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INTERPRETATIONS OF SCHIZOPHRENIA

INTRODUCTION

Richard Warner, a social psychiatrist and anthropologist, has presented a new interpretation of schizophrenia in his book, "Recovery from Schizophrenia: Psychiatry and Political Economy" (Routledge and Kegan Paul 1985). In this review, I sympathetically evaluate his major thesis linking political economy to the prevalence and outcome of schizophrenia and point to its deficiencies by calling into question the assumptions upon which the central argument is based. This critique does not seek to negate Warner's findings but extend them by arguing that schizophrenia must also be understood from a broader interpretive perspective which Warner does not provide. Warner writes clearly, succinctly summarising his thesis at every juncture. His case is powerfully argued with the support of an encyclopaedic command of the vast literature in this area. For the important new insights which it provides into schizophrenia and also for its manifest weaknesses, this book will become essential reading for those interested in the relationship between mental illness and society.

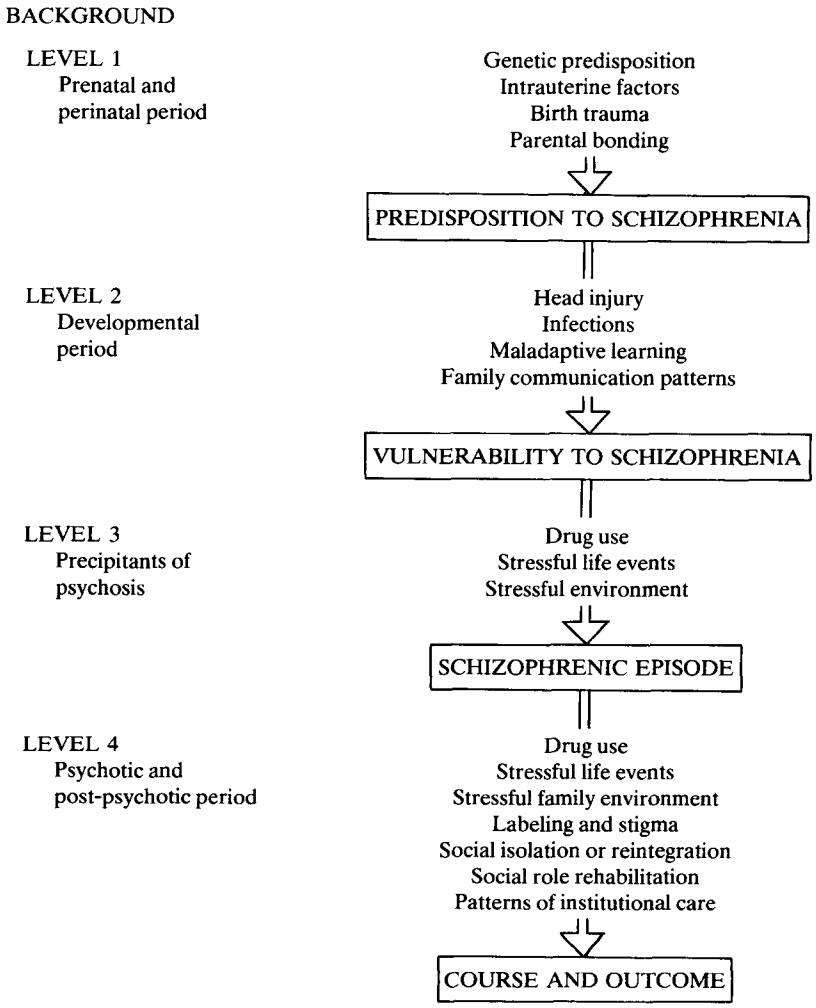
THE FIRST AXIOM: WARNER'S PSYCHIATRIC PERSPECTIVE ON SCHIZOPHRENIA

Warner opens with a conventional, contemporary psychiatric definition of schizophrenia. No mere Szaszian myth, schizophrenia, for Warner, is an illness by any standard; a non-volitional, maladaptive condition with more or less discretely definable characteristics, which impairs the individual's capacity to function. Medical research is beginning to identify the biological substrate of this disorder, twin and adoption studies having provided strong evidence that schizophrenia is genetically transmitted. Medical science has also furnished certain knowledge of differences in brain neurophysiology in schizophrenia, suggesting an underlying abnormality in brain neurotransmitters with the prevailing hypothesis being that schizophrenia involves an abnormality in 'dopamine' metabolism. Though emphasising the temporal and causal priority of the genetic and the biochemical, Warner's definition does not remain within the confines of a narrow biomedical model but takes a broader bio-psycho-social approach

Culture, Medicine and Psychiatry **12** (1988) 357–388.

adapted from the vulnerability/stress model of Strauss and Carpenter (1981). This model arranges a variety of contributing aetiological factors on a temporal schema representing the life history of the patient. Vulnerability factors are located in the premorbid period, clustering at the beginning of the patient's life, while stress factors are located closer to the emergence of the overt disorder, precipitating and perpetuating the clinical episode of schizophrenia itself.[1]

Though there is little evidence to implicate most of the so called early predisposing factors to schizophrenia, especially parental bonding, infec-



tions, maladaptive learning and family communication patterns,[2] Warner nonetheless includes them in the model, for they reinforce the central belief in schizophrenia as a vulnerability which stems from defects acquired in the earliest years of the patient's life.

THE SECOND AXIOM: WARNER'S MATERIALIST PERSPECTIVE ON POLITICAL ECONOMY

The second point of departure of this book is political economy, by which he refers to the political structures which organise and distribute the productive forces within society. Warner focuses on class, caste, patterns of labour use, unemployment, poverty and fluctuations in the business cycle and is particularly concerned with the differences between capitalist economic formations and agrarian subsistence economies. This approach is explicitly materialist, an approach which he states is not commonly applied to problems in psychiatry. "The central premise of the approach is that in order to understand human thought and behaviour it is essential to begin with the material conditions of mankind's existence and productive processes. The origins of philosophical and social change, the materialist argues, are likely to be found in changes in technology" (p. 2). Ideology is shaped by the political economy which in turn is moulded by the forces and technology of production. This generates the hypothesis that psychiatric ideology is partly determined by economic conditions and more specifically that "the course of schizophrenia is influenced by class, status, sex roles and labour dynamics; or that variations in the prevalence of the illness may reflect differences in modes of subsistence and production" (p. 2). Testing these hypotheses against empirical evidence forms the substance of this book.

THE CENTRAL THESIS: THE RELATIONSHIP BETWEEN POLITICAL ECONOMY AND SCHIZOPHRENIA

Warner begins by reexamining the problem of the higher prevalence of schizophrenia found in lower social classes, a finding which has been confirmed by all studies except those performed during times of full employment. In the past, this class differential has been explained either in terms of a "social drift" (jetsam) argument that schizophrenia causes downward social mobility, or alternatively a "social stress" argument that the conditions of lower class existence generate schizophrenia in the genetically predisposed. Since there was evidence to support both argu-

ments, this debate reached a stalemate a decade ago. Warner brings a new perspective, new questions and new empirical material to reopen it. While not dismissing the social drift hypothesis out of hand, he amassess a considerable body of evidence to strengthen the case for the social stress hypothesis. Foremost is the observation that in some Third World countries, notably India, increased rates of schizophrenia are associated with *higher* social class and caste, a finding scarcely compatible with social drift unless a peculiar flotsam version of this argument were proposed which suggested that schizophrenia could lead to upward social mobility. Conversely, this striking finding is highly compatible with the social stress argument for it is precisely this class, comprising the educated, managerial and professional groups, who in India are exposed to the competition of a highly restricted labour market. Here social stress is maximal in upper classes or castes. The underclasses, by contrast, often work outside the wage economy in subsistence agriculture, where structured unemployment is not an issue. It is not class alone which is associated with high rates of schizophrenia, argues Warner, but the specific psychosocial stresses of involvement in wage labour in a setting of high unemployment. As predicted by this hypothesis, with advancing industrialisation, which is characteristically accompanied by a fall in middle class unemployment and a rise in lower class unemployment, the class differential reverses to resemble the gradient found in the West. Further evidence in support of the social stress hypothesis is the *absence* of a class gradient in the prevalence of schizophrenia among rural populations. This stems from the protection from psychosocial stresses of unemployment and economic fluctuations which rural dwellers often enjoy as a result of their more extensive and effective family and social support networks.

Warner's examination of the impact of the economic cycles of capitalism on patterns of *recovery* from schizophrenia is a tour de force which provides a number of important new interpretations by a careful examination of 68 long term studies. He compares the recovery rates for patients initially diagnosed in the following five periods: 1881—1900 (a period of economic depression, clinical pessimism and overcrowded institutions); 1901—1920 (improving employment and more active treatment methods); 1921—1940 (severe economic depression, introduction of E.C.T., insulin coma, and psychosurgery); 1941—1955 (full employment in Europe, a social revolution in psychiatric treatment); 1956 onward (economic stagflation, introduction of major tranquillisers). The results of this painstaking comparison indicate that "recovery rates from schizophrenia are not significantly better than they were during the first two decades of

the century. The arrival of the antipsychotic drugs shortly before 1955 appears to have had little effect on long-term outcome" (p. 70). Instead, "the state of the economy appears to be linked to outcome in schizophrenia." It affects not only social recovery (good social functioning in spite of persistence of symptoms), which fell from 41% to 29% during the Great Depression and improved to 44% in the post war era, but also complete symptomatic recovery, which fell from 20% to 12% and improved to 23% during these same three periods. These data also suggest that the economic depression of the late nineteenth century had a similar depressing effect on recovery rates, though Warner is cautious in drawing conclusions from the limited evidence available. He addresses the many concerns which might be raised about comparing studies which employed quite different diagnostic criteria and different definitions of what constitutes recovery. These differences, he argues, balance out given the large number of studies compared (11,120 patients in all) and furthermore, any bias stemming from differing diagnostic practices would tend to strengthen not weaken the findings.[3] Warner argues that the correlation between poor outcome and economic depression is best explained in terms of the psychological stress resulting from unemployment. During economic depression, patients in the recovery phase of schizophrenia find it difficult to reenter the work force and are likely to be located either in understimulated environments or in prolonged face-to-face contact with relatives, both of which are known to hamper recovery. Furthermore, reduced labour demand decreases rehabilitative efforts to reintegrate patients into the work force, since these programmes cannot be justified when the able bodied are unemployed. This is a powerful argument. It is consistent with lower recovery rates among lower class patients who are more vulnerable to the impact of labour market fluctuations and it is consistent with the good recovery rates which have been reported in a broad range of full employment economies. It is also consistent with the finding that in societies where men but not women are involved in wage labour, men experience a worse outcome than women, but with the increasing involvement of women in wage labour, the prognosis among women worsens.

Warner extends the argument by demonstrating how the stresses of unemployment (loss of self esteem, status, and independence, uncertainty and economic hardship) not only impede recovery from schizophrenia but also operate as triggers which precipitate new cases of schizophrenia. Hence the peak incidence of schizophrenia in males is in the years between 15 and 24 when young men first enter the work force and

experience high levels of unemployment, whereas the peak incidence in females is a decade later, a time of maximal role stress for women. Historically, in economies where men are mainly involved in wage labour, schizophrenia has been predominantly a disease of men; as women increasingly enter the work place, however, the prevalence among women climbs to approximate that of men. It is also consistent with his thesis that economic depression leads to a true increase in the incidence of schizophrenia, for this increase occurs mainly in the working aged men with moderate education. At times of economic depression, men in this group are most likely to experience the psychological stressors which precipitate schizophrenia because they are the ones most likely to experience unemployment. The only weakness in this argument is that Warner, temporarily dropping the usually rigorous standards of empirical proof, argues without any supportive evidence that the increased incidence occurs in those who must have been already predisposed to schizophrenia.

The strength of the overall argument lies in its broad ranging explanatory power. For example, Warner reexamines the great nineteenth century debates concerning the curability of the insane and shows that recovery rates were high in the first half of the nineteenth century in America, an expanding, industrialising economy with a labour shortage. Here the quality of asylum care was relatively good and the principles of moral treatment were pursued in private and some state asylums, with much emphasis placed on work and social rehabilitation and early release. By contrast, America of the Victorian depressions had an economy of high unemployment where cost cutting led to the demoralisation of moral treatment, decreased rehabilitative efforts and an increasingly gloomy outlook for the mentally ill. Turning his analysis to this century, Warner demonstrates that deinstitutionalisation in Europe preceded the introduction of major tranquillisers by ten years and was related predominantly to a renewed emphasis on rehabilitation and community treatment at a time of full employment and high demand for the labour of the impaired. By contrast, in the United States where unemployment remained higher, deinstitutionalisation lagged behind Europe and relied more heavily on drug treatment than the provision of adequate community care and occupational rehabilitation.

Warner's thesis is further supported by the large body of evidence that schizophrenia runs a more benign course in the Third World. The best known study in this area is the World Health Organisation's (1979) multinational comparison of outcome of schizophrenia in nine centres. The least industrialised centres, Ibadan (Nigeria) and Agra (India) have

the best outcome, whereas recovery rates in urbanised Cali (Columbia) are less impressive, and those of industrialised Taipei (Taiwan), which has a high unemployment rate, are comparable with the poorer recovery rates found in the developed world. The crucial issue is the degree of involvement in a wage economy. In agrarian subsistence economies, work is less sharply demarcated from other domains of social life, is less competitive and is collectively organised through village or kin groups. Warner is not simply arguing, as many have, that village life and work are so undemanding that even people with schizophrenia can do it. Rather he contends that there is more opportunity within this mode of organisation of labour for the gradual and successful reintegration of a recovering patient into work, by titrating increasing complexity of task against improving level of functioning, thus enhancing the chances for both social and symptomatic recovery. Hence the best recovery rates occur among farmers, the worst among the unemployed and the educated.

Similar findings emerge from a comparison of cross cultural prevalence rates of schizophrenia. Here again, Warner's treatment of the material is comprehensive (68 studies) and careful (he excludes studies with a sample size smaller than 1,000 adults and deals with the issue of age corrections), and he is able to demonstrate how scholars who lack his rigour, or his *awesome* appetite for library searches, report only those studies which support their argument. Leff (1981), for example, in the service of demonstrating that schizophrenia has the same prevalence all over the globe, tends only to present those studies reporting similar prevalence. Torrey (1980), on the other hand, in the service of demonstrating that schizophrenia is a viral disease of civilisation, selectively reports Western studies showing the highest prevalence. Warner mercilessly displays such statistical jiggery-pokery as two instances of statistics being, as Disraeli would have it, like the lamp post to the drunkard — more for support than illumination. By contrast, Warner's intelligent assessment of a large body of epidemiological data concludes that the overall prevalence rates tend to be lower in the developing world though the difference is not dramatic. More interesting is the finding of especially high rates in a number of specific social groups such as Canadian Indians, Canadian Eskimos and Australian Aborigines, all characterised by a disintegrated economic infrastructure, loss of traditionally valued roles, high levels of unemployment and a government welfare assisted economy. By contrast, the low prevalence of schizophrenia in Hutterite and Amish communities may be explained in terms of full employment, involvement in subsistence agriculture, and the preservation of traditional roles and family structures.

Within the paradigm he adopts, Warner's case is sound, and he maintains an intellectually honest approach by exhaustively documenting and discussing the instances which contradict his predictions.

CRITIQUE OF WARNER'S SCHIZOPHRENIA

In spite of the internal validity of the argument, I have reservations concerning the two assumptions upon which Warner's paradigm rests. First, I question Warner's uncritical treatment of the category of schizophrenia; second, I question his unabashedly reductive, materialist, theoretical approach.

Warner's schizophrenia may be critically examined not only from the standpoint of psychiatric science but also from a broader perspective which examines schizophrenia as an historically and culturally contingent category of psychiatric discourse. Warner has presented "the facts and features of the illness" (p. 3) in the pedagogic style of the specialist educating the intelligent layman. Within his aetiological scheme, genetic transmission is treated as a prior and necessary (though not sufficient) cause of schizophrenia. This is presented as if it were an uncontested, unproblematic fact of nature, proved beyond reasonable doubt by psychiatric science. Yet psychiatric research shows that only a minority of patients with a diagnosis of schizophrenia have relatives with schizophrenia. *Twin studies* of schizophrenia are currently in a state of flux. Earlier investigations showing that up to 86% of monozygotic twin pairs are concordant[4] for schizophrenia have been countered by more recent studies that show a concordance rate as low as 0% (Tienari 1971: 97). Generally speaking, the greater the methodological rigour, the lower the concordance rates. The problem of discordance — Kendler and Robinette's (1983) recent study for example indicated that in 81.7% of monozygous twin pairs in which one twin had a diagnosis of schizophrenia, the other did not — raises the possibility that in a majority of cases of schizophrenia genetic transmission plays no part. This simple explanation however is unsatisfactory to Warner and others, who instead develop the secondary elaboration[5] that it is a *vulnerability*, not schizophrenia *per se*, which is inherited. According to this ideology, family members of patients with a diagnosis of schizophrenia possess a mysterious genetic code for schizophrenia, an enigmatic essence of schizophrenia; enigmatic because it is not openly expressed, always present but latent, waiting to declare itself should a psychosocial stressor trigger it off. Precious little evidence is provided for the existence of this genetically encoded vulnerability in relatives. Only a small minority of first degree relatives[6] receive a

diagnosis of schizophrenia. A slightly larger minority have been observed to develop other non-schizophrenic disorders sometimes referred to as the 'Schizophrenic Spectrum.'[7] Hence, the *failure* to make a diagnosis of schizophrenia in most relatives of patients with schizophrenia is adduced as evidence that these relatives contain a genetic predisposition to schizophrenia! This secondary elaboration enables psychiatric science to preserve the notion of a fundamental and unalterable flaw in the essential biological code of *all* patients with a diagnosis of schizophrenia, even that great majority of patients with no family history of the disorder. This preserves the entire category of schizophrenia as a partly inherited disease in the face of contradictory evidence.

I would be cautious about the dissemination of these 'facts' since they may have the effect of convincing patients and their relatives that they contain an unalterable genetic flaw — a permanent taint. Another of Warner's variations on a Mendelian theme is the assertion that severe, deteriorating forms of the disorder have a high genetic loading and milder forms do not. It is alarming that, in support of this, he cites figures from Kallman's (1946) methodologically outdated twin study.[8] While it is true that some of the more recent genetic studies have confirmed this assertion (Dworkin and Lenzenweger 1984), other studies have not. As with twin studies, a new rigour has come to *family studies* of schizophrenia with the introduction of operationally defined research diagnostic criteria and the use of prospective identification of probands, control groups, semistructured interviews, as well as blind, independent diagnoses for probands and relatives. One interesting family study which fullfilled many of these criteria was that of Abrams and Taylor (1983), who deliberately employed the narrowest diagnostic criteria in order to examine that most severe form of schizophrenia known as process, core or chronic schizophrenia. This exacting study found an extremely low age-corrected "morbidity risk of schizophrenia of 1.61% in first-degree relatives of schizophrenic probands,"[9] which may not be significantly higher than the risk expected in the general population, "a figure that would only support familial transmission if the true population prevalence of schizophrenia were 0.2% or less," that is, if schizophrenia were an extremely rare disease. The findings of this study challenge Warner's assertion that the more servere forms of schizophrenia have a stronger genetic component. Furthermore if severe forms of the disorder are not genetically transmitted, it is unlikely that the less severe forms and variants are. Indeed, this study challenges the genetic hypothesis as a whole and concludes that "the case for familial transmission of narrowly defined schizophrenia is weak." Abrams and Taylor are not the only psychiatric investigators to critically reexamine the

heritability of schizophrenia (Pope et al. 1982).[10] Contrary to what Warner would have us believe, the heritability of schizophrenia is the subject of active debate within the psychiatric literature.[11] I do not wish to argue that there are *no* cases of schizophrenia in which genetic transmission is an aetiological factor. But I do argue that the issue of genetic transmission in schizophrenia as a whole is by no means clear. Far from presenting us with the 'facts' of schizophrenia, Warner has withheld from the intelligent lay readership important areas of contention and debate within psychiatric science which throw open to question the genetic hypothesis of the condition.

I am equally unhappy with Warner's claim that what is inherited is an underlying biochemical disturbance in brain function. Though he briefly canvasses other hypotheses, he places major emphasis on the 'dopamine hypothesis' that patients with schizophrenia have an excess ratio of dopamine molecules to dopamine receptor sites at neuronal synaptic clefts in specific areas of the brain. Warner does not claim that this is any more than an hypothesis, yet the ideology of the 'dopamine hypothesis' accrues a certain Popperian facticity which derives from being the best available idea — refutable but not yet refuted. The major evidence in favour of this hypothesis is indirect. First, amphetamine stimulates dopamine release and may produce a psychosis clinically indistinguishable from schizophrenia. Second, major tranquillisers which have an antipsychotic action are known to block the effects of dopamine: the stronger the antipsychotic action the stronger the dopamine blocking effect. As with his handling of genetics, Warner simplifies psychiatric knowledge concerning the neurochemistry of schizophrenia in a way that fails to acknowledge important areas of contention in psychiatric research. Though referencing Haracz' (1982) fine review of 245 empirical tests of the dopamine hypothesis, Warner fails to inform us that Haracz, far from supporting this hypothesis, concluded:

> For the past decade, the dopamine hypothesis of schizophrenia has been the predominant biochemical theory of schizophrenia. Despite the extensive study of tissue samples obtained from schizophrenics, indirect pharmacological evidence still provides the major support for the hypothesis. Direct support is either uncompelling or has not been widely replicated. The dopamine hypothesis is limited in theoretical scope and in the range of schizophrenic patients to which it applies. (Haracz 1982: 438).

By limited "theoretical scope" Haracz refers to the fact that, given the current level of understanding of synaptic transmission, which emphasises complexity, interplay between multiple neurotransmitters, and a dynamic concept of the neurone receptor site, the concept of defective functioning in neurones subserved by a *single* neurotransmitter such as dopamine is neurophysiologically naive and theoretically untenable. This conclusion

raises the question of why Warner, like so many psychiatric educators, continues to disperse among laymen a defunct dopamine hypothesis under the heading of "What Causes Schizophrenia?" I suggest that one answer can be found in psychiatry's need to produce certain knowledge in the face of uncertainty, not only to an expectant public but also to the suffering patient and the distressed relative. The dopamine hypothesis of schizophrenia is also situated within a symbolic domain, mobilising powerful biological imagery concerned with the excesses of autotoxins — 'self' poisons — that circulate in the primitive and inner areas of the brain (the limbic system). Pharmaceutical manufacturers employ these symbols in advertisements which are designed to persuade psychiatrists to prescribe their particular brand of major tranquilliser.[12] Since its main supportive evidence comes from the antipsychotic efficacy of major tranquillisers which are known to block dopamine receptors, the dopamine hypothesis has a powerful rhetorical capacity to legitimise their use. The biological reality of schizophrenia emerges *a posteriori* from neurophysiological knowledge of drug action, and just as headache might be conceptualised as a genetically transmitted aspirin deficiency disorder, so schizophrenia becomes a genetically transmitted dopamine excess disorder. The reproduction of this knowledge should also be understood in terms of the location of psychiatric experts within an interrelated institutional complex — research laboratory/pharamaceutical industry/academic psychiatry/professional journal — which channels resources into the investigation and dissemination of this knowledge. My point in drawing attention to the dopamine hypothesis is again to show how Warner simplifies by failing to mention important areas of contention within psychiatry[13] and to point to the way accounts such as Warner's, by reproducing ideas concerning a fundamental defect in genetic code and basic flaw in brain chemistry, reinforce that the underlying biological basis of schizophrenia is permanent.

Similar doubts may be raised concerning computerised axial tomographic (CAT scan) evidence of anatomical changes in the brains of patients with schizophrenia. Some recent studies suggest that such changes may not be specific to schizophrenia (Reider et al. 1983); indeed other investigations using more rigorous methodology have found only equivocal evidence for any anatomical changes at all (Benes et al. 1982; Jernigan et al. 1983). I do not wish to argue that there are no biological correlates of schizophrenia, for genetic and biochemical mechanisms may be elucidated in some cases. However I do argue, following Carpenter, McGlashan and Strauss (1977: 14), that "recognition of the paucity of etiological knowledge about schizophrenia is important since psychiatrists often

assume that a reasoned understanding of its cause does exist, lacking only in detail." Given this situation it is mischievous to present highly questionable hypotheses as the 'facts' of schizophrenia.

I have raised these doubts from within the frame of psychiatric science in order make the point that Warner has failed to reflexively examine his own definition of schizophrenia, reifying it as an ontological entity[14] which lies outside the discourse within which it is constituted. This definition, however, is firmly located within a professional discourse which itself is both embedded within and reflects back upon core values and problematics within Western medicine and Western society. Irrespective of biological correlates, the disease schizophrenia is a symbolic reality, constituted within a network of metaphors which derive their salience from their relation to root metaphors within Western culture, notably the metaphors of personhood. Specifically, Warner's schizophrenia rests upon particular culturally embedded assumptions about the *individualistic* notion of personhood. Schizophrenia, for Warner, finds its locus in the individual, modified, shaped and moulded to be sure by the effects of political economy, but nonetheless realised primarily in individuals. This view is inscribed in his aetiological model. Within this schema, the source of schizophrenia lies in the domain of the biological and flows down by means of unidirectional temporal/causal arrows through the psychological to the interpersonal and the cultural. By ascribing a priority to the biological as the enabling though not sufficient cause, Warner locates the source of schizophrenia deeply and unalterably within the material substance of the patient. Since the body is one powerful metaphor for individuality within Western culture, he is locating schizophrenia within the core of the patient's identity as an individual. And since there is an implicit nature/culture dichotomy in this model (nature as the source, culture as the modifier) Warner is drawing upon the ethnocentric, materialist equation which associates nature with the body, a symbolic relation that is central to secular Western medicine. As a consequence, schizophrenia is construed as a feature of the individual's basic nature, not just the circumstances and contingencies of his life. Furthermore his scheme also expresses a temporal passage from conception, through prenatal and early developmental periods to the preschizophrenia and post schizophrenia phase. Here, within a biographical schema in which the most powerful and pervasive effects are said to operate at the beginning, the very earliness of the emergence of the disorder (at conception) signifies that schizophrenia is a fundamental quality of the patient's identity. Again this biographical model locates schizophrenia within the core of the patient as an individual person because the notion of unique life history is

one of the more powerful metaphors of individuality within Western culture.

Warner's schizophrenia rests upon and silently reproduces central beliefs concerning the individualistic nature of personhood and, as many commentators have noted, this is an historically and culturally contingent notion of what it is to be a person. This intimate relationship between Warner's definitions and Western conceptions of individuality strongly indicates that the category schizophrenia should itself be examined as an ideological product. Why has Warner failed to do this? Why has he been so scrupulous in examining the class relations of those who suffer from schizophrenia, while remaining blind to the class relations of those who reproduce the ideology of schizophrenia? This analytic scotoma derives from the weaknesses inherent in his reductionistic materialism. Before sketching an alternative to Warner's interpretation it is necessary first to explore these weaknesses.

CRITIQUE OF WARNER'S MATERIALISM

Within Warner's mechanical materialism, the forces of production are *sui generis* and stand in a causal or generative relation to the cultural superstructure, which includes lay and professional attitudes and approaches to schizophrenia. Economic boom, for example, results in a political consensus emphasising reintegrative community care and work rehabilitation while at the same time shaping a psychiatric consensus that schizophrenia is curable and that psychosocial factors are paramount in understanding its cause and effecting treatment. Economic depression, by contrast, results in a political consensus emphasising exclusionary custodial care and shapes a psychiatric consensus that schizophrenia is incurable and that biological factors are paramount in understanding its cause and effecting treatment. Although he asserts that this materialist perspective is not commonly applied to questions in psychiatry there is nonetheless a close affinity between a materialist approach to cultural formations and materialist medical science. Materialism is a necessary methodological postulate of a secular, Western medical tradition which as a clinical practice has, since Hippocratic medicine, conceptualised the human body "by reference to mechanistic analysis by which disease was the effect of known, physical causes" (Turner 1984: 74). The materialist postulate also underpins medicine as a scientific practice (Burke 1969: 131) which employs the model of natural scientific enquiry emphasising empirical verification, dependent and independent variables and the drawing of cause-effect conclusions from statistical correlations. It should come as no

surprise that Warner is a psychiatrist who views the body of the patient in mechanistic metaphors (overactivity in dopaminergic neurones), a medical scientist who relies predominantly on the epidemiological paradigm and a political theorist who espouses economic determinism.

Warner clearly indicates that he draws his materialist thesis from Marx and Engels. In fact, an adequate refutation of Warner's vulgar version of materialism was first advanced by Marx (1967a: 400—402) in the 1845 "Theses on Feuerbach,"[15] in which Marx argued that Feuerbach had reduced materialism to a deterministic, philosophical doctrine which portrayed ideas as mere reflections of material reality, a critique which could equally be applied to Warner. A more powerful interpretation of Marx would afford a central place to praxis in the production and transformation of human life and would pursue a more rigorously dialectical materialism which views ideology as "conditioned in the dialectical interplay between subject and object, in which man actively shapes the world he lives in at the same time as it shapes him" (Giddens 1971: 21).

One useful example of such an approach is contained in Foucault's (1977) notion of disciplinary society. Taking, as one point of departure, Marx's[16] discussion of vagrancy legislation which subjected the expropriated peasantry to the discipline necessary for the wages system, Foucault (1977: 135—228) traces the growth and transformation of an entire system of enclosed sites of discipline — prisons, schools, barracks, hospitals, asylums, workshops and manufactories. For Foucault, these are functional sites for the production of docile individuals who may be usefully deployed in productive labour. Power within these institutions is gentle, diffuse and silent,[17] operating less by repression or domination than by the creative production of categories of knowledge. Such power is exercised by means of normalising judgement based on a meticulous machinery of observation and measurement — the examination, the file, the case history, the accumulation, counting and comparison of cases, the system of rewards and punishments. Central is the discrimination between the normal and the abnormal subject and at the same time the individualisation of each subject. Situated within these sites of discipline, experts enunciate a discourse on the normal and pathological individual. This approach is a useful corrective to Warner's materialism because it argues not only that the capitalist mode of production makes possible the development of sites of discipline and an ideology of individualism, but also that these practices and ideas organise the accumulation of men which fuels capitalism. "Each makes the other possible and necessary; each provides a model for the other" (Foucault 1977: 221).

This approach also entails a more powerful analysis of psychiatric

ideology which examines not only values and attitudes of psychiatrists, but the central categories of psychiatric thought such as 'schizophrenia,' 'biological,' 'genetic vulnerability,' 'dopamine hypothesis,' or 'stress.'[18] Warner's narrow concept of ideology is limited mainly to the different professional and lay attitudes toward patients, their treatment and rehabilitation. It is true that within this restricted notion of ideology, Warner mounts an important critique of psychiatry's progressivist rhetoric which asserts that modern treatment methods have led to an improved outlook (despite lack of evidence), that psychotropic drugs exerted a revolutionary effect in enabling deinstitutionalisation (despite lack of evidence), and that class is unimportant in the genesis and maintenance of schizophrenia (despite ample evidence to the contrary). Indeed he allies himself with labeling theorists and argues that stigma and labeling negatively influence patients, citing evidence that patients who reject their diagnosis of schizophrenia have a better outcome than those who accept it. But Warner is always careful to exclude schizophrenia itself from the domain of ideology, restricting himself to a negative perspective which equates ideology with error or illusion (bad attitudes) as opposed to truth or reality (the facts of schizophrenia). It is as if the stigma we associate with schizophrenia (bad) can and should be distinguished from schizophrenia (neutral), a position which fails to recognise the way stigma and schizophrenia are inextricably linked, each epitomising the other, each being quintessentially, negatively valued states.

An alternative analysis would not only examine these negative, mystificatory, and concealing aspects of ideology but also the positive, creative, reality constructing aspects of ideology.[19] I am not recommending a retreat to the Szaszian polemics of schizophrenia as a myth, a nominalist argument which rests upon an anthropologically naive understanding of myth as falsehood, which is scarcely true to the experience of patient, and which has served mainly as an apology for laissez-faire capitalism and private practice psychiatry. Instead I am arguing that we treat schizophrenia as a category of a discourse which has emerged in relation to psychiatric institutions and practices. It is not a fabrication but a category of knowledge which describes and constitutes a very real reality. Unlike Szasz', this approach treats the experience of patients as factual, not fictive; indeed this is crucial to our understanding of schizophrenia, for it is the very massive facticity of the patients' experiences and suffering which give credence to the aetiological theories of schizophrenia and serve to legitimise psychiatric definitions and treatments. (Hence it is argued that something *this* bizarre and awful *must* be biological.) At the same time this approach would examine the institutional structures which enable

psychiatric experts to enunciate a scientific discourse on schizophrenia and would examine the radiating consequences of this discourse on patients' experiences. Schizophrenia would not be seen, on the one hand, as an ontological entity residing in patients which awaits description and unravelling by psychiatric science, nor on the other hand as a mere label applied by conspirator/psychiatrists, but as an interactional reality, the product of a discourse between madness and psychiatric science.

AN ALTERNATIVE PERSPECTIVE

This sketch of an alternative interpretation emphasises the historically and culturally contingent nature of the categories of dementia praecox and schizophrenia. As novel categories of psychiatric knowledge, they emerged in the nineteenth and twentieth centuries within a psychopathological discourse articulated from the site of a complex institutional space — the lunatic or insane asylum, the mental hospital, the modern psychiatric hospital, academic psychiatry, the university, and the research institute. Not only were these categories absent prior to the nineteenth century, but so too were the cases which, with the aid of a Maudsley trained psychiatrist in a time machine, might have received these diagnoses. There have been sporadic, unsuccessful attempts to find case descriptions of schizophrenia in ancient texts or in minor Shakespearean characters.[20] But the weight of evidence suggests that, unlike melancholia or epilepsy, both of which have long pedigrees in Western medical thought, case descriptions closely resembling what is now known as schizophrenia are not easily found in clinical documents or medical treatises written prior to the late eighteenth century (Jaspers 1963: 733; Jablensky and Sartorius 1975; Hare 1979 & 1983: 450).

As categories of psychiatric knowledge, these diseases are to be understood in the context of the discursive and clinical practices of the rapidly expanding asylums in nineteenth century Europe and North America. Of central interest are the core symbols employed within asylum discourse and their relation to dominant cultural symbols more widely available within the society in which the asylum was located. Drawing upon Foucault's notion of disciplinary society, these asylums may be seen to have been operating within a wider field of disciplinary institutions concerned with the concentration, deployment and distribution of labour within expanding capitalist economies and concerned to discriminate between those unwilling to work — the slothful — and those incapable of working — the physically and mentally incapacitated. The asylum confined and stigmatised the latter and in its rehabilitative phases retrieved them for

productive labour. The asylum was a site in which stigmatising symbols were concentrated, refined and applied to those who could or did not engage in productive social relations, and thus any disease category coined by psychiatric experts within these institutions would emerge from and remain saturated by this stigmatising discourse. The asylum was increasingly medicalised during this period and is best conceived as a hybrid form, a legal and medical institution for the confinement, observation, description and treatment of pauper lunatics. Not only was there an increasing confinement of the insane during the nineteenth century but also the development of a meticulous, rational machinery which for the first time systematically counted them, observed the details of their clinical features, compared cases and outcomes, produced statistics, case descriptions, case series and monographs — in short a machinery which generated a new systematised psychiatric discourse which was dispersed through the emerging learned journals and international associations of psychiatrists and superintendents of the insane. It is not surprising that the chronic course of mental illness should become a central focus of scientific attention in an era which enhanced chronicity by prolonged confinement.[21] It is not surprising that chronicity, weakness, inevitable deterioration and 'recovery with defect' should emerge as a dominant cluster of themes of psychiatric discourse, exemplifed in the writings of such prominent experts as Esquirol or Neuman.[22] These themes, interwoven with the Darwinian ideology of nineteenth century science, came to be understood within an evolutionary metaphor. The pauper lunatic was conceptualised as the converse of Darwinian man — the individual member of the species, engaged in a competitive interaction with other individuals that would result in progress and betterment of the species. Morel, who in mid century coined the term 'démence précoce' to describe a single case, placed great emphasis on the progressive degeneration which he discerned as the essence of chronic disorders (Rogler and Hollingshead 1965: 3). He predicted that these unfit members of the species would become increasingly degenerate from one generation to the next and would eventually breed themselves into extinction. Another closely related set of symbols of this psychiatric discourse revolved around a mind/body polarity which rested on a more deeply located nature/culture dichotomy and which found expression in the great debates between the 'Somaticists' (such as Heinroth) and 'Psychists' (such as Griesinger, Meynert, Wernicke and Kraepelin) within nineteenth century German psychiatry (Doerner 1981: 245–291).

Emil Kraepelin and his categories may be situated within these prevailing sets of ideas and practices. Warner would have it that Kraepelin

first discovered that many of these patients were actually suffering from dementia praecox and then described the clinical manifestations of this disease with great accuracy apart from the one error of mistakenly emphasising its malignant, chronic course. But a closer examination of Kraepelin's writings shows that his descriptions and models were not only influenced by his clinical observations, but were also structured by the dominant network of symbols of the contemporary psychiatric discourse. Tracing the seven classifications which he produced between 1883 and 1915,[23] one can see that 'psychological weakness,' 'psychic degeneracy,' 'metabolic diseases,' 'endogenous,' and 'deterioration' were the organising symbols of his classificatory logic, and throughout this period he repeatedly rearranged these symbols in different relations to each other. They were symbols, as it were, in search of a disease. By 1896 dementia praecox had provided this disease. Such an account of dementia praecox treats it as the product of a clinically accurate but politically saturated discourse generated by an emerging European professional class in dialogue with the insane of a pauper class, a discourse which was inclined to characterise the latter in terms of an endogenous, biological flaw which leads to a failure of capacity to be productive, to compete and adapt, and ultimately to an evolutionary decline. Warner sees chronicity as a distinct quality which Kraepelin and many other psychiatrists since him have wrongly ascribed to dementia praecox. By contrast I view chronicity as a powerful discursive symbol which, in part, generated the category dementia praecox. Chronicity structures the very constitution of the disease category itself. The contemporary Kraepelinian resurgence within psychiatry, exemplified most vividly in the definition provided by the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III), a definition which emphasises "deterioration from a previous level of function" and "continuous signs of the illness for at least six months" (American Psychiatric Association 1980: 189), indicates that the mutually significatory relationship between schizophrenia and chronicity is alive and well.

Warner contends that Bleuler changed all this by emphasising that patients with schizophrenia (Bleuler's term for the patients that Kraepelin described as having dementia praecox) had a better prognosis than had previously been thought. While Bleuler's data may have indicated a somewhat better prognosis, Warner fails to appreciate that Bleuler continued to operate within the same semantic field in which chronicity and schizophrenia stood as metaphors for each other. Hence, although Bleuler claimed that many of his patients improved, he nonetheless *emphasised* chronicity by asserting that patients who had apparently recovered in fact

continued to carry their schizophrenia around with them in a vestigial or dormant state until they died. Schizophrenia "does not permit a full *restitutio ad integrum*." (Bleuler 1950: 9). It was Bleuler who emphasised the mysterious notion of 'latent' schizophrenia, and who popularised Diem's concept of simple schizophrenia, that is to say, schizophrenia without any of the clinical features of schizophrenia other than deterioration. Indeed Bleuler made one of the great contributions in strengthening the association between schizophrenia and chronicity by introducing the term itself. Bleuler wrote that one consideration in introducing the word schizophrenia was that, unlike dementia praecox, which "only designates the disease not the diseased" (Bleuler 1950: 7), schizophrenia could be felicitously transformed into an adjective which might then be used to describe the patient. This enabled a subtle but powerful transformation wherein a noun denominating a disease could be rendered into an adjective predicating a person. This is the transformation from a patient being diagnosed as having or suffering from *schizophrenia* to a patient being a *schizophrenic*. Hence, qualities of the disease come to pervade the total identity of the patient. It was this innovation which enables Warner and many others to engage in the irritating practice of referring to patients as 'schizophrenics.' Patients who in the first instance are described as experiencing the onset of an episode of schizophrenia become redefined through this subtle but powerful transformation into patients who have had the seeds of schizophrenia in their biological and biographic origins, who come to express their schizophrenic identity in all aspects of their person, and who remain schizophrenic even after recovering from that initial episode.

I have argued that the institutional practices of nineteenth and twentieth century psychiatry made possible the production of a new category of knowledge — schizophrenia — and that this must be understood as a polysemic symbol, for into it are condensed some of the dominant meanings and values of psychiatric discourse including stigma, weakness, inner degeneration, brain disease and chronicity. These extremely negative values are not, as Warner would argue, an unfortunate and correctable side effect of the misuse of schizophrenia. Rather, they are the fundamental framework of ideas within which schizophrenia becomes possible. Furthermore, there is a striking resonance between schizophrenia and the ideology of individualism within modern capitalism. Although it is mistaken to see individualism in a simplistic, one to one relation with capitalism (Turner 1984: 13), nonetheless an individualistic concept of personhood has acquired a special salience within capitalism and has reflected back upon and enhanced the productive forces of capitalism. If the school, the

factory, the military organisation produced, specified and deployed the useful, productive individual, then the asylum produced, specified and contained the shadow of this ideal, the pathologised individual. Viewing psychiatric knowledge as, in part, a discourse on individualism focuses attention on the important theme of the divided, split or disintegrated individual (Scharfetter 1975: 5—9), which ran through nineteenth century psychiatric discourse, emerging in the early part of the century in the works of Herbart[24] and subsequently appearing in the writings of Neumann, Kahlbaum, Hecker, Griesinger, Meynert and Wernicke. This was not limited to German psychiatry for it also found expression in the work of Esquirol and became the dominant symbol which structured Janet's notion of dissociation. The image of the split person was not limited to asylum discourse, but also found expression in Mesmerism and the doctrine of 'polypsychism' within the hypnotism movement (Noll 1985). It has been argued that this symbol was more broadly pervasive within Enlightenment and post Enlightenment thinking and became, for example, a dominant motif within European romanticism.[25] Asylum discourse appropriated this theme of disintegrated individuality, and employed it to specify the insane. Indeed Kraepelin's essential definition of dementia praecox as a "loss of inner unity," a "peculiar destruction of internal connections of the psychic personality" (Kraepelin 1919: 3), was informed by this concept. The insane came to be depicted in terms of a quintessential failure to achieve the qualities of successful individuality in capitalist society, a failure to achieve psychic unity, autonomy, self containment, full possession of thoughts, and willed, rational, purposive action directed to useful production. It was as if the symbolism of failed and divided individuality were awaiting a disease. Many of the various contenders for the new name of this category were generated by this symbolism, including 'schizophrenia,' 'dissociative psychosis,' 'dementia dissociative,' 'dementia dissecans,' 'dementia sejunctiva,'[26] and 'intrapsychic ataxia,' — each reproducing in different ways the central concept of splitting or disintegration. 'Intrapsychic ataxia,' Stansky's term for the incongruity or disjunction between the noopsyche and the thymopsyche (Jung 1982: 19—21) is of special interest, not only because it became central to Bleuler's notion of schizophrenia, but also because it was the most articulate expression of split man signified in dichotomous terms of the culturally embedded contrast between cognition and emotion. Schizophrenia, the 'split mind,' won the day and became the quintessential metaphor within Western medical thought for the pathological converse of the discrete atomistic individual.[27] This symbolism was not restricted to schizophrenia, for it also informed a variety of psychopathological categories.[28] Nonetheless schizophrenia emerged as the major disease category

of twentieth century Western medical discourse that was generated by and expressive of an ideology of individualism. Perhaps this is why, despite (or perhaps because of) intensive public education, schizophrenia is so often equated in the popular imagination with 'split personality' or 'Dr. Jekyll and Mr. Hyde,' for both constructs, one professional and the other lay, are transformations on the root metaphor of divided individuality.

This is not a medical aetiological argument, for I am not concerned to add to the mammoth list of putative causes of schizophrenia. Rather, it is an interpretive argument which states that whatever these patients have in common, they come to be interpreted and categorised through a culturally specific ideology of individualism as broken individuals, and that this interpretive lens informs and shapes their own experience of their disorder. Within twentieth century psychiatric thought, schizophrenia has continued to be formulated within the framework of an individualistic concept of personhood. Schizophrenia is perceived as the converse of autonomy and boundedness, a state in which loose ego boundaries allow the individual to seep out into the social environment.[29] The influential diagnostic criteria developed by Schneider, the so called First Rank Symptoms of schizophrenia, speak to a "permeability of the ego-world boundary" (Koehler 1979: 236). In the words of Fabrega (1982: 56—7):

> These symptoms imply to a large extent persons are independent beings whose bodies and minds are separated from each other and function autonomously. In particular, they imply that under ordinary conditions external influences do not operate on and influence an individual: that thoughts, are recurring inner happenings that the self 'has'; that thoughts, feelings, and actions are separable sorts of things which together account for self identity; that thoughts and feelings are silent and exquisitely private; that one's body is independent of what one feels or thinks; and finally that one's body, feelings and impulses have a purely naturalistic basis and cannot be modified by outside 'supernatural' agents. In brief, contemporary Western psychology articulates a highly differentiated mentalistic self which is highly individuated and which looks out on an objective, impersonal and naturalistic world; and it is based on this psychology (i.e. a Western cultural perspective) that schizophrenic symptoms have been articulated.

In sum I have sketched a view of schizophrenia as a culturally embedded disease category which accurately describes patients' experiences within a Western psychiatric idiom that is saturated by and constituted within symbols of individuality, chronicity, deterioration, stigma and mind/body dualism. To categorise patients as suffering from schizophrenia implies a specific ideological stance which may highlight, problematise and reinforce certain experiences such as auditory hallucinations. This may have the effect of shaping these experiences and may play a part in propelling patients toward the very chronicity which is so ingrained within the concept of schizophrenia.

This perspective also implies a reappraisal of the cross cultural litera-

ture on schizophrenia. Warner briefly raises the issue of whether or not those cases in the developing world which have a such a good prognosis are actually cases of schizophrenia or not, for schizophrenia, by many definitions, is a chronic illness. He then peremptorily dismisses this important question by stating. "This is a terminological issue which must not be allowed to obscure the point of logic. . . . To argue that these are not schizophrenia, is to prejudge the issue" (p. 150). Warner provides his own prejudgement, declaring by fiat that these *are* cases of schizophrenia. Consequently much of his subsequent treatment of the cross cultural literature remains trapped within what Kleinman (1977) has referred to as the 'category fallacy,' the imposition of Western ethnomedical categories upon other cultures, as if the former were culture free.[30] While not wishing to focus too much attention on a debate which is frequently non-productive, I would nonetheless argue that the rich variety of different culturally located conceptions of states which resemble schizophrenia are excluded by Warner as he reduces them to 'schizophrenia' and to the stark business of counting 'schizophrenics.' It is true that Western trained psychiatrists can and do reliably make diagnoses of schizophrenia in non-Western settings and that states categorised as schizophrenia may closely resemble states categorised for example as 'Gila' in Malay cultures or 'Kichaa' within certain cultures in East Africa. However ethnographic evidence strongly suggests that the world is carved up and attended to in fundamentally distinct ways in different cultures. For example the fundamental Cartesian distinction between mental and physical illness inscribed into the institutional and nosological landscape of Western medicine is not a dichotomy which has a universal cultural salience. And the related distinction between cognition and emotion so central to Western ethnopsychology makes no sense in some cultures (Lutz 1985). Hence the distinction between the two major psychoses of Western psychiatry, manic depressive psychosis (the disorder of emotions) and schizophrenia (the disorder of the cognition and perception), might be irrelevant in these settings. The very notion of mind as a rich and deep interior space populated by perceptions, thoughts, emotions and memories and a possible site for mental illness may not be important in cultures characterised by sociocentric rather than individualistic concepts of personhood. It is precisely these distinctive concepts of personhood and illness which become excised from the analysis in the contemporary epidemiological fervour to rationalise and reduce the rich variety of folk categories resembling schizophrenia to 'actually-schizophrenia-under-another-name.'

Warner has reviewed a large body of ethnographic studies of states resembling schizophrenia undertaken in non-Western settings. However,

this review sits uncomfortably within the overall scheme of the book, scarcely integrated into the main argument, for if he were to pursue the implications of these studies to their logical conclusion, he would be forced to raise doubts about the ontological status of the disease schizophrenia. Just taking the studies he reviews, there is compelling evidence that auditory hallucinations, one of the central, though not essential, feaures of schizophrenia[31] are not necessarily regarded as unreal or even pathological and, indeed, may be positively valorised in some cultural settings. Some people who would fall within the ambit of schizophrenia for a Western diagnostician would elsewhere fall outside the ambit of illness altogether. This finding is *not* consistent with the old cross-cultural psychiatric thesis advanced by Warner (pp. 22), that schizophrenia is a biological reality which in its basic features and form is the same the world over, merely expressing itself in different symptom contents in different cultural settings. Instead, this evidence suggests that the fundamental constitutive components of schizophrenia may not necessarily be found in some non-Western cultural settings. Thus, in some cultures, especially those which do not employ concept of 'mind' as opposed to 'body,' the closest equivalents to schizophrenia are not concerned with 'mental experiences' at all, but employ criteria related to impairment in social functioning or persistent rule violation.

Another foundation stone of the Western ethnopsychological concept of schizophrenia is the naturalistic explanatory schema of secular medicine, such as that employed by Warner, which emphasises genetic/biochemical predispositions and psychosocial precipitants. Yet Warner himself reviews a number of studies which have emphasised that states which would be understood by the Western trained psychiatrist within this idiom, are conceptualised instead within a radically different supernatural idiom. Edgerton's (1966) comparative study of conceptions of 'Kichaa' is particularly telling for it indicates that, at least in the East African societies which he examined, the employment of naturalistic explanatory models may be equated with pessimistic attitudes, harsh treatment methods and a poor outcome while supernaturalistic explanatory models may be equated with more optimistic attitudes, sympathetic treatment and better outcome. Another aspect of schizophrenia is its intimate semantic relation to popular concepts of madness and craziness and legal notions of insanity. While these concepts are probably not to be found explicitly listed in any set of diagnostic criteria,[32] nonetheless schizophrenia so epitomises madness, craziness and insanity in the popular and professional imagination that these latter must be regarded as fundamental meanings which constitute the symbolic reality of schizophrenia. Yet schizophrenia-like states

in some Latin cultures do not necessarily connote 'locura' but may instead connote 'nervios.' Finally, chronicity itself is not necessarily an issue which is linked to categories resembling schizophrenia. One of the major arguments to emerge from Waxler's (1979) study in Sri Lanka was that Sinhalese do not thematise chronicity in the same way as do Western psychiatric constructions of schizophrenia. If similar episodes appear subsequently in a person's life, "they are believed to be another illness, not simply the same underlying disease process appearing again after a period of remission" (Waxler 1979: 157).

On the basis of these studies, an approach which suspends judgement about whether these states are really schizophrenia or not, or even avoids this problematic altogether, provides us with a more powerful analysis, one which emphasises cultural categories in the understanding of schizophrenia in the West, Gila in Malaysia, Baa in Laos, and so on. This approach would integrate the reality of alternative cultural constructions more firmly into Warner's general thesis by arguing that certain ideas inimical to the notion of schizophrenia (supernatural rather than biological cause, behavioural rather than mentalistic definitions, focus on curability rather than chronicity, and sociocentric rather than individualistic concepts of personhood), are powerful determinants of the experience and the course of these various disorders. Such categories are both products of specific cultural traditions and emerge within certain relations of production (non-wage economy, the predominance of kinship in social relations), at the same time reflecting back upon and shaping these relations. It is precisely the non-schizophrenia-like aspects of these categories which organise the family and community oriented healing practices of toleration and reintegration rather than stigmatisation and alienation, practices which Warner has identified as essential to successful treatment.

FINAL RECOMMENDATIONS

In the last section of his book, Warner provides recommendations for the treatment of schizophrenia. Apart from his careful evaluation of the benefits and serious drawbacks of major tranquillisers, however, these recommendations come as a disappointment. Given his sympathy toward a Marxian analysis, we might have expected his advice to embody a critique of capitalism; yet he tamely accepts that a full employment economy is unlikely within capitalism, a passive acknowledgement that patients with schizophrenia are likely in future to remain unemployable. His chief recommendation in this area is that these patients should engage in status-degrading sheltered and voluntary work. We might have expected,

as a consequence of his argument that the stresses of social inequality contribute to the genesis and perpetuation of schizophrenia, that the principal intervention should occur at the macrosocial level. But Warner silently permits the preservation of social inequality inherent in capitalism and focuses instead on individualised clinical treatment accompanied by small-scale social interventions which humanely assist patients to make adjustments to their plight.

His vision of a comprehensive psychiatric community treatment system is to be applauded for its pursuit of humane care and nonrestraint. However, Warner appears to be recommending little other than an extension of institutional psychiatry into the community. His model inpatient unit, though small and located in the suburbs, bears close resemblance to a standard psychiatric hospital, being expensive, professionally staffed and offering a full range of investigations and treatments. Its chief difference perhaps is that it more clearly expresses middle class ideology — "the environment is similar to that of a middle class home" (p. 288) — and values of "self-control" and "cooperation." Although minimising overt coercion, Warner recommends a gentle persuasion, a more silent, invisible form of power in which the patient is treated in an open facility, yet reminded that if he does not comply he may be confined in the psychiatric hospital, which is reserved for those "who consistently refuse treatment" (p. 292), who "walk away from an open door establishment," who become violent or who "routinely exacerbate their condition" (p. 293) by the constant use of drugs. This draws upon and maximises the stigmatising and coercive potential of the psychiatric hospital, for none of his patients like the idea of psychiatric hospitalisation. With Warner, the deterrent power of the psychiatric hospital and its lock-up facilities becomes more efficient than ever before, extending far beyond those few patients who are actually physically confined, to underwrite a *pax psychiatrica* across the entire system of open community units. Finally, Warner's psychotherapeutic recommendations are an expression of the inconsistencies which pervade his approach to schizophrenia. Although acknowledging that patients with schizophrenia do not respond well to ambiguity, he nonetheless recommends an ambiguous combination of optimistic encouragement with warnings to the patient and family to limit expectations and ambitions for complete recovery (p. 301). Equally ambiguous is the recommendation that the patient should be given the hope that one day medication will be unnecessary, yet at the same time gently encouraged to continue taking the medication by psychotherapeutic handling of the patient's fears and concerns about side effects and by giving the patient some measure of control over the fine tuning of the

dosage (p. 301). This equivocation is a prescription for chronicity, as is the recommendation that patients should *not* be told that full recovery is possible through counselling and insight. This flies in the face of his own assessment that drug free treatment is possible in many patients and that up to 23% of patients may make a full symptomatic recovery while up to 44% of patients may make a good social recovery. As recipients of this equivocal advice, patients may become suspended in a liminal environment, an environment which is "protective but not regressive, stimulating but not stressful, and warm but not intrusive" (p. 257).

To conclude, Warner's book advances important new arguments concerning the effects of class, unemployment, labour dynamics and the social organisation of work on those who suffer from schizophrenia. However, I have argued that this thesis could be expanded considerably by an approach which pays equal attention to the class relations of those who produce, disperse and implement the ideology of schizophrenia. This more reflective approach adds to Warner's contribution by suggesting that the constitutive elements of schizophrenia be reexamined as cultural products, and recommends that, in the light of cross cultural evidence, there may be more fruitful and less ambiguous ways of thinking about the serious problems which these patients present than treating them as 'schizophrenics.'

ACKNOWLEDGEMENTS

This work was supported by a Neil Hamilton Fairley Fellowship from the National Health and Medical Research Council, Australia. The author would like to thank Roy Fitzhenry, Byron Good, Don Pollock, Carla Fujimoto and Sanghamitra Guha for their helpful comments on drafts of the paper.

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NOTES

[1] From Warner (1985: 24, Figure 1.2).

[2] Psychiatry still awaits the results of longitudinal studies which might prospectively establish links between early developmental influences and the subsequent development of schizophrenia (Liem 1980: 452).

[3] We expect that studies employing broad diagnostic criteria would show better rates of recovery since they include a greater proportion of good prognosis patients; yet similar

fluctuations in recovery rate have been equally demonstrated by studies employing broad and narrow criteria. Indeed the studies performed during the Great Depression showing the worst outcomes used the broader Bleulerian criteria.

[4] 'Pairwise concordance' refers to the percentage of *twin pairs* in which both twins have a diagnosis of schizophrenia. 'Probandwise concordance' by contrast refers to the percentage of *individual twins* who have a twin with a diagnosis of schizophrenia and tends to boost the figures because each twin of a pair may be counted as concordant for schizophrenia (Kendler 1983: 1422—23).

[5] I refer to Kuhn's (1962) use of the term to refer to the development of theoretical elaborations within a moribund paradigm to account for an increasing weight of contradictory evidence.

[6] Estimates vary between 1.6% and 12% (Kendler et al. 1985: 775; Abrams and Taylor 1983).

[7] The 'spectrum concept,' initially associated with Heston (1966), has included an enormous gamut of psychiatric categories such as ambulatory, pseudoneurotic, uncertain and latent schizophrenia, schizoid, paranoid, inadequate and schizotypal personality disorders, schizoaffective disorder, atypical psychosis, neurosis and alcoholism. It has even included such categories as 'the strange,' and 'the creative' — the so called 'superphrenic.' This concept is highly contentious and the subject of active debate between its chief proponent, Kety, and chief critic, Lidz. For a discussion of this debate see Baron et al. (1985).

[8] See Kallman's (1946: 312) four line description of the methods used to determine zygocity and diagnosis, relying only on "personal investigations" and "extended observations."

[9] Compare with Tsuang et al. (1980), who found that the morbidity risk for schizophrenia in first-degree relatives of patients with schizophrenia was 3.2% and Kendler et al. (1985), who found a morbidity risk between 1.8% and 3.7%. In both these studies the risk, though extremely low, was significantly higher than in relatives of control patients.

[10] A number of investigators (Gottesman and Shields 1982; McGruffin et al. 1984) have shown that the narrowest diagnostic criteria, or extremely broad diagnostic criteria for that matter, yield a heritability of zero. Psychiatric geneticists have therefore learned to choose middle-of-the-road definitions which yield the highest heritability, a clear example of the psychiatric definition of schizophrenia being shaped by the organising concept of genetic transmission.

[11] For an example of this debate, see Kendler (1985: 775), as well as the Letters to the Editor section of the American Journal of Psychiatry (1983, Vol. 140, No 1: 131—133), in which Kendler as well as Weissman's group take issue with Pope's group.

[12] See Sandoz' advertisement for Mellaril (thioridazine) which have been printed in the Archives of General Psychiatry.

[13] Another area in which Warner distorts to simplify is his assertion that manic depressive psychosis is essentially different from schizophrenia, which ignores the active debate within contemporary psychiatry (Pope and Lipinski 1978) concerning the problematic relation between the two disorders and the uncertain state of psychiatry's knowledge concerning intermediate states such as schizo-affective psychosis. See for example, Schizophrenia Bulletin 1984, Vol. 10, No. 1, an issue devoted to the unsuccessful attempt to tease out these problems.

[14] See Engelhardt (1975) for a critical discussion of the "ontological" view of disease.

[15] See also "The German Ideology" (Marx and Engels 1947: 33—43), which argues for a careful analysis of the conditions of production and the producers of ideas.

[16] See "Capital," Vol. I, Chapter XXVIII (Marx, 1967b: Vol. I: 686—693).

[17] Foucault (1977: 163—4) acknowledges an indebtedness to the discussion in Capital, Vol I, Chapter XIII (Marx: 1967b Vol 1: 305—317) of the complex and microscopic

organisation, similar to military organisation, of cooperative labor within the institutions of work under capitalism.

[18] See for example, Young (1980) whose examination of the social production of stress research indicates that the psychiatric discourse on stress reproduces historically and culturally contingent beliefs about persons while at the same time making claims to describe a universal reality.

[19] Warner's approach may be likened to the so called 'weak programme' within the sociology of knowledge of science, which restricts itself to the study of the social organisation of the production, regulation and distribution of scientific knowledge. The approach I suggest may be likened to the 'strong programme' which argues that the content of scientific knowledge itself should be subject to social scientific critique. For a discussion of this debate, see Mulkey (1979).

[20] Bark (1985) for example found that "poor mad Tom" was actually a "schizophrenic"! Jeste et al. (1985) have found "schizophrenics" in ancient Mesopotamia, in India, in the writings of Herodotus, Horace, Celcus and "The Book of the Foundations of Saint Bartholemew's Church in London"!

[21] See Hare (1983: 449) for a discussion of chronicity within the nineteenth century asylum.

[22] See Kant (1974) for an early (1797) and influential statement of mental disorders as incurable and attributable to an inherent "weakness" of the mind (Doerner 1981: 180—188).

[23] Menninger's (1963: 457—464) collection contains all Kraepelin's classificatory schemata.

[24] Herbart enunciated the principle of autonomous 'complexes' which could displace each other within the field of consciousness.

[25] See Jung (1982: 50), for discussions of the recurrent problem within Goethe of the 'two souls,' a problem taken up by many other German romantics. Van Den Berg (1978) writing on the theme of the split man within German literature, has commented on the recurrent motif of the 'double existence,' and the 'doppleganger' within the nineteenth century. An explicit example of the treatment of this problem is Dostoyevsky's (1972) "The Double." The most celebrated example within English literature is Stevenson's (1910) "The Strange Case of Dr. Jekyll and Mr. Hyde," first published in 1885.

[26] Wernicke's notion of neuronal disjunction.

[27] "In every case," writes Bleuler (1950: 9), "we are confronted with a more or less clear-cut splitting of the psychic functions. If the disease is marked, the personality loses its unity."

[28] Examples include the 'double,' or 'heutoscopy,' (Jaspers, 1963: 92), the Fregoli syndrome (named after Fregoli, a celebrated nineteenth century quick change artist), the Capgras syndrome, the 'illusion of doubles,' and the various 'depersonalisation' states. Hysteria itself was recast in terms of 'splitting of consciousness' (Freud 1962: 11—12, 23—24). However, nowhere within the category of the neuroses was this symbolism more clearly expressed than in the 'split' or 'multiple' personality disorder. More recently splitting has become an organising concept in psychiatric conceptualisations of schizoid, narcissitic, and borderline states (Akhtar and Byrne 1983).

[29] Tausk and Federn (1952: 10—14, 230—236) provided early formulations of this concept.

[30] See Obeyesekere's (1985: 136) discussion of this problem and his facetious recommendations for reverse ethnocentrism. If Warner's methodology had emerged from a Malay context, he might have decided that all cases of schizophrenia in the West are actually cases of "Gila," and proceeded to measure the varying prevalence of this universal disease in other cultures.

[31] These phenomena are prominent within the Kraepelinian notion of schizophrenia, and although for Bleuler they were secondary features of the disease, they still assumed diagnostic importance. In the Schneiderian diagnostic scheme, auditory hallucinations of a certain type are pathognomonic of schizophrenia. Schneider's thinking has strongly influenced contemporary British psychiatric epidemiology and Schneiderian auditory hallucinations form a prominent component of the diagnostic instruments which have been employed in cross cultural studies of schizophrenia.

[32] It could be argued that the crucial DSM III diagnostic criteria of "bizarre" and "patently absurd" or "grossly disorganised" (American Psychiatric Association 1980: 189), tap direcly into the semantic domain of craziness and madness.

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