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Taking pills for developmental ails in Southern Brazil: The biologization of adolescence?

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ABSTRACT

In the late 1990s researchers in Pelotas Southern Brazil began documenting what they considered to be unacceptably high rates of licensed psychotropic use among individuals of all ages, including youth. This came as a surprise, since the vast majority of psychiatrists in Pelotas draw on psychoanalytic theory and approach pharmaceutical use, especially for children and adolescents, in a consciously tempered way. Drawing from a longitudinal ethnographic sub-study, part of a larger 1982 birth cohort study, this paper follows the circuitous trajectories of emergent pharma-patterns among "shantytown" youth over a ten-year period, exploring the thickly layered and often moralized contingencies in which psychodynamic psychiatrists' intention to resist excessive pharmaceuticalization both succeed and crumble. I juxtapose these trajectories with the growing salience of an "anti-biologizing" explanatory framework that psychiatrists and researchers are using to pre-empt the kind of diagnostics-driven "biopsychiatrization" so prevalent in North America. My analysis suggests that psychiatrists' use of this framework ironically contributes to their failed attempts to "resist" pharmaceuticalization.

1. Introduction

In the 1990s researchers in Pelotas, Southern Brazil, began documenting what they considered to be unacceptably high rates of psychotropic use among individuals of all ages (Rodrigues et al., 2006). For many, this was unsettling news. Data suggested that much of this use resulted from prescriptions written by psychiatrists, yet the vast majority of psychiatrists in Pelotas are psychodynamic in orientation and though they have been prescribing medications since the 1950s, they have always done so in a consciously tempered and temporary way, subservient to the deeper work of psychodynamic therapy. Elevated levels of psychotropic medication-use among children and youth came as a particular surprise, since Pelotense child psychiatrists rely on the works of Heinz Kohut and Donald Winnicott, amongst others, for whom environment and sociality are therapeutically central. The impetus to be cautious about psychotropic drugs has only grown since Brazil's de-institutionalization movement of the 1990s. Rejecting both the elitism of "pure" psychoanalysis and bio-neurological models of the brain, Pelotense psychiatrists have worked hard to create a re-invigorated, decentralized, and democratic social psychiatry.

How might one analyze this paradox? Are therapists saying one thing and doing another? Are patients and parents demanding pharmaceuticals in ways that challenge therapists' ideals? Perhaps all are being subtly persuaded by larger forces: the globalization of diagnostic manuals, bioscience, the market, and industry?

These are the questions that Pelotense psychiatrists and researchers are themselves beginning to ask. Referring to international literature concerned with the globalization of Anglophone biopsychiatry (e.g. Watters, 2010), many are concerned that a rapidly globalizing and highly-profitable pharmaceuticalized North American model of the brain will soon pervade and that psychodynamic orientations will in turn subside. I was often told, for example, that newly emerging diagnoses in biopsychiatry such as depression and attention-deficit disorder (ADD) are "socially constructed" symbols of Anglo neuro-psychiatry, canonized in diagnostic manuals and backed by industry. Or, even more powerfully, that therapists who are unable to "resist pharmaceuticalization," prescribing when unnecessary or failing to transition patients off

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medications, are unwilling pawns of the broader industry-infused globalization of biopsychiatric ways of reasoning.

It would be tempting to adopt my interlocutors' interpretative framework and assume that will only be a matter of time before biopsychiatry comes to dominate over dwindling socially-psychodynamics orientations. Yet psychiatrists' emphasis on a biologizing episteme as the key modality through which professionals and patients are persuaded to prescribe and use pharmaceuticals seemed misplaced. On the ground – in everyday life, in clinics, in formal interviews – the language of the brain and biological immutability rarely surfaced spontaneously or in any sustained way. And, as scholars have shown (and my interlocutors frequently acknowledged), psychodynamic theories are not impervious to pharmaceutical reductions (Metzl, 2003), nor does pharmaceuticalization always proceed through biologizing logics (Kitanaka, 2012; Lakoff, 2006). There is clearly more at play in pharmaceuticalization and more at stake, also, in the rise of an anti-biologizing anti-pharma episteme.

In this paper, I follow the circuitous trajectories of emergent pharma-practices among "shantytown" youth over a ten-year period, exploring the thickly layered contingencies through which psychodynamic psychiatrists' intention to resist excessive pharmaceuticalization both succeed and crumble. I juxtapose these contingencies with the way Pelotense therapists variously construct knowledge about the diverse therapeutic trajectories they observe and help to produce. Of the various ways of knowing that are at play, I give specific attention the increasingly salience of an anti-biopsychiatric episteme. Why is this episteme compelling if biopsychiatric logics are not pervasive? How does it seep into and transform clinical and social life, shaping lives of therapists and patients alike? And what other ways of knowing does it obscure from view?

My answer to these questions points to the interplay of two epistemic modalities for understanding pill-taking – the (rationalist) explanatory model and the (morally-infused) prototype. I explore how these modalities become entangled with therapeutic practices, mental states, and life-course trajectories. Among the many consequences produced by this entanglement is this one: reliance on explanatory models of how biopsychiatric logics hold sway (or can be resisted) diverts attention from the broader moral, social, structural, and economic contingencies that drive (or circumvent) pharmaceuticalization. This reliance paradoxically contributes to psychiatrists' failed attempts to "resist" pharmaceuticalization, thus helping to produce an emergent biotherapeutic form.

2. Methods

I draw empirical material from long-term (1997–2007) fieldwork with an array of experts ($N = 92$), including therapists, school staff, local government officials, those involved in grass-roots movements, and with a sample of 96 young people and their families. These young people were selected at random from a pool of participants interviewed in the 1997 survey of the 1982 Pelotas birth cohort study, a prospective ongoing study of 5914 children (Victora et al., 2003). Random sampling was used not because we intended to conduct probabilistic analyses, but because we sought to capture a full array of life-course experiences, including those of particularly introverted and socially isolated youth.

Using participant observation and repeated semi-structured and informal interviewing with youth, their mothers and other key family members and friends, our research was conducted over a decade in the lives of these youths, from the time they were 15 to their 26th birthdays (from 1997/98–2007/08). Fieldwork was conducted by myself, another anthropologist, and four research assistants (see Béhague et al., 2008; Victora et al., 2003 for methodological and analytical details). Ethics approval was obtained from the Federal University of Pelotas' Faculty of Medicine ethics board at each new follow-up; informed consent was elicited from participants at each of these. When cohort children were under 18 years of age, informed consent was obtained from parents and children; once over 18 years of age, informed consent was obtained only from cohort youth.

3. Theorizing the social life of ways of knowing

In the early 1980s, Allan Young called attention to the theoretical limitations of the "explanatory model" approach for understanding how patients' make sense of their illnesses (Young, 1982a). The explanatory model was originally proposed by Arthur Kleinman in the 1970s as a framework for use in both research and the clinical encounter, and it continues to be widely used, especially for promoting cultural sensitivity in the clinic. Young argued that explanatory models, though useful pedagogically, are rationalist forms of knowledge premised on linear logics and causal propositions. Because explanatory models presuppose that the classification of etiology, symptoms, and treatment is a central feature in all ways of knowing, they fail to recognize the myriad and non-linear ways people produce knowledge about health and illness (Young, 1982a).

Young's argument was initially built upon empirical work with 'lay' knowledge systems in which cause-and-effect logics are not always central defining characteristics. But he and other scholars have also pointed to the ways rationalist assumptions can skew our understandings of how biomedicine becomes persuasive and authoritative (Lock et al., 2000; Young, 1980). This argument is a more difficult one to make, and may appear counter-intuitive, for biomedicine's unparalleled power rests precisely on its "rationality": the search for clear codification and causal relationship, the operational value of simplification, and the lure of quick fixes (Good, 1994). Indeed, researchers have consistently underscored the way simplifying theories of brain disorders, used in highly effective ways by industry, constitute the key mechanism through which widespread acceptance of specific diagnostic categories and associated psychotropic medications have proliferated (Conrad and Bergey, 2014; Timimi, 2005).

Yet I want to argue that a great deal of social science research on biomedicine privileges its *bioepistemic* powers, over and above other forces at play. In Pelotas, I am not convinced that "resistance" to "bioepistemic" rationales actually accounts for the tempered use of pharmaceuticals that psychodynamic psychiatrists strive for, nor do I think that bioepistemic rationales are core to the recent rise in psychotropic use. Yet this is precisely the story – an explanatory model – that has gained circulation globally (e.g. Watters, 2010), and it is the story that Pelotense therapists and experts are beginning to endorse as their own. This explanatory model can be put succinctly thus: the notion that brain disorders are caused by underlying biological–neurological phenomenon and can be treated with pharmaceuticals underpins widespread acceptance of and desire for pill-taking. Within this model is the converse notion: namely, if more complex understanding of suffering linked to mind, person and society are retained, all would see the pill for it is: a bioreductionist quick fix with potentially long-term negative effects. I will call this an explanatory model of bioepistemic authority.

This explanatory model is not merely a theoretical abstraction. It has a social life and is in this sense 'operative.' Succinct and persuasive in its etiological attributions, its retelling creates a unifying, provocative, and stabilizing call-to-action (Löwy, 1988). As I became attentive to the contexts in which an explanatory model of bioepistemic authority is elicited, I noticed that therapists, teachers,