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EDITORIAL

Putting meaning into medicine: why context matters in psychiatry

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Mainstream psychiatry emphasises controlling symptoms by taking medications. This approach ignores the role of context in shaping illness experiences and how people engage with mental health professionals. The focus on symptom control and medication management also narrows the function of the psychiatrist. This editorial argues that knowledge of patients' lives is important for providing empathic care that is oriented to the outcomes that matter to patients. In addition, care that attends to the person-in-context motivates and sustains mental health providers by putting meaning back into medicine. Truly patient-centred care demands pushing back against the reductionism of contemporary psychiatry to thoughtfully engage with the complexities of patients' lives.

Key words: Social anthropology, psychiatric services, health services research, quality of care.

In *The Birth of the Clinic* philosopher Foucault (1973) states that the rise of modern medicine brought a fundamental shift in the orientation of the physician to the patient. According to Foucault, the question at the heart of pre-modern medicine was, 'How do you feel?' This question was grounded in the totality of the subjective experience of the ill individual. By contrast, in modern medicine the central question becomes, 'Where does it hurt?' This change in the focus of the physician signals a shift away from the person-in-context and a narrowing of the gaze of the physician to bodily signifiers of disease.

I was reminded of Foucault's argument during two recent interviews with a psychiatrist and patient. When I asked the psychiatrist to describe the goal of his clinical care, he unhesitatingly responded, 'Symptom suppression and symptom control.' A few weeks later, I had this exchange with a patient during an interview:

> Interviewer: Do you feel like [your psychiatrist] knows about your life? You mentioned in the beginning [of the interview] that you talk with [your counsellor] about what's going on with you and your family and your loved ones and your future husband. Do you talk about those things with Dr [X], too?
> Patient: No. No.
> Interviewer: Why is that?
> Patient: I ain't never talked to Dr [X] about my family and my loved ones with Dr [X]. Not that I can I remember. No.
> Interviewer: Why is that?
> Patient: She never asks me about them. I never mention it. Nope, I never mention them to her.

The privileging of symptom control and the muting of context in psychiatry

These exchanges each illustrate the privileging of symptom control that has taken hold within mainstream psychiatry in the USA and other Western settings. In each case, the broader context of the patient's life does not enter into the provision of psychiatric treatment. The psychiatrist defines the goal of his clinical care in narrow terms, not taking into account the ways in which knowledge of the patient's life – what brings meaning, what are the person's aspirations – could help to define outcomes that matter. The patient's account is notable for its uncritical acceptance of psychiatric encounters stripped of the knowledge of the patient's family members.

The focus on symptom control has emerged over the course of a sea change away from intrapsychic and interpersonal explanatory models of mental illness towards biological psychiatry (Luhrmann, 2000). Certainly, much of this shift is a welcome move away from the family-blaming discourse that dominated mid-century psychiatry, typified in notions of the 'schizophrenogenic mother' (Fromm-Reichmann, 1948). Yet the ascendance of biological psychiatry and the ensuing dominance of psychotropic medications have had the unfortunate consequence of muting context in contemporary psychiatry. This is exacerbated by the time and productivity pressures of current practice (Torrey & Drake, 2010). Making space for complex problems is difficult in the current treatment milieu. The emphasis on controlling symptoms

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through medications in psychiatry reflects the culture of biomedicine more broadly and is deeply aligned with American cultural values of individualism, efficiency and scientific progress (Good, 1994, 2001). Doctors and patients alike are susceptible to the allure of medication-focused treatment (Good, 2001; Carpenter-Song, 2009*a*; Jenkins, 2011). In contrast to the prospect of 'better living through chemistry,' attending to the circumstances and contingencies of mental health recovery involves the 'messy business of putting disrupted lives back together' (Hopper, 2002).

Why context matters

Messy as it may be, as we learn more about the social determinants of mental health, it is clear that knowledge of the person-in-context is not a luxury. Decades of research in psychiatric epidemiology demonstrates the robust association between socioeconomic status and mental health, with those at the top enjoying the best and those at the bottom the worst outcomes, respectively (Ng *et al*. 2014). Moreover, the vast majority of decisions about health care, efforts to manage illness and behaviours that impact health occur outside of clinical settings (Bodenheimer *et al*. 2002). Context is key.

As a medical anthropologist specialising in mental health research, my work involves engaging with individuals, families and communities to learn about the lived experiences and meanings of mental health problems. Anthropological inquiry involves, 'studying human life up close and in context' (Singer & Baer, 2012, p. 8). Medical anthropologists are relentlessly curious about, and aim to elicit, the insider's perspective on the personal and cultural meanings of illness. The field has provided key insights into how illness experiences and help-seeking behaviours are shaped by the social and cultural environment. How problems are identified, conceptualised and explained by sufferers and the social meanings of maladies influence decisions about whether or not to seek help and what type of help is considered appropriate (Kleinman, 1980). For example, problems diagnosed as mental illnesses can be variously understood as arising from chemical imbalances, stress and trauma, interpersonal conflict, personal moral failure, or supernatural causes (Jenkins, 1988; Jenkins & Barrett, 2004; Carpenter-Song *et al*. 2010). These diverse 'explanatory models' (Kleinman, 1980) of distress would each suggest a specific pathway for treatment (e.g., psychotropic medication for a chemical imbalance or a community ritual to mitigate social conflict).

Anthropological research has demonstrated that psychiatric conceptualisations of mental health problems often do not resonate with how individuals, families and communities understand problems (Jenkins, 1988; Carpenter-Song, 2009*b*, Carpenter-Song *et al*. 2010, 2014). We have learned from urban, low-income participants from racial and ethnic minority backgrounds that mental illnesses are understood and experienced in relation to daily lives marked by the threat of violence, histories of trauma and the stresses of financial insecurity. African-American mothers in one study attributed their experiences of mental illness to the broader context of danger, loss and insecurity in which they lived (Carpenter-Song *et al*. 2014). Possibilities of recovery for these women were grounded in the work of raising children and their strong religious faith, not in the promises of pharmaceuticals.

The dissonance between clinical and community understandings of problems may account, in part, for why the majority of people with mental health problems do not seek professional treatment (Wang *et al*. 2005). Anthropological research has offered insights into the logic of why even severely ill and impoverished individuals may still elect not to participate in mental health services (Luhrmann, 2008). In recent work with low-income rural families in New England, I have observed the tenuous ties that marginalised individuals have to professional mental health services despite numerous mental health and substance use problems. Knowledge of the lifeworlds of these families recasts an understanding of this behaviour from being an irrational 'failure' to seek help. I have learned that marginalised rural individuals feel alienated from the health system and middle class providers who 'have not been through the same stuff' and thus, 'do not understand' their experiences. Healthcare providers are often seen as out-of-touch with the harsh realities of living in poverty and, in some cases, people have felt insulted by providers. These problems are likely to be amplified in cases in which providers and patients do not share a common language or cultural background. Indeed, these narratives echo the experiences of urban, low-income African-American participants with whom we have worked, many of whom felt that mental health providers 'do not care' and 'do not provide solutions. They are mainly concerned about you taking your medications' (Carpenter-Song *et al*. 2010). With this information, people's reluctance to engage in professional treatment and their wariness towards providers is much more understandable. Moreover, it points to the need for healthcare providers who can engage empathically with the complex lives of their patients.

Putting meaning into medicine

Psychiatric encounters that are about more than the assessment of symptoms and the prescription of medications to control symptoms are good not only for

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patients but also for doctors. In a recent study of community psychiatrists (Carpenter-Song & Torrey, 2015), we found that healthcare providers were motivated and sustained in their work by cultivating relationships with patients, orienting their clinical care towards recovery, and engaging with psychiatric practice as intellectually stimulating work. This group of community psychiatrists worked in settings characterised by limited financial resources; time and productivity pressures; and with patients who were marginalised by serious mental illnesses, poverty and discrimination. Yet, even years into practice, they continued to find this difficult work meaningful by nurturing a deeply patient-centred and recovery-oriented clinical practice.

These psychiatrists emphasised that their work was about much more than prescribing medications and viewed themselves as educators and advisers in the lives of their patients. Unlike the psychiatrist quoted previously who viewed the goal of clinical care as 'symptom suppression and symptom control,' this group of psychiatrists defined their successes in terms of patients achieving functional goals such as getting a job or reuniting with family members. The ability of these psychiatrists to push back against the reductionism of mainstream psychiatry was facilitated by agency leaders who shared the values of psychiatry as mission-driven and recovery-oriented work. These values, in turn, were inscribed in more flexible workflows and, in some cases, the ability of psychiatrists to spend more time with patients.

Re-defining the mission of mainstream psychiatry to amplify the moral impulse of physicians (Good, 1994) may mitigate the demoralisation of some providers (Bullon *et al*. 2011). Psychiatry in the USA faces serious workforce challenges (Thomas *et al*. 2009; DeMello & Deshpande, 2011) and putting meaning at the heart of practice may attract a new generation of providers to this difficult and rewarding work.

Concluding remarks

The thinning out of psychiatry by focusing on decontextualised symptoms and the narrowing of the psychiatrist's function to prescribing medications eclipses meaningful attention to the conditions of suffering and possibilities for recovery. Being open to, and making space for, patients to share their lived experiences may illuminate opportunities for healing by linking individual experiences of suffering to legacies of oppression, trauma, or the daily grind of lives on the 'institutional circuit' (Hopper *et al*. 1997). Knowledge of patients' lives is important for providing empathic care that is oriented to the outcomes that matter to patients (Deegan & Drake, 2006). In addition, care that attends to the person-in-context motivates and sustains mental health providers by putting meaning back into medicine (Carpenter-Song & Torrey, 2015). Truly patient-centred care demands pushing back against the reductionism of contemporary psychiatry to thoughtfully engage with the complexities of patients' lives.

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Conflict of Interest

None.

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