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ABSTRACT This article considers the ethical guidelines concerning autonomy, negotiated consent and transparency in relation to an ethnography of psychiatry. It suggests that the complexities and unequal power distribution of the psychiatric consultation make these guidelines difficult to apply. Rather an attempt is made to develop an ethics of patient acknowledgement even where this presents ethical misgivings vis-à-vis psychiatrists. I argue for the importance of ethnography rather than the instantiation of abstract principles to the development of an ethical perspective.

KEYWORDS *ethics; ethnographic contextualization; psychiatric dialogue*

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> He felt as though he had been sucked into a machine that was dismembering him into impersonal, general components before the question of his guilt or innocence came up at all. (Musil, 1997: 168)

Ethnographic encounters with patients and their psychiatrists bring ethical dilemmas into painful focus. The title of my article was deliberately chosen to reflect what I see as a central ethical problem in psychiatric practice. Deception and distrust characterize the relationship between Latvians and wider society and these qualities have inevitably come to shape the relationship between patients and their psychiatrists. What Frank describes as 'the subversive voice' of suffering is a protest against the ideological voice of psychiatry (2001: 360).

The very rapid economic liberalization of the Baltic States and its problematic relationship with an unrealistic philosophy of limitless individual opportunity has made deception harder to pin down but has intensified distrust and isolated the subversive voice. The process of economic

liberalization has scooped up psychiatric theory and practice. Earlier somatic diagnoses have been replaced by psychological diagnoses. Psychiatry, medicine and the social sciences have all been implicated in the process of fragmenting and reconstructing individual experience to fit in with what Smith calls their own specialist 'textually mediated forms of ruling' (1993: 212). However, in most cases such processes are ongoing, and patients and respondents have become habituated and embedded within these discursive projects. Approval of medical or sociological texts is to be understood not as authentic approval but as capitulation to relations of ruling (Frank, 2001: 356). Following Bourdieu (2002), I would describe some psychiatric interchanges as misrecognition and relate such misrecognition to contradictions between the philosophy and implementation of liberalism in Latvia and the consequences of such contradictions for individuals. Ironically, however, this knowledge has only been made possible at a cost of fudging issues to do with negotiated consent and transparency. In post-Soviet Latvia we can witness western psychiatry in the process of trying to articulate its discursive project and to establish relations of ruling. As a result of the uncertain hegemony of a changing psychiatric discourse the discordant voice of patients' suffering is more apparent.

Latvia along with the two other Baltic States played a key role in accelerating the dismantling of the Soviet Union (Lieven, 1993). These countries were keen to end their very real experience of Soviet oppression. At the same time their new democratic leaders were ready to embark upon an immediate and radical programme of economic reform.

> Latvia through numerous governments has not strayed from this liberal economic path. Its firm acceptance of the market and concomitant rejection of state interventionism has placed Latvia among the top tier of the reforming countries in the eyes of international financial organisations. (Pabriks and Purs, 2002: 95)

However, for many Balts these economic changes, involving as they did the end of socialist support structures such as free health care, brought about considerable personal hardship and insecurity. Political and economic liberalization affected every aspect of society including medicine and psychiatry for which charges were introduced in 1995.

My thematic interests arise without exception from my need to acknowledge the experience of individuals and to put on record my encounter with them. That is not to say that I wish to exclude theory altogether. But the task of anthropology as of philosophy 'is to say whatever can be said that is as general as the field permits' (Toulmin, 1988: 348). My field, in this case, focused on the dialogue between patients and their psychiatrists: an exchange between narratives of despair and a discourse of diagnoses and medication. Patient narratives included a polyphony of voices that spoke of cramped accommodation, unemployment and poverty as well as of shame and self-blame. Through listening to these consultations I became

interested in three areas: first, in identifying the key features of change from a Soviet and socialist society to a liberal capitalist one that impinge upon lay conceptions of the self and narratives of distress; second, in understanding how these shifts in culture have permeated the theories and treatment strategies of mental health professionals; and, finally, in mapping the extent to which understandings of lay people and mental health professionals converge or diverge and how this contributes to personal suffering. All of these questions have an ethical dimension. Radical economic and political changes have brought with them a shift in the locus of deception, which has resulted in guilt and shame for many. Under Soviet occupation the mismatch between official versions of history and actual experience could not be openly acknowledged but was keenly felt and easy to identify. The collapse of Soviet power has brought with it a policy of economic liberalism, which rests upon a conception of individual power that fits badly with the reality of everyday life. However, the philosophy of agency has powerfully penetrated individual psyches so that makes its mismatch with available opportunities harder to identify. Psychiatrists play an important role in this process in that the language they use has a huge potential for affirming or diminishing self-worth and in shaping conceptions of the self. And third, an increasing divergence between lay and professional understandings undermines the project of finding meaning in illness.

These three concerns confronted my fieldwork throughout its entirety. It seems to me that they raise ethical issues of a more fundamental nature than those traditionally associated with anthropological research. They challenge but also transcend issues to do with autonomy, informed consent and transparency, both in relation to psychiatrists and in relation to their patients. What kind of autonomy is being given to patients? Miller distinguishes four different meanings of autonomy: namely, as freedom of action, as authenticity, as effective deliberation and moral reflection (1981: 22). My encounter with patients and psychiatrists suggests that there is a tension and contradiction between their conceptions of autonomy. Psychiatrists appear to be concerned with nurturing a sense of autonomy to do with recognizing and conforming to a particular kind of patient role. Patients' concern with autonomy is of a different order and relates to moral deliberation and authenticity. This in turn raises the question of whether transparency within the research relationship is of paramount importance or whether it can be overridden in favour of making a long-term contribution to the well-being of psychiatric patients? How can one negotiate the differences in ethical position of a Soviet-grown psychiatry and British anthropology? To what extent do institutional constraints and official ethical guidelines influence the actual practice of psychiatrists? What are the ethical implications of listening to the misery of others with a view to translating such misery into an anthropological text? Frank writes of balancing on the edge between symbolic violence and silence (2001: 361). And finally, in what ways has the westernization of psychiatry altered the practice of psychiatry in Latvia and

changed relations between doctors and their patients? The answers to these questions lie not in ethical theory but in ethnographic contextualization. We must look to areas that the early moral philosophers chose to ignore. Toulmin writes: 'In four sets of topics and spheres of thought, they were especially *un*interested: the "oral", the "particular", the "local", and the "timely"' (1988: 338, emphasis in original). Toulmin argues that if ethics is to have meaning it must embed itself in ethnographic and clinical context. Others have argued that without ethnography ethics cannot survive:

> Theoretical systematisation supposedly transubstantiates the water of moral experience into the wine of moral knowledge. Although the ritual may continue to play a role in the cathedral of academia, it remains peripheral to the outside world. There moral experience retains its primacy, and it is appreciating the primacy of experience and in providing ways of understanding and guiding that experience that ethnography can be useful. (Hoffmaster, 1992: 1424)

Ethical questions are easier to formulate than to answer. My answers indicate the beginnings of an argument and the tentative mapping out of a moral domain. Autonomy, like freedom, has multiple meanings but essentially they relate to two dimensions. They are the freedom to act and the freedom to take up a moral position and to be a particular kind of person. Taylor (1985) and Frankfort (1988) both argue that freedom in the latter sense is more important: 'Agents are beings for whom things matter, who are subjects of significance' (Taylor, 1985: 104). Thus what matters to the patient must be recognized within the psychiatric consultation. Issues of transparency raise the question of transparency for whom? Rendering the research transparent to the psychiatrist might have made research impossible and thus ultimately have silenced the voice of the patient. And finally with regard to translating the misery of others into an anthropological text, my view is that, by and large, psychiatry carries greater risks of symbolic violence and misrecognition than does a humanistic anthropology. In part this is no doubt due to the greater institutional and financial backing of psychiatry. Bourdieu puts this well:

> The symbolic violence that any ideological discourse implies, in so far as it is based on misrecognition, is only operative inasmuch as it is able to make its addressees treat it the way it demands to be treated, namely with all due respect, observing the proper formalities required by its formal properties. Ideological production is all the more successful when it is able to *put in the wrong* anyone who attempts to reduce it to its objective truth. (2002: 153)

Although the three Baltic States are cited as an economic success story, this has been, as I have indicated, at considerable human cost for large numbers of people. The problem for many middle-aged people is that they have learnt to live life, to play the game, according to one set of rules and that mid-way through their lives those rules have undergone a radical change. Playing by the rules no longer brings them the rewards they were promised. The result is a huge feeling of loss and wasted lives. Furthermore,

the locus of responsibility for an individual's well-being has shifted from collective imaginings such as the state, history and destiny to the individual agent. Nuckolls has made an interesting attempt to relate histrionic and anti-social personality disorders to Weber's ideal types configured around moralism and materialism (1992: 37). These twin pillars of the capitalist self exert an influence beyond specific psychiatric diagnoses and combine to constrain individuals in a particularly painful grip, making them feel acutely responsible and ashamed of a lack of material success. The dramatic changes in conceptions of the self and responsibility remind us forcefully that the self has a history (Bruner, 1986, 1990; Gergen and Gergen, 1986; Rose, 1997).

A unifying characteristic of both the Soviet and the post-Soviet era is an absence of trust in the workings of society. Numerous studies have shown that physical and psychological well-being are directly related to the levels of inequality in a society, rather than absolute poverty (Wilkinson, 1996). And social inequality is in turn related to the levels of connectedness and trust between people (House et al., 1988; Berkman, 1995; Seeman, 1996; Putnam, 2000). However, the absence of trust has had different mental health manifestations in the Soviet and the post-Soviet era.

Fieldwork background

My own work has been carried out in Latvia over the past 12 years. It has involved talking with people who described themselves as psychologically damaged and who may or may not have sought medical help for their condition (Skultans, 1996, 1997a, 1997b, 1997c, 1998, 1999). It involved talking to doctors and psychiatrists and, more recently, it has involved sitting in on psychiatric consultations as a semi-participant observer (Skultans, 2003). Throughout my periods of fieldwork and in the transcription and interpretation of interviews I have been uneasily aware of the ways in which my work has fallen short of the formal guidelines suggested for ethical anthropological practice. But had I followed the guidelines in a strict sense, my fieldwork could not have been carried out.

My article is based upon 12 months of fieldwork carried out in Latvia between 1991 and 1992, and seven months during 2001. During the first period of fieldwork I talked with more than a hundred people who considered their health, in particular their nervous health, to be damaged. In 2001 I spoke with psychiatrists and their patients. I was allowed to sit in on some 300 psychiatric consultations and to tape-record these consultations. Without a doubt, the location and focus of my research, particularly in 2001, brought the traditional ethical problems of transparency and informed consent to a particularly sharp edge. However, over and above these traditional concerns was an acute moral discomfiture that some psychiatrists were promoting an account of patients' distress that was totally at odds with the patients' views of what was wrong and why and, indeed, with my own perceptions.

Negotiating 'consent' and fudging transparency

Negotiating consent to carry out an ethnography of psychiatric consultations reveals the unequal distribution of power between psychiatrists and their patients. The difficult part was gaining permission from psychiatrists to sit in on and record their consultations. Thereafter, the patient's consent appeared to be part and parcel of agreeing to the consultation as such. Patients were asked something along the lines of, 'You don't mind if the anthropologist from England listens to our conversation?' or 'You don't mind if the professor from England sits in on the consultation, do you?' No patient refused permission for me to listen. Of the ten psychiatrists whom I approached, two refused collaboration. The other eight showed an extraordinary degree of tolerance and generosity in overcoming distrust of my presence, fear of how I might judge their professional competence and the uses to which I might put the recordings. Their friendly generosity has placed me in a moral quandary. How can I square the hospitality and cooperation offered me by Latvian psychiatrists with my sometimes critical stance of their ideas and practice? The result is that I feel rather like a guest who eats a meal only to speak badly of the host's cooking skills afterwards. I am not sure how to resolve this unease, save to say that ethical obligations form a hierarchical structure. Taken singly, each has weight but taken together some override others.

Understanding other cultures on their own terms requires a certain suspension of judgement. And yet recent developments in epistemological theory have highlighted the naivety and unattainability of aspirations towards ethical neutrality. How to find a middle way between openness to cultural difference and ethical indifference is an ongoing problem in ethnographic research. The emphasis on transparency and openness in the research situation influenced largely by feminist practice has been shown to have major pitfalls of its own. Stacey has argued that it is precisely the closeness engendered by feminist ethnographic practice that is responsible for 'inauthenticity, dissimilitude, and potential, perhaps inevitable, betrayal' (1988: 22). Emotional connectedness and empathic understanding should not disguise the fact that the ethnographer and informant have different motivations in participating in the research. Glucksmann describes this as: 'the different and unequal relation to knowledge of the researched and researcher' (1994: 159). Re-naming informants as respondents or participants does not empower them in any real sense. It may simply be a way of 'attempting to establish an egalitarianism in the research situation as a substitute for establishing it in the "real world"' (Glucksmann, 1994: 151). And, as Smith argues, obtaining approval for sociological texts is often not real approval but a form of capitulation (Frank, 2001: 356).

The American Anthropological Association published a statement on ethical practice that contained the following injunction: 'In research, anthropologists' paramount responsibility is to those they study. When

there is a conflict of interests these individuals must come first' (1986: 2). This statement poses special problems for the ethnographic study of psychiatric practice, which encompasses both psychiatrists and their patients. While the statement recognizes the 'plurality of values, interests and demands' in the societies studied by anthropologists, the study of psychiatric consultations often encapsulates a conflict of interests that are particularly difficult to work with. Some of these misgivings may be resolved by the directive 'to contribute to an "adequate definition of reality" upon which public opinion and public policy may be based' (1986: 3). However, the equivalent British statement of the Association of Social Anthropologists is more cautious: 'The advancement of knowledge and the pursuit of information are not in themselves sufficient justifications for overriding the values and ignoring the interests of those studied' (ASA, 1999: 2).

Perhaps more than other areas of anthropological study cross-cultural psychiatry is faced with the problem of how to adjudicate between competing definitions of reality and normality. Some years ago Kleinman (1977) advocated a 'new cross-cultural psychiatry'. His argument for the more radical approach of cross-cultural psychiatry rested on epistemological considerations to do with the social construction of knowledge. The imposition of western psychiatric categories for understanding the behaviour of people in other societies was, he argued, a form of psychiatric imperialism. Each society has developed concepts for understanding disordered behaviour, and to impose western categories is to distort a reality that has already been filtered through local concepts. It involves imposing second-order categories on first-order categories and was, he argued, an illegitimate move.

These problems, which are a regular feature of ethnographic research, appear in a more acute form in the anthropological study of mental illness and its treatment. Disordered behaviour, which causes distress to the individual and those around him/her, rules out moral indifference. Unequal access to knowledge within a psychiatric consultation makes true equality difficult and inequality may in any case be further ensconced by institutional arrangements of inequality. A divergence between the individual's experience and psychiatric theories may feed a conflict of interests. Competition over the right to define reality acquires a new meaning in the triangulation that takes place between the anthropologist, the psychiatrist and his/her patients. And how does the demand for informed consent fit into the ethnographic study of psychiatric practice? What counts as informed consent in the context of a psychiatric consultation? Whose consent is required: the patient's, the psychiatrist's or both? And, given the conflict of interests and perspectives, is it realistic to expect such consent?

The ASA ethical guidelines describe informed consent as expressing 'the belief in the need for truthful and respectful exchanges between social researchers and the people whom they study' (1999: 3). And moreover, it is not enough to be given consent once only. Consent 'may require renegotiation over time; it is an issue to which the anthropologist should

return periodically' (1999: 3). In my case, consent to listen to and record consultations was obtained from psychiatrists through informal discussion who then asked for 'consent' from their patients at the beginning of the consultation. Typically, this took the form of cursory questions already alluded to. As I said earlier, permission was never withheld. Whether their agreement constituted informed consent is another matter. But certainly my presence in the consultations was not, I think, perceived as particularly unusual.

This ready agreement within the context of a psychiatric consultation is not only about informed consent. It concerns a clash of cultural and professional expectations. Medical consultations in Soviet Latvia lacked the privacy with which they are associated in the West. Access to consulting rooms is seldom restricted to a doctor and her patient. Besides the prescribing nurse who shares the consulting room, other staff and, indeed, patients frequently interrupt an ongoing consultation. Moreover, the ringing telephone regularly intrudes with other patients' problems as well as with the doctor's domestic troubles. Neither the boundaries of the patient's nor the doctor's problems are guarded as rigorously as they are in western medical practice. Patients were, until recently, in charge of their own notes. In such contexts, problems are publicly shared. However, the idea of informed consent only makes sense in the context of guarded boundaries and appropriated knowledge. To have pushed for more explicit consent would have been to challenge and possibly undermine the existing understandings and practices surrounding medical and psychiatric consultations in Latvia. Not only might my motives have become suspect but also those of the psychiatrist. The emphasis on returning to the issue of informed consent and renegotiating it suggests, in fact, that informants may wish to push the anthropologist's agenda out of their mind.

Changing conceptions of self under communism and capitalism

Weber first alerted us to 'the way in which "ideas" have, like switchmen, determined the tracks along which action has been pushed by the dynamic of interest' (1991: 280). But action is intrinsically connected to intention, which in turn brings in the idea of agency. But agency is itself a slippery term and means different things at different periods. Kemp has identified five types of agency: moral, embodied, volitional, behavioural and social, which may or may not co-exist (2004: 63). Under Soviet rule, agency for many Latvians was confined to the moral sphere. It related to an individual's ability to take up a moral position despite an absence of behavioural and social agency. Paradoxically, under economic liberalism, which emphasizes the individual's power to change his or her life circumstances, there has been an erosion of moral agency. There has been an unquestioning internalization of a liberal philosophy of the self. However, in the

absence of behavioural and social agency this uncritical acceptance of an ideologically enlarged conception of the self is a source of pain and discomfort to many. Thus the changes from a command to a market economy have been accompanied by equally painful intra-psychic changes. I would like to present images of social and psychological change by using excerpts from my conversations with psychiatrists and patients over a 10-year span. My excerpts come from my fieldwork in 1992 and 2001. They illustrate the way in which both understandings of distress, the positioning of the individual vis-à-vis society, the divergence between lay and professional understandings of mental ill health and the sources of distrust and disconnectedness have changed.

In 1992 I had many conversations with Anna, a psychiatrist. Initially I was interested in her practice and her patients' problems. However, as we became friends the conversation shifted to her own life and the way in which she felt the events in her life had damaged her health. Her own shorthand term for her problems was summed up by the quasi-medical term 'neurosis'. She attributed the condition to herself and claimed that it had developed as a result of the particular course her life had taken and the historical and social conditions in which it was embedded. However, in making these claims and admissions, Anna was making a connection with other Latvians.

For example, Anna says:

> I don't for one moment consider that I am the only one who hasn't succeeded or something like that. I have always told myself that I am not the only one like that. The whole Latvian nation is like that. I think that every other family has all sorts of problems. You could call it destiny, or the situation or this communist epoch. I don't know how to put it more precisely: there is nowhere where this mystical epoch hasn't interfered and hasn't transformed life. My destiny isn't anything special. There are many more tragic destinies than mine.

Anna's life history is almost a social history detailing as it does the problems of returning from Siberia and subsequent problems with accommodation:

> People were very intimidated here. They didn't want to socialize freely. It was difficult to find anywhere to live, although houses were empty. They didn't let us in. We lived with relatives for three or four months, then we found a little old woman, she lived in a private house and she gave us a room.

Anna also relates her neurosis, as she terms it, to her subsequent difficult living circumstances. I asked her whether she had sought help for her problems.

> Well, I think I could be helped with the nerve illness. But I think that while the cause has not been liquidated, the cause of my neurosis, the cause of my stress, until I have peaceful home circumstances, at work I am tense, I have to listen to different people, different complaints, different characters, I have to be calm all the time, and when I go home I can't rest and again I have to hear . . . to be

> specific I have to hear various swear words addressed to me. Actually, I don't get any rest anywhere.
>
> But most of all I suffer from the fact that my children hear those rude Russian swear words. I'm not so concerned about myself however unpleasant it may be and the same goes for grandmother, but a child. Those children are growing up the same way as me – neurotic. A new generation of neurotics, because they're already afraid. A young child doesn't understand swear words. I remember that my youngest daughter was five years old. She comes in and calls me swear words. My daughter asks me what they mean. I have to tell her that those are bad words. It hurts me especially for the children, that a new generation will also suffer from accommodation neurosis.

The neurosis seems to have an existence that is almost independent of the individual. Accommodation neurosis suggests that the neurosis resides outside the individual. But at the same time Anna retains her ability and right to pass judgement on her difficult circumstances even though she lacks the ability to change her circumstances. Anna is typical of many doctors who in 1992 were ready to be open about their problems and see their source in the difficult circumstances through which they had lived and were living. Although psychiatrists during the Soviet era were perceived as agents of social control and, indeed, some were involved in medicalizing political dissent, many others were ready to acknowledge the harsh impact of historical and social circumstances on individual well-being. The role of psychiatrists in promoting a misrecognition of the noxious influence of certain forms of social oppression has not been confined to the Soviet era.

Images of change in 2001 are drawn from 35 open-ended conversations I conducted in the polyclinic of a provincial town in north Vidzeme. This clinic had no psychotherapist or psychiatrist and for this reason the director of the clinic was happy for me to see patients who wanted to talk about their problems. I explained to the director that I was an anthropologist interested in social change and its effect on self-concepts and discourses of distress. A poster to that effect was put up in the clinic and a notice was published in the local paper. However, it soon became clear that I was cast in the role of a psychotherapist. One patient opened the interview by saying that she had never consulted a psychotherapist but that she had seen psychotherapists in action in American soaps. All 35 of the patients who came to see me were women and all were struggling with extremely difficult financial and domestic circumstances. All the conversations were tape-recorded.

A unifying characteristic of all the accounts is that, while patients described their difficult circumstances and the impossibility of making ends meet, all adopted a judgemental and even a punitive attitude towards themselves and what they perceived as an inability to control their painful emotions and to cope. For example, Milda is a 46-year-old woman due to have an operation for a pituitary tumour. She blames herself for her lack of control: 'The tears flow by themselves. Even if I don't want it the tears

flow. It's some sort of weakness. It's bad. Probably someone else could control themselves but my tears just flow and flow. I don't know.'

Nearly everyone used phrases to do with management, control, order and cultivation. The inability to manage one's finances is mirrored by an inability to manage one's self. As one 29-year-old woman said: 'If there is order around me, then I myself feel ordered.'

Aija is 47 years old and started the conversation as follows: 'It all started because my husband has a job where he is supposed to be paid but isn't paid.' Aija herself cannot get a job because she has tiny stubs in place of teeth: 'I can't get a job, for example, because I don't have teeth. A paradox so to speak. It's a kind of joke.' But it is a joke that makes her cry even as she talks about it. And she condemns herself for crying: 'I cry over nothing. I always manage. I don't know how to find a solution. There's nothing to cry about.' Like many others, she manages in the sense of surviving and yet does not manage in any decent and meaningful way. The difficult financial situation creates a feeling of futility and purposelessness. A senior nurse at the polyclinic described it thus: 'All my life I've saved, all my life. But I'm still short of money and short of money.'

The financial difficulties are accentuated in cases of illness. Forty-six-year-old Biruta has an ailing 65-year-old mother and two boys who are studying and not yet financially independent. This is how she describes the problem:

> Father had a bigger pension. At that time there were two pensions. And one pension could go [on] medicines. Then they could afford 20 lats and buy Cipramil, for example. But now there is just one pension. And during the winter my husband doesn't have a proper job and I still have to support my children and to pay the bills. I can't take my mother to the doctor and get all her prescriptions because mother's pension just won't cover them. She has heart, she has liver, she has kidneys, she has legs, she has back. Well you understand, when you have all the ailments, all the money goes on medicines. And now, for example, when she gets her pension she will have just five lats in her purse.

The rhetorical detailing of ailments and precise sums of money serves to bring home the impossibility of making the sums add up in a satisfactory way. However, beyond the impossible sums and the paradox of not being able to get a job without teeth or teeth without a job lies the shame that such situations engender. The feelings of shame and self-blame are most acutely conveyed in the anxieties aroused by the ceremonial functions of school leaving. In Latvia, both during the Soviet era and continuing to the present, school leaving was associated with a number of public occasions demanding lavish expenditure on clothes for children and parents, flowers and presents for teachers. Many women spoke of the nightmarish anticipation of these events; of not knowing how to find the necessary money and yet being terrified of exposing the shame of their poverty to schoolmates, other parents and neighbours.

These extracts demonstrate important differences in the articulation of

distress between 1992 and 2001. In 1992, abnormality was perceived as an attribute of social circumstances and their shaping of individual lives. People described their abnormal life '*šitā nenormālā dzīve*' as damaging nerves '*sadragā nervus*' in a very concrete way. It is the individual's life experiences, rather than their personality, which is abnormal. The verb '*sadragāt*' is primarily used to convey the infliction of physical damage as in the case of using an insufficiently inflated car tyre or the scuffing of a shoe by a careless child. The term brings to mind a careless and brutal assault and its physical consequences. Here the explanations speak of the contingency of existence and suggest a fine understanding of the historical and social embedding of their lives. In 2001 the locus of responsibility for distress has shifted. Although life now presents an equally difficult, though different, set of circumstances, people do not judge their responses as inevitable and, therefore, in some sense appropriate. Instead, their distress is tied up with feelings of shame and self-blame. Whereas Anna in 1992 connected her feelings with those of others, Milda in 1992 distinguishes her responses from those of others: 'Probably someone else could control themselves.' These changes have taken place independently of the intervention of psychiatrists or psychotherapists, as my conversations in the polyclinic indicate. My own understanding of the patients' distress pointed to contradictions between the new ideology of economic liberalism and the actual opportunities that were available to people. Indeed, I felt it was right to make my views known to patients if only to lessen the punitive burden of self-blame. In articulating my own position, at odds with that of the patients', I was, I suppose, trying to give them a lost sense of community and to relieve them of the burden of self-blame.

Changing psychiatric language

Psychiatry, as practised in Latvia, has until fairly recently been very much in the Soviet mould. This has meant that the psychiatrist's duty to the patient has been counterbalanced by 'the interests of society' and 'the principles of communist morality' (The Physician's Oath of the Soviet Union 1971 in Bloch and Chodoff, 1984: 114). Certainly, the social and political abuses of Soviet psychiatry have been widely publicized (Medvedev and Medvedev, 1971; Bloch and Reddaway, 1977; Lader, 1977; Podrabinek, 1980). These writings have largely dealt with the diagnosis of 'sluggish schizophrenia' and the ways in which it has been used to incarcerate and silence political dissidents. The misuse of psychiatry for political ends led to the expulsion of the Soviet Union from the World Psychiatric Association in 1983. They were readmitted in 1989.

For these reasons, Soviet psychiatry has been held up as an extreme example of the potential abuse of psychiatry for political ends. Soviet psychiatry 'demonstrates, with grim clarity, how a system that appears to have only scientific origins and professional goals can, simply by virtue of

its own nature as a systematic psychiatric technology, result in significant human harm' (Reich, 1991: 66). The development of Soviet psychiatry and, in particular, the diagnosis of 'sluggish schizophrenia' illustrates the dramatic ways in which psychiatric categories can come to influence the perception of behaviour and, therefore, of course the experience of patients:

> Those Soviet psychiatrists really saw the patients as schizophrenic; or, to put it another way, the system created a category, first on paper and then, with training, in the minds of Soviet psychiatrists, which was eventually assumed to represent a real class of patients and which was inevitably filled by real persons. (Reich, 1991: 71)

However, in the process of identifying the misuses of Soviet psychiatry, the everyday practice of psychiatry has been neglected and the ethical dilemmas encountered in all psychiatric practice have been glossed over. I would argue that it is precisely the ubiquity of certain psychiatric conditions such as neurasthenia that rendered them invisible. Conversations with Dr Alka, the principal doctor at the headquarters of the Riga emergency ambulance service, suggested that the majority of Latvians suffered from damaged nerves in some form or other. In people under 35 years of age this manifested itself as a dysthesia of the autonomic nervous system, in Latvian *vegetativā distonija*. The Chambers dictionary defines dysthesia as 'a morbid habit of body, resulting in general discomfort or impatience'. Dr Alka listed chest pains, headaches, sudden changes in blood pressure as symptoms of *vegetativā distonija*. In patients over 35 the diagnosis was neurasthenia, suggestive of a more entrenched condition that had moved beyond mere habit but was associated with similar symptoms. Dr Alka referred to the difficulty of distinguishing between functional and organic conditions: 'Well, you see, we are afraid of overlooking organic illnesses. Because in principle almost every person has these neurasthenia problems. Those or some others, because all these social things leave a very heavy imprint on a person.' Thus Latvian psychiatry embodied a paradox. On the one hand, it had assimilated a Pavlovian theory of character types, which accounted for a variety of weaknesses of the nervous system. Underpinning this categorization was a dualistic theory that divided people into social and egoistic types (Skultans, 1997a: 9). But on the other hand, these diagnostic categories have a semantic complexity that included a critique of society. People, including doctors, described the dishonesty and disorder of society eroding their health in a very direct and brutal fashion.

Independence and westernization have brought with them many changes in psychiatric theory and practice not easy to describe under a single rubric. Two new helping professions have appeared, namely, psychotherapists and psychologists. Experts from the Scandinavian countries, France, Germany and the United Kingdom travel regularly to Riga to give seminars and training courses. Considerable diversity has thus been introduced into

psychotherapeutic practice. However, countering these centrifugal tendencies is the centripetal effect of the translation of the *International Classification of Diseases* into Latvian. Whereas earlier versions of the *ICD* were adapted to local circumstances, the *ICD 10* aims to be an exact translation. The large section on Disorders of the Autonomic Nervous System has disappeared. In their place have appeared psychoneurotic disorders such as depression, anxiety and acute panic disorder. The very active presence of two pharmaceutical companies, namely, Solvay Pharma and Lundbeck, has also played a large part in shaping psychiatric treatment and theory. The monthly day conferences organized by pharmaceutical companies are well attended by provincial family doctors and psychiatrists. The diagnosis and discussion of disorders such as depression are linked to new possibilities of treatment. In some ways the sudden influx of a variety of drug treatments has become an iconic representation of the new market economy, which in theory is open to all but in practice is beyond the reach of most.

In practice these diagnostic changes have led to changes that involve a fragmentation of feelings and their decontextualization. By and large, psychiatrists are interested in the intensity and duration of feelings and their response to medication but not the circumstances that give rise to these feelings. This means that feelings are stripped of their narrative structure and come to be seen as quasi-physical objects rather than socially embedded feelings. The novelist/philosopher Robert Musil captures this way of viewing human experience in his novel *The man without qualities*:

> Who has not noticed how independent experiences have made themselves of humans? They have gone on the stage, into books, into the reports of scientific institutions and expeditions, into communities based on religious or other beliefs, which cultivate certain kinds of experience rather than others, as a kind of social experiment, and insofar as experiences are not merely found in work, they are simply in the air . . . There has arisen a world of qualities without a man to them, of experiences without anyone to experience them, and it almost looks as though, in the ideal case, people would no longer experience anything privately at all, and the comforting weight of personal responsibility would dissolve into a system of formulae for potential meanings. (1997: 158)

Divergence in conceptual understandings and the implications for meaning loss

The fit between clinical concepts of disease and lay concepts of illness is never perfect. Theories of disease involve generalization and aim to identify patients as instances of a particular disease. Illness focuses on the particularity, the non-repeatability and life-threatening quality of suffering. Illness is a prime example of the vulnerability and non-repeatability of human projects and the elusiveness of our aspirations for control (Nussbaum, 2001: 42). However, there must be some degree of overlap for understanding and dialogue to take place. I would argue that during the era of Soviet

psychiatry there was a divergence between professional and lay uses of language but that this served to disguise an underlying agreement in meaning and a fundamental solidarity between psychiatrist and patient. Doctors like Anna and Dr Alka were ready to admit that they themselves might suffer from neurasthenia. Although the psychological language of depression might prima facie suggest the possibility of convergence, in fact, it has served to exacerbate differences between people by linking depression with vulnerable personalities. Dr Helga expresses this difference by saying: 'For the patient the doctor is more powerful. Because he is a more powerful personality and more unified. And that is more healthy for the patient. Because the process of re-constructing is quicker.' The new psychiatric language, rather than promoting empathy and the recognition of suffering, has created hierarchical boundaries and a widening gap between local and extra-local meanings.

Lack of consensus and dialogue compounds pain and creates confusion. The following excerpts from a consultation between Valerijs, a middle-aged man diagnosed as having depression, and the psychiatrist Dr Helga, illustrate the way in which the diagnosis of depression serves to deny suffering and promotes non-communication. The patient's suffering has a narrative structure intimately linked to the chronological unfolding and contingencies of his work situation. The psychiatrist, however, introduces a medical discourse of 'insufficiency' that explicitly excludes the patient's concerns.

Patient: Fundamentally I had problems with work. Ours is a changeable situation. At the moment, for example . . . It's very interesting that last year I came because of problems at work and as a result depression set in, nothing interests me and it's difficult to get involved in anything. And now after a year I have exactly the same situation, except that the firm where I worked . . . Well, they just made me redundant without a reason. I asked them, 'What's the reason?' There's no reason. I've got no protection. At present the social security systems are insufficiently developed. A person is very vulnerable.

Interestingly, the patient uses the same term 'insufficiency' that the doctor later uses to describe his brain. There follows a conversational exchange in which there is a considerable amount of agreement and support for the patient partly because of my own interventions and sympathy for the patient's plight. The worthlessness of contracts and absence of employees' safeguards is discussed. However, when the consultation moves on to address issues of health the polyphonic and dialogic quality disappear and the psychiatrist begins to assert her clinical authority. Ironically it is I who move the conversation on to the subject of health.

VS: And how is your health?

Patient: My health . . . thank God. Well, it depends in what sense. I suppose in one sense it's good and in another sense it's so . . . Well thanks to the medication, of course, it's good. I'd stopped. I told you I'd stopped

> taking the medicines. It must have been about a week. And then I felt straight away that dark thoughts started to crowd in upon me. I started to feel bad. I didn't think that would happen because I thought am I going to be dependent on medicines forever.

The patient's uncertainty and hesitation over what is wrong, why things are wrong and how to put them right emerge at this point. It is clear that there is a fundamental disagreement between the patient's and the psychiatrist's views of the problem. Valerijs is concerned about dependency and recovering a sense of his own agency, whereas the psychiatrist seems to have in mind an explanatory model based on constitutional deficiency.

Doctor: That's not dependency, Valerij. That's not dependency.
Patient: Yes, but I am dependent right now.
Doctor: No, it's not dependency but insufficiency. It's insufficiency. In the same way that, for example, you can have cardiac insufficiency, or lung insufficiency or liver insufficiency, so you can have insufficiency of the brain synapses. Or more accurately the mediators of the synapses.
Patient: But is it temporary?
Doctor: It is temporary. No, rather it can be compensated for. Temporary is perhaps not the correct description; it is compensatory.
Patient: Does that mean that I shall never be the same as I once was?

The directness of Valerij's question conveys both poetry and anguish and is in stark contrast to the psychiatrist's obfuscating and dilatory replies. She does not attempt to answer his question but instead pursues a pseudo-scientific theory.

Doctor: Why do you say that? If it is compensatory then you can compensate for the condition. It can be improved and maintained. But it needs long-term . . . well it needs a long-term foundation, so to speak. Well, just as for any insufficiency. Because that's how it is in fact. And that's what we spoke about earlier – why these disturbances recur. Because these are micro-organic disturbances. And as we know – the organic does not get better by itself. It returns and it can only be compensated for. That's why I compare it to weakness and insufficiency. It's to do with the mediators of the synapses.
Patient: But if all the circumstances were very favourable, then perhaps one could recover?
Doctor: Yes, but you need compensation.

In this sequence the psychiatrist defines the terms of the discussion. She introduces the idea of 'the return of the organic' representing the patient as its harbinger. The patient's anxious questions about dependency on medication suggest that for him the psychiatrist's theories about compensation for insufficiency carry little weight. Certainly, the questions are not addressed and issues of dependency are redefined as an organic defect. Again the essence of the patient's emotive plea: 'Does that mean I shall never be as I once was?' is left unanswered. The question is about the

patient's sense of himself, and the convoluted answer in terms of brain synapses does not address the patient's anxieties. However, the patient does not give up and tries to relate his problems to the social circumstances of his work thereby implying that recovery might just be possible. The interchange between patient and psychiatrist illustrates the moral implications of mind/body problems. As Toulmin argues: 'Far from being purely theoretical questions about how we can distinguish psychological explanations from physiological ones, the issues now become intensely practical ones, about how we are to treat people at the crucial moments of their lives' (1988: 344). Toulmin is discussing medical technology and dying patients but his point applies with equal force to patients consulting a psychiatrist.

Patient: Well, for example, what do favourable circumstances mean? Literally one month ago favourable circumstances started to develop when I achieved a more or less normal financial situation – well, according to today's standards anyway. I sat down with my wife and we sorted our budget out. We knew we could cover this and this and this. And that went on for a week and I was in a very good mood and I was already starting to plan. I started to think about tomorrow. And Monday I arrived at work and I had totally unexpected news – I was told I had to look for other work. And immediately I stopped thinking about tomorrow. So about tomorrow . . . I just have today. I no longer have a tomorrow. So to speak.

Doctor: Well, that's quite right.

Patient: In the stress situation I was in I felt . . .

Doctor: Yes, quite right.

The doctor's replies are perfunctory. Indeed, as the patient tries to elaborate on his feelings she cuts him short. The patient then offers a symptom that the doctor may be more ready to respond to: 'My only complaint is that I'm terribly sleepy.' At this point in the consultation the doctor at once becomes more alert and shows interest. However, when the patient voices the suspicion that his tiredness may be due to diabetes and that he should consult a different kind of specialist the psychiatrist bluntly contradicts him: 'That's not diabetes. That's hypochondria.' The psychiatrist then switches tack and seems to undermine her own previous model of disease.

Doctor: Well you see . . . You must understand that you shouldn't put demands on yourself. Otherwise you won't be able to start your internal motor. You can't buy strength in a shop. Unfortunately, even though many would like to. Surprisingly, many people want to.

The patient's reply suggests that he has more insight into the implications of the doctor's approach than she does herself: 'Well, maybe if we develop in the capitalist direction, then we'll be able to buy strength.'

After discussing the combinations and strengths of his various medications the doctor emphasizes the importance of rest for restoring the patient's strength. Surprisingly in view of the fact that much of the

discussion has been about purchasing medication to compensate for nervous insufficiency, she tells the patient that he cannot buy strength. Clearly the patient, although not the psychiatrist, is unaware of the negative connotations of the term 'hypochondria'. When the patient makes a tentative suggestion that extends beyond the limits of the psychiatrist's professional competence, namely, that perhaps his problems fall within the area of another medical speciality such as endocrinology, the psychiatrist quickly abandons the organic model. Instead the pejorative term 'hypochondria' is introduced which questions character and motives. Finally, the consultation is wrapped up by looking through the prescriptions. The psychiatrist effects closure by saying, 'If there is anything, let me know. If anything is unclear? Yes?' Much in the consultation has been left unclear and created bewilderment in the patient but clarity is confined to timing and dosage of medication.

Throughout the consultation the doctor skilfully directs the conversation away from the social polyphony of his life to something narrower and more tangible, thereby asserting her clinical authority. Only when her authority is challenged does the organic model flounder. However, no real dialogue develops between this patient and the psychiatrist. The voices of the patient and psychiatrist extend in parallel without meeting. The patient's account encompasses both an interpretation of the social forces that give his suffering its particular shape and the existential anguish to which they give rise. He knows, for example, that, 'The market does not work in my favour'. As a consequence he describes his existential dilemma as having 'no tomorrow'.

Discussion

So what do these voices from a psychiatrist's consulting room tell us about ethics? And how do they relate to my earlier discussion of self-understanding, psychiatric language and divergences of meaning? Latvian psychiatrists, like their colleagues elsewhere, have humanitarian and pragmatic goals, which are to do with reducing painful feelings and making life more tolerable for their patients. In order to put these goals into practice they focus on the efficacy of diagnoses and medications. However, my observation of consultations and the broader existential issues that these raise suggest that an exclusive focus on painful feelings and their alleviation is counterproductive and, indeed, increases suffering. The decontextualization and denarrativization of emotion are a powerful assault on the patient's search for meaning. They constitute a refusal to engage with the patient as a moral agent. By contrast, as an anthropologist my interests in the psychiatrist's habitual ways of dealing with patients and their responses, was not primarily to do with efficacy, but rather with the social forces that shape the understanding and practice of both. In having this broader social agenda I would like to think I was closer to acknowledging the suffering of the patient.

A number of colleagues have rightly pointed out that in all societies

misunderstandings between doctors and their patients are common and between psychiatrists and their patients they are very common. So in what ways does my ethnography illustrate problems that are specific to Latvia? I would answer that the speed of political and economic change has put special pressures on psychiatry as one of the institutions responsible for transforming conceptions of the self and its ills. Psychiatrists have often unwittingly acted as agents of a total institution that has stripped people of their earlier identities and reconstituted them in its preferred image. The 'environmental niche' that allowed conceptions of illness as normal and as part and parcel of a collective identity has disappeared. For Latvians, normality was elsewhere, most probably in Western Europe. But now that Latvia is in Europe, normality has arrived and with it the need to draw sharp lines between those who achieve and those who fail to achieve normality. The mercurial quality of this social situation highlights the inadequacy of traditional ethical theorizing and suggests instead that only a finely tuned ethnography can access the painful particularity of individual predicaments.

So where does this leave transparency within the research relationship? Transparency implies a certain congruence of perspective. But it may be that certain intellectual perspectives are, by their very nature, incongruent. Perhaps, therefore, anthropology is destined to remain opaque from the perspective of certain kinds of psychiatric practice. Notwithstanding the claims of hybrids such as Devereux (1978, 1980), medical anthropology is, after all, in the business of destabilizing, if not dissolving, psychiatric categories – the very tools of the psychiatrist's trade. The psychiatrist's pragmatic goals make them less aware of their own theoretical assumptions. The insistence on transparency, given the divergence of interests, might constitute an obstacle to getting on with the business of the consultation. Does this mean that anthropological fieldwork necessarily involves betrayal and if so how can it be justified? Was I listening to the misery of others with a view to gaining more publications and furthering my own career? Stacey reveals her ambivalent position over an informant's death providing her, as it does, with rich fieldwork opportunities (1988: 23). I suppose to be honest I would have to recognize that one's motives are always a varying mixture of the personal and the altruistic and that it is their combination that matters particularly as it affects the practice of ethnography at particular moments. If at the most painful culmination of a patient's story my concern is for my tape-recorder rather than the patient, then there is clearly something wrong with the combination. These are the dilemmas of witnessing that Behar attempts to identify (1996). She writes:

> In the midst of a massacre, in the face of torture, in the eye of a hurricane, in the aftermath of an earthquake, or even, say, when horror looms apparently more gently, in memories that won't recede and so come pouring forth in the late-night quiet of a kitchen, as a storyteller opens her heart to a story listener, recounting hurts that cut deep and raw into the gullies of the self, do you, the observer, stay behind the lens of the camera, switch on the tape-recorder, keep

> pen in hand? Are there limits – of respect, piety, pathos – that should not be crossed, even to leave a record? (1996: 2)

Her way of resolving such dilemmas is not to separate the ethnographic voice from the personal and emotional voice, but to write personally and vulnerably (1996: 17). How one puts this into practice is another matter, for there is no single model to follow. And yet I hope that an anthropological perspective, which includes the voices of both patients and psychiatrists and is both personal and critical, may make a longer-term contribution to psychiatric practice and the well-being of patients.

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