which I want to examine in this article is that the Irish are particularly subject to mental illness' (p. 542).

Kane briefly discusses Scheper-Hughes's *Saints, Scholars and Schizophrenics* (again) before moving on to the core issue of whether or not the Irish are particularly vulnerable to mental illness in general and schizophrenia in particular. After a brisk summary of the epidemiological evidence, she concludes that while 'the high hospitalization rates in the western as opposed to the eastern parts of the country have long been held, in both popular thinking and scholarly research, to be indicative of high rates of western mental illness', studies 'using both in-patient and out-patient data, find the regional pattern to be reversed' (p. 544):

> The incidence rates of schizophrenia [in Ireland] are within internationally-recognized levels of acceptability which are thought to approximate 15 per 100 000 [. . .] This research by the Medico-Social Research Board will be an important contribution not only to psychiatry but also to anthropology. It appears that the question is no longer '*Do* the Irish have a high incidence of mental illness?' (a question which was rarely asked, anyhow), or 'What are the causes of Ireland's high incidence of mental illness?' (a much more frequent source of speculation) but 'What explains the high prevalence?' (p. 545).

This difference between incidence (the rate of occurrence of new cases) and prevalence (how many people have the disorder at a given point in time) is critical, not least because the latter reflects not only incidence but also chronicity, treatment, outcome, population structure and a range of other factors. So, for Kane, the key question becomes *why* people 'persist in a 'false' belief' about high rates of mental illness in Ireland, when all the evidence now points the other way (p. 547).

Kane notes that, despite the figures showing clearly that Ireland does not have a raised incidence of schizophrenia, Kane 'encountered few who dispute the figures and very few who haven't tried to find a way around them' (p. 546). In other words, people do not argue with the epidemiology itself but choose instead to ignore it and to search for reasons to persist with their pre-existing belief in the 'mad Irish', despite the overwhelming evidence against it. Even the Irish do this. Why?

> First of all, we may not be talking about the same things: people's conceptions of mental illness do not necessarily correspond to those of the

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> 'experts'. Within cognitive anthropology, ethnoscience distinguishes between 'emic' or locally-meaningful categories of reality, and 'etic' categories, which are 'outside' categories used to make cross-cultural comparisons. 'Schizophrenia', 'neurosis', 'organic psychosis', etc. are all etic categories upon which comparative figures are based; 'a wee bit simple', 'not the full shilling', 'mental', 'on tablets', 'nervous', 'a slate loose', 'a bit touched', 'not all there', 'nervous breakdown' are emic [. . .]
>
> We might look for another explanation drawn from cognitive anthropology, based on the different ways people establish the 'truth' of what they believe: rationally, irrationally, and non-rationally. The first and simplest of these is that since the mid-1800s, figures have been used to support a rational argument in favour of a high rate of mental illness. Authorities such as the World Health Organization have said it was so. If that is the sole source of the belief, new research should cause some alteration. I suggest that this will not happen (p. 547).

One of the key reasons for this state of affairs is that, 'most interestingly, 'facts', 'truths', 'validity', or 'proof' may be irrelevant in attempting to understand areas of cognitive systems' (pp. 547–548). 'Cultural frames', according to Kane, 'do not admit of cross-cultural comparison since the cultural frames of each group are fundamentally different':

> These cultural frames do not reflect reality; they construct reality. This is not to say that they are not understandable; they are understandable in their own context, and through their own rules, which must be ascertained. In the case of mental illness in Ireland, two kinds of propositions appear to coexist: a popular proposition about a high incidence of mental illness, and a 'scientific' proposition about non-exceptional incidence, developed by the established canons of evidence (p. 548).

There are many reasons for persisting with an erroneous belief including the fact that, as Kane notes, 'a belief in a high incidence of mental illness may be a cultural boundary marker' or, in other words, a way of distinguishing 'us' from England and other countries – a marker of identity and a way of seeing ourselves as unique (p. 549). After all, 'ordinariness is not distinctive':

> I could, of course, be creating another kind of trope: a mare's nest. It could be that people will not continue to hold the belief that the Irish have a high incidence of mental illness. Or it could be, as Professor Ivor Browne points out, that 'want' in Swift's famous sardonic self-eulogy may have a double meaning:
>
> *He gave the little Wealth he had*
> *To build a House for Fools and Mad*
> *And shew'd by one satyric Touch*
> *No Nation wanted it so much* (p. 550).

'The hospital and the Holy Spirit'

In the wake of Scheper-Hughes's elegant examination of village life in 'Ballybran' and its relation to high rates of psychiatric hospitalisation (rather than high rates of schizophrenia), and Kane's equally elegant dismantling of the myth of the 'mad Irish', where next for anthropology and psychiatry in Ireland? The demise of the mental hospitals in the second half of the 20th century created a new context for both Irish psychiatry and its anthropology, which has continued to grow in depth and breadth over the past three decades (see, e.g., Saris, 1996; Saris, 2008; Roch, 2017; Dunne *et al.* 2018). In 2012, the open-access *Irish Journal of Anthropology* published a special section on 'suicide in Ireland'.[1]

Against this background, the third work chosen for examination in this paper is Michael D'Arcy's conference paper, 'The hospital and the Holy Spirit: psychotic subjectivity and institutional returns in Dublin, Ireland', delivered at the Society for Psychological Anthropology in Boston in 2015 (D'Arcy, 2015), based on his PhD dissertation submitted to the University of California, Berkeley and San Francisco, in 2018, titled *Uncertain Adherence: Psychosis, Anti-Psychosis, and Medicated Subjectivity in Dublin, Ireland* (D'Arcy, 2018). This paper was chosen because it is based on recent fieldwork with a community mental health team in Dublin and it represents a significant development in the anthropology of psychiatry in Ireland, both acknowledging the shadow of the mental hospitals and moving firmly to the contemporary, apparently post-institutional context.

D'Arcy's 2015 paper presents the story of 'Ray' who had 'seen the Holy Spirit out in Drogheda . . . When I was high, you see, I was guided by the Lord':

> In the shadow of the shuttered institution, [Ray] found a great, white bird – a dove, impossibly large – that hovered silently above him like a hummingbird. Under its guidance, he spent the night walking 20 more kilometres to the coast, where he felt impelled to go to England. The trip was not an easy one. He was briefly imprisoned shortly after he arrived across the Irish Sea, ultimately returning to Dublin where he received

[1]http://anthropologyireland.org/wp-content/uploads/2018/05/IJA_15_2_2012.pdf (accessed 5 March 2020).

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> various diagnoses, including schizoaffective and, most recently, bipolar disorder. His vision of the Spirit frightened him, he said, but it also filled him with a powerful sense of purpose and an unshakeable faith in the existence of God. It did nothing for his solitude and isolation (p. 1).

Ray's attitude to psychiatric care was complex, nuanced and ultimately pragmatic:

> Despite his dissatisfaction with the services provided by the community psychiatry team at the day hospital, Ray claimed to feel at home in St Dymphna's Ward, the inpatient psychiatric unit where I conducted much of my fieldwork on antipsychotic adherence and psychotic subjectivity. I came to understand this curious preference for the locked ward in relation to Ray's avowed loneliness and through the lens of one of the most fundamental dimensions of his unusual (and at least partly mad) experiences. Namely, Ray seemed to be caught within a cycle of institutional returns that was markedly different from the usual rhythms of relative stability and periodic hospitalisation that shape the ebb and flow of the lives of many men and women living with chronic mental illnesses (p. 2).

More specifically, 'at the intersection of [Ray's] professions of divine inspiration and painful isolation, I heard a request for asylum, for community, for subjective containment'.

When the inpatient psychiatry team assessed Ray, they expressed the view that his admission was, in fact, precipitated by his mother refusing to let him stay at her flat and Ray's dislike of supported accommodation. Asked what was ailing him, Ray's first response was 'I have no friends' (p. 3), before he requested better housing and made various other points. Following some discussion, the team 'decided to acquiesce to the only request that they could conceivably grant, specifically the unspoken plea for shelter that lay, barely hidden, within Ray's list of demands' (p. 4).

Ray's request for asylum in an inpatient psychiatry ward and D'Arcy's ready recognition of this reflect a new development in the anthropology of psychiatry in Ireland, shaped by both the decline of the old 'mental hospitals' *and* the complexities and limitations of contemporary community care, combined with a lingering fear of inadvertent institutionalisation:

> Though it bears repeating that the ultimate goal of inpatient psychiatric units like St Dymphna's ward is to stabilize the acutely ill before overseeing their return to outpatient and community based care, warnings to the many patients who wished to remain in the hospital about the dangers of staying in the ward for too long were always shot through with the implicit and in some cases *ex*plicit threat that one might become an 'institutionalized' person (p. 5).

As D'Arcy points out, 'if the asylum has been largely buried in much of the west, the grave is shallow in Ireland, if occupied at all' (p. 6).

As it turned out, 'Ray was not, in fact, suicidal. He sheepishly admitted as much halfway through our first interview. He had lied his way into inpatient care because, as he reiterated, he felt at home in St Dymphna's Ward. Moreover, Ray felt he could make friends in the inpatient unit due to the unspoken understanding that he could expect from his fellow patients' (p. 7). Ultimately, despite benefitting from community care and subsidised housing, Ray was 'still plagued by questions regarding his place within a larger social world, regarding his relation to the other' (p. 8). In other words, despite community nurses, outpatient clinics, day hospitals and offers of supported housing, Ray found 'no community in the context of community mental health'.

And this realisation brings us to one of the key issues at the heart of the anthropology of psychiatry in Ireland and, arguably, the heart of contemporary psychiatry itself: the complex relations between institutional and community care. This theme is in clear evidence in all three publications examined in this paper, which were purposively chosen to illustrate key points about the evolution of the anthropology of psychiatry in Ireland over the past half century. Other works by these or other authors could equally have been chosen (see, e.g., D'Arcy, 2019), but these three publications offer key perspectives that are linked with each other in various ways but are also distinct, are spread over more than four decades and reflect recent developments in the field.

It is fitting to conclude with D'Arcy because his work, like much good anthropology, is rooted in the lived experience of his interlocutors and combines a deep awareness of the past with a tolerance of multiple, ostensibly contradictory narratives in the present. These qualities are necessary for any true understanding of psychiatry in Ireland and, arguably, anywhere. As D'Arcy concludes (p. 10):

> At the very least, and despite all of the horrors of the old hospitals, despite the nearly anomic loss of faith by mainstream Irish society in institutions of care, particularly those historically associated with the Catholic Church, I want to leave a space for Ray's perspective on the social good of the total institution. I also want to acknowledge that Dr Lynch and his colleagues, despite their trepidation in the face of the spectre of

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> institutionalization, were able to hear Ray, after a fashion, and honour his request for community and perhaps for containment, if only for a little while. I want to be able to reject the terms of Ray's final question for me – 'am I a holy man, or am I crazy?' – and answer 'why not both?'

There are likely no definitive answers to the questions raised in D'Arcy's work, but there are many compelling reasons to continue to explore the issues that they present. Anthropology is uniquely placed to contribute to this work, bringing a crucial perspective to our understanding of the practice of psychiatry and – especially – our understanding of Irish psychiatry's complex trajectory from institutionalisation to community care.

A note on language

Throughout this paper, original language and terminology from the past and from various papers and reports have been maintained, except where explicitly indicated otherwise. This reflects an attempt to optimise fidelity to historical sources and does not reflect an endorsement of the broader use of such terminology in contemporary settings.

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Conflict of interest

Michael D'Arcy consulted with Brendan D. Kelly in his anthropology fieldwork in Dublin. There is no other potential conflict of interest to disclose.

Ethical standards

The author asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The author asserts that ethical approval for publication of this perspective piece was not required by their local Ethics Committee.

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