

### **Outline for an externalist psychiatry (3):**

#### **Social aetiology and the tension between constraints and the possibilities of construction**

##### **Abstract**

Any progress in shaping up an externalist psychiatry, so previous discussion suggested, must begin from questions about the ontology of social causation. So far, research and theory have adhered to a naturalistic approach to the social causes of illness, concentrating mostly on the ‘social determinants of mental health’ (inequality, discrimination, housing insecurity, etc.). The paper starts with an assessment of ‘social determinants’ through the lens of epidemiology and critical psychiatry. It illustrates existing practical and political approaches that fight these constraints and it highlights their therapeutic value. It argues, though, that a focus on social determinants is not sufficient for fully realising externalism because a great portion of sociogenic illness remains causally indeterminate. Alongside political action, externalism requires a social aetiology that is established by virtue of the meaning that it holds for patients, rather than by virtue of its capacity to identify objective social causes of illness. This entails abandoning naturalism about social causation and embracing constructivism. The paper shows that this methodological shift is less contradictory and more effective than it is commonly imagined. Drawing from further anthropological evidence, it concludes that only by lending support to projects that balance a focus on constraints with social construction will psychiatry be truly externalist. At stake is a prospect of effective treatment for sociogenic illness for the countless in struggle.

**Keywords:**

Social ontology, social determinants of mental health, naturalism, social construction, social aetiology, externalist psychiatry

## Introduction

In an externalist psychiatric system like the Akha's, a patient's condition is firstly associated to an external phenomenon that is taken as its cause, which is then subjected to change (via ritual), which, it is hoped, will affect the course of the illness in turn. This general principle needn't be confined to spiritual phenomena. To imagine a hypothetical scenario, suppose a patient is persuaded to think of their condition as dependent on the success of an election or a political movement. If the association is sufficiently strong, and the movement is successful, chances are that the condition will be affected for the better. The treatment does not lie in operating on the patient's psyche; rather, the core of the treatment consists in making the initial externalised associations, and let the external world accomplish the rest. For this to occur there must be a meaningful explanatory framework in place – held by a trusted community of people – within which these associations can be made.

In outlining this general principle through Akha ethnography, the previous paper proposed that spirits can count as legitimate social causes, which differ in kind from biological and psychological causes. It is thus misleading to label the effects of Akha rituals as 'placebo effects' unless we are willing to extend this term to everything non-biological, including, say, the effect of finding secure housing or rewarding work. The argument heavily relied on a homology between Akha spirits and 'social determinants of mental illness': their effects, I argued, depend in both cases on the collective acceptance of a given social ontology. I intentionally postponed discussing the most significant difference between these two, however, which I address in this paper. The difference lies in the fact that in societies where modern psychiatry operates this collective acceptance is much more of a *forced* acceptance. It is an acceptance enforced by political power and the threat of violence that binds the possibilities of social construction onto rigid legal realities. Power structures turn the social determinants of mental illness – poverty, inequality, discrimination, social isolation, etc. – into deeply

entrenched constraints. It becomes more difficult, under these circumstances, to shift the social world around the patient. And it is a well-known ideological capability of this system that of convincing its adherents that certain aspects of our world that are ultimately social and transformable in nature are instead natural and inevitable (Fisher, 2009).

It seems obvious, then, that any prospect of working out an externalist psychiatry must start from facing the ‘social determinants of health’. This paper takes stock of what we know about social determinants through the lens of epidemiology and critical psychiatry and offers newfound support to the view that political problems demand a political solution. Drawing again from the field of functional neurological disorders (FNDs), I nevertheless argue that tackling social determinants will not be sufficient for fully realising externalism. This is so because determinants do not account for the whole spectrum of sociogenic mental illness, and, for related reasons, do not serve as meaningful explanatory narratives that can be deployed in the clinic to therapeutic effect. To make progress on these fronts clinical psychiatry must radically change its approach to the ontology of social causation. It should abandon its existing grounding in methodological naturalism and embrace methodological constructivism. Research and treatment will not be rooted in scientifically investigating social causes, but in establishing them, doing so by virtue of the meaning they hold for patients. There is a tension between political constraints and the possibilities of social construction, and I argue that it is by understanding this tension that an externalist psychiatry, if supported, will find success.

### **The social determinants of mental illness**

There is an awkward rift between analytic philosophy of psychiatry and critical psychiatry in the approach to externalism, a slight variant of the rift between analytic and continental traditions. While the case for externalism in analytic philosophy is made rigorously but with rather vague therapeutic implications, the externalism in critical psychiatry is conceptually nebulous but has a clear target: the contemporary sociopolitical conditions psychiatry operates

within. The argument from critical psychiatry runs broadly as follows: the individualistic ideology that feeds our current capitalist system compels the psychiatric profession to treat disorders that are ultimately social (external) as bio-psychological (internal). Marxist analyses push the argument further, suggesting we see the entirety of the psy-professions as a direct product of capitalism which serve to reinforce such ideological prerogatives as natural and inevitable (Cohen 2016; Ferguson 2023). These go hand in hand with the ‘psychologization of social life’ (Parker, 2007) that has come to dominate so many areas of our existence, from our alienated relation to work to thin connections with other people. Looked at from this perspective, treatments like psychopharmaceuticals or CBT represent quick fixes for patients to return to work. HR departments offer counselling to the same end. Even well-intentioned mental health awareness campaigns treat illness as if this occurred in a sociopolitical vacuum, without contemplating the root causes of malaise that produces it in the first place. In the eyes of critical psychiatry, capitalism emerges as an ideology that robs people of a satisfactory public life to the detriment of mental health. Critics have been sounding the alarm: we are living in the midst of a global mental health crisis where the mechanisms that favour internalist bio-psychological psychiatry – individualism, depoliticization of distress, etc. – are also the very same mechanisms responsible for crisis that the latter tries to mend (Smail, 2005; Davies, 2021; Frazer-Carroll, 2023).

To varying degrees, the claims advanced by critical theorists find backing from epidemiological data on the ‘social determinants of mental health’. Plenty of evidence shows that declining mental health significantly correlates with levels of inequality, poverty, class struggle, discrimination, unemployment, and social isolation. To cite examples, Black Caribbean people living in the UK are 9 times more likely to receive a diagnosis of schizophrenia than white counterparts (Fearon et al., 2006), and the risk increases as the neighbourhood they settle in whitens (Halpern & Nazroo, 2000). Stressful work is strongly

associated with common mental health conditions, but so is unemployment and precariousness, proving, arguably, that there is something inherently distressful with people's relation to work under current conditions (Davies, 2021). Loneliness, rising sky-high in modern times, correlates closely with the onset of depression and beats smoking as a cause of premature death (Mann et al., 2022). Disorders such as depression and anxiety "are distributed according to a gradient of economic disadvantage across society" (Campion et al., 2013); and so forth (Whitaker, 2011; R. G. Wilkinson & Pickett, 2010; World Health Organization, 2014; Allen et al., 2014; Alegría et al., 2023). Whether this data can be traced directly to the intrinsic logic of neoliberal capitalism is contested. It is crystal-clear, though, that at the heart of the current mental health crisis lies a political problem, which has made even very balanced commentators state that "these figures, so stark and compelling, seem to speak for themselves of the need for political action" (Rose, 2018:35).

There were times when prominent psychiatrists (one thinks of Franz Fanon or Félix Guattari) would join forces with political revolutionaries, conscious of the intimate link between politics and the mind. It seems obvious to me that one of the logical implications of externalism in psychiatry is to re-engage with these connections. This would mean turning psychiatry into a politicised profession which, at the very least, should be aware that the therapeutic alliance in the clinic often fulfils a palliative role. One might respond that doing so amounts to taking an ideological stance before realising that it is exactly the other way around: if a key objective of a society is to improve its people's mental health to the point that the society establishes a psychiatric profession as a way to strive towards that goal, then arbitrarily selecting one way of striving towards that goal over another amounts to adopting an ideological stance. The contradictions engendered by the depoliticization of mental health are many and all too patent. The fact that a potential (though extremely unlikely) drug discovery that cuts depression rates by, say, 20%, would be hailed as a Nobel prize-worthy breakthrough, while it

is perfectly imaginable to achieve the same outcome by way of simple political moves, should be eloquent of the lopsided nature of the internalist worldview vis-à-vis the conditions that sustains it. With epidemiological data at hand, it is unscientific to dismiss political action.<sup>1</sup>

Nothing in all this should (though sadly often does, by way of binary thinking, Aftab 2020; Aftab et al. 2022) dismiss the value of psychiatric work in the clinic. This is partly because some psychiatric conditions do have biological and psychological dimensions that demand corresponding treatment. One reason why 1960/70s anti-psychiatry floundered lied in its mistaken causal account of conditions that it deemed to be entirely social in nature: by treating complex, multifactorial conditions like schizophrenic symptoms as purely social in origin, anti-psychiatrists entertained a mistaken view of biopsychosocial causal integration. This is why the ‘integration challenge’ is so important, and why a BPS model that lives up to it has the potential of accommodating and transcending some of anti-psychiatry’s views.

More crucially, clinical work can be externalising because there is room for psychiatrists to reconfigure the relation of the patient with their broader community. I am referring, for example, to approaches in ‘structural competency’ that draw from local resources for changing patients’ living conditions (for instance by improving neighbourhood quality via community organizing; integrating health-related interventions into non-medical agencies like housing and education; forming medico-legal coalitions to access benefits, etc. Metzl & Hansen 2014). Or cultural mediation approaches that assist patients, particularly from minority backgrounds, engaging with the wider community and leading them toward appropriate treatment (Miklavcic & LeBlanc, 2014). Efforts of this kind, which make up the field of social psychiatry, are drastically underfunded but represent an important form of psychiatric externalism that sees the source of illness in ‘social determinants of illness’ around the patient. They consider housing, economic justice, or social emancipation as healthcare, *tout court*. They also tend to be very effective (Hansen & Metzl 2019). Their large-scale adoption is essential

for a psychiatry that has come of age by realizing its role and place within the political conditions that shape its subjects (Kirmayer et al., 2018).

### **The limits of ‘social determinants’**

That said, expecting psychiatry to radically reroute its focus towards the social determinants of health likely would assume an unrealistic amount of agency on the part of individual psychiatrists. As Engel wisely noted, “nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to healthcare” (Engel, 1977). Those who control resources at higher levels have always held understated steering power over the discipline (Ikkos & Bouras, 2021). This is also why I think the grassroots politicization of practitioners is fundamental in keeping a collective awareness of psychiatry’s primary purpose – taking care of the mental well-being of people – and in resisting policies that manifestly undermine it. Drawing from the experience of countries where political battle has been a default stance for psychiatrists (e.g. Ramos 2013) might be important to this end. Still, I believe there is a chance for psychiatry to effect change from within, which involves a change in philosophical outlook and which begins precisely at the point where its capacity to tackle social determinants wears off.

What follows is an exploration of the epistemological shifts that could allow for alternative forms of externalism to take hold. It begins by recognizing that insofar as social determinants are probabilistic factors and not necessarily causes of illness, addressing them won’t be sufficient in fully realising an externalist psychiatry. My purpose in bringing up the case of FNDs was to illustrate this point. FNDs reveal the messy and unpredictable – at times truly unfathomable – nature that social causation can take, a nature that while most salient in FNDs arguably defines a wide range of other conditions. Even if we were to eliminate income inequality or racial discrimination, it is unlikely the elimination of these conditions will follow suit. Psychiatric illness arises within dysfunctions in developmental trajectories that *can* be



independent of well-defined systemic factors; that, even if traceable to a negative life event, patients might resist confronting it directly; or that might defy any attempt at identifying a clear-cut social cause altogether. Sociogenic illness, I noted, can appear causally indeterminate. At least when approached scientifically.

One reason why the Akha have been ‘good to think with’ as a society is that they are relatively unscathed by the most common ‘social determinants of mental health’ that plague Western medical systems. With the significant exception of gender inequality (discussed below), factors such as income inequality, discrimination, loneliness, housing insecurity or precarious work are either minimal or non-applicable in the Akha context. Protection from these threats is guaranteed by a set of values that revolve around mutual care, ensuring that, regardless of what happens to an individual, there will always be someone providing support, food to eat or a roof to sleep under. The Akha community is sustained by political and economic system geared towards the reproduction of people and human connections. Anthropologists have aptly described it as a ‘care-taking society’ (Tooker, 2012; Wang, 2019).

While relatively free from the most well-known ‘social determinants of illness’, Akha undoubtedly present cases of sociogenic illness which, *in all instances*, are explained and treated as spirit afflictions. By overlaying the whole spectrum of ‘objective’ social causes with the category of spirit affliction, the system bypasses the problem of social indeterminacy that affect the treatment of FNDs and many other disorders in Western psychiatric settings. I noted that it transforms all social illness into meaningful experience that is directly actionable through ritual. In contrast to the ‘weakly specified’ (D. Rose & Rose, 2023) social domain of modern psychiatry, Akha have an elaborate and highly meaningful explanatory framework that fills this domain. To understand more precisely the epistemological shift that grant the Akha system success on this front, and why modern psychiatry falls short in comparison, we must now turn

to a larger discussion about the foundations of psychiatry as a science. Keeping our focus on aetiology, the time is ripe to weigh in directly on the ontology of social causation.

### **The ontology of social aetiology**

A debate on the ontology of social causes of illness would be something of a novelty in philosophy. To be sure, there is at present a lively philosophical debate about social ontology – about the nature of social phenomena (Epstein, 2018) – but it has been noted (Berrios, 2015:112) that arguing about the kind of entities that make up social causes, particularly social causes of illness, would make for an entirely different type of discussion. By and large, this is not a discussion people have had. If there is a problem with lack of debate on the matter is that everyone tends to adhere implicitly to one default mode of talking about social aetiology. I believe (uncontroversially, I think) that this mode is that of ‘methodological naturalism’. It is premised on the idea that all areas of reality, including the ‘social’, should be investigated using the scientific method, disallowing explanations that fall outside the naturalistic vocabulary.

In philosophy of psychiatry there is a long-standing debate about whether the field fully counts as a science. The debate admits a wide range of perspectives (Cooper, 2009), but, starting from Hempel (1965), the general assumption has been that it would be good if it were. Both researchers and philosophers tacitly assume that to explain psychiatric illness we must achieve a fine-grained scientific understanding of the complex causal pathways involved and, *moreover*, that progress in this scientific endeavour will be directly linked to progress in treatment. This is the premise and promise of research papers and grants applications on this subject. “As in all biomedical sciences”, writes Woodward, “causal claims are critical in psychiatry because we want to learn how to prevent and treat our disorders” (Woodward, 2008:133; see also Pernu 2019). Scientific understanding of aetiology and the prospects of treatment are brought up in the same breath and assumed to be connected to one another.

But when it comes to the ‘social’, this assumption is unwarranted at best. While the scientific understanding of biological causation is generally in line with the therapeutic approach to biological causation of illness, I suggest that the scientific approach to social causation actually *hinders* the therapeutic approach to the social causes of illness. To date, scientific research on the social causes of mental illness has ranged from the abovementioned analyses of social determinants and social stressors; to related studies on the relation between mental illness and ‘social capital’ (De Silva et al., 2005), to the more recent ‘symptom network theories’ that attempt, by way of looking at symptoms, to disentangle their varied biopsychosocial causes and connections (Borsboom et al. 2019), among others. These lines of research are important. They have implications for public health *prevention* of mental illness and for informing the kind of externalist social psychiatry discussed above that concentrates on fighting structural constraints. They are also ways of tackling the ‘integration challenge’ by gauging the relative weight that social causes have with respect to biological and psychological ones. But how exactly these theories can possibly improve clinical outcomes in any other way remains unclear.

One thing seems certain: if we acknowledge that one powerful means by which explanations of illness affect clinical outcomes is by revealing them to the patient, knowing that explanatory narratives – when legitimated by a community – can have powerful therapeutic effects in themselves, then it is doubtful that a naturalistic conception of social aetiology will ever hold much meaning and efficacy. It is doubtful that explaining illness as the result of, say, ‘lack of social capital’ will be much therapeutically effective on patients. Not only are such explanations detached from direct solutions; for related reasons, they do not possess the immediacy, emotional charge, and embodied meaning that could make them therapeutically effective in the same way that Akha explanations for spirit affliction are. Spirits among the Akha are constituent elements of the cosmos and, at the same time, the essential

background for illness and healing. Spiritual illness thus becomes a ‘problem in living’, which acquires a salience for individuals that is privy to no other formulation. Naturalistic explanations of social illness are unlikely to live up to this effect, even less so when aiming for sophistication. A more sophisticated scientific account of social aetiology may supersede older explanatory models, only to make them horrendously complex and clinically useless, because meaningless to the patient (Schaffner, 2008). Insofar as it favours scientific validity at the expense of potential meaning it holds for patients, naturalism stands in the way of coming up with effective treatments for the social dimension of illness.

I am writing this under the assumption that efficacy should be the ultimate concern for psychiatry; that the profession should privilege outcome over method, and that if the ultimate goal is to help people who struggle, then pragmatism – availing of what’s best out there to achieve this goal – should be the default stance in the discipline (suggesting otherwise would require declaring what psychiatry is actually for). By wedding itself to methodological naturalism about social aetiology, psychiatry might stray from this pragmatic path. It risks running into something analogous to the ‘efficacy paradox’ in evidence-based medicine (Walach, 2001), which occurs when a treatment is dismissed because it fails to outperform placebo even when it is more effective than another RCT-tested treatment for the same condition (e.g. Haake et al. 2007). Privileging methods over outcome is another way of taking an ideological stance.

Modern psychiatry should move away from methodological naturalism about social aetiology and embrace ‘methodological constructivism’. Let this be the key message of the paper. A successful biopsychosocial psychiatry will be naturalistic about BPS integration – about the extent in which an illness has bio, psycho, or social causes – as well as on the social determinants of mental health, but constructivist when it comes to social aetiology. Philosophically, this entails a commitment to metaphysical antirealism about social causation

(Fellowes, 2019), and fictionalism more specifically (S. Wilkinson, 2022). Practically, it means shifting research efforts towards the development of an ontology of social causes of illness whose nature should solely be determined by (testable) therapeutic efficacy, regardless of whether it clings onto scientific reality. In other words, research and treatment will not be rooted in investigating causes, but in establishing them, doing so by virtue of the meaning they hold for the sick. This effort goes hand in hand with community building and structures of mutual care because it is only collectives (or ‘communities of believers’) that can legitimate a social ontology in which a person’s illness can become open to transformation.

There are existing approaches that broadly follow these lines. Like the externalist approaches mentioned earlier, they are heterodox and underfunded despite their promises. ‘Liberation psychiatry’ serves as a good example. Originating in South America as part of ‘liberation psychology’, liberation psychiatry starts from the premise that mental illness is not solely in the head but stems from specific socio-historical processes of oppression and alienation (Martín-Baró 1996). It was designed to be effective in contexts of inequality, oppression, immigration, discrimination, and warfare – all breeding grounds for psychiatric illness. Essentially, the approach starts from the recognition of all the common ‘social determinants of illness’. But if such parlance is ordinarily not on its own illuminating to patients (for the reasons we have discerned above), the purpose of liberation psychiatry is to build narratives around ‘social determinants’ to the point that these become meaningful social causes patients explain their illness with. The underlying premise is that individual transformation goes hand in hand with social transformation, and that linking one’s problem to a social one is therapeutic in itself. Practically, this works by guiding the patient through a gradual decoding of their world as they grasp the structural mechanisms of oppression that cause distress, while building collective consciousness among people in the same condition (Montero 2009a; Comas-Días & Torres Rivera 2020). The idea is not so much centred on turning practitioners

to politics, but on turning patients into politically conscious actors as a genuine therapeutic process. Does it really matter whether one's social cause of distress cannot be neatly traced to sociopolitical oppression? From a constructivist perspective, the answer is no. The main goal will be to employ a 'blanket' explanatory narrative whose value should be judged in terms of its efficacy, not for its capacity to identify 'objective' pathways of social causation, particularly as these can remain indeterminate.<sup>ii</sup>

The principles of constructivist externalism are also at play in the dynamics of therapeutic communities. Out of common gatherings among patients with similar conditions emerge new ways of articulating illness and explanatory narratives that escape internalist language by engaging with broader cultural narratives. Examples vary widely. From the 'institutional psychiatry' of Tosquelle at Saint-Alban (Robcis, 2021), to the *psichiatria democratica* of Basaglia in Gorizia and Trieste (Foot, 2015), to the actions of the Sozialistisches Patientenkollektiv in Heidelberg (Adler-Bolton & Vierkant, 2022), therapeutic communities institute the 'social' from within. Another notable example, albeit distinct in nature, has been the Hearing Voices Network and associated support groups. This is a network of people 'hearing voices' that refuses to treat the latter as symptom of a disorder but seek instead to accept and find meaning in them. The group's ethos is based on the rejection of the idea of an objective reality. This does not entail the rejection of an objective *natural* reality (e.g., declaring that cats can fly), but of an objective *social* reality. External voices belong to social beings that come to inhabit one's world and need to be dealt with in some way. What usually happens is that people shift from perceiving voices as amorphous and pathologized forces that threaten personal integrity (in similar way FNDs symptoms are typically perceived) to engaging them, so that voices become at times comforting companions in daily life, at times still vexing and frightening, but meaningful, nonetheless. The reason this is therapeutic is that "people can only be supported to recover fully when the reality of hearing voices is also

accepted by others and the meaningfulness is explored” (Romme 2012:164). For a social world to come into being one must find shared legitimacy in this world. That’s what therapeutic communities afford.

Finally, there are spiritual communities, of which the Akha shamanic circle described earlier is a great illustration. The scope is too broad here to go into a detailed appraisal, so let me instead reflect on the reason why their therapeutic value has been dismissed by modern psychiatry. Ultimately, this has to do with the constitutive unease towards the idea of ‘belief’ that typifies the naturalistic worldview. Anthropologists have long attempted to clear up misconceptions surrounding the way this concept is used in relation to spiritual practices. A core argument has been that spiritual practice need not entail propositional mental states with truth value about the nature of the world, which is what the term ‘belief’ usually implies (Good, 1994). Though a potential facet of religious experience, particularly in theological contexts, this idea does not accurately portray the experiential state of a person who approaches the spiritual realm. Spiritual beings can be held as a social construction in self-conscious fashion, without a commitment to their natural reality, and without feeling contradiction in doing so. The idea that ‘belief’ must make factual claims about the world is, itself, a by-product of the naturalistic worldview so deeply entrenched in our culture.

Although I was familiar with this anthropological line of thinking, nothing convinced me more of its validity than doing fieldwork among the Akha, who, I discovered, had similarly convinced anthropologists who went there prior to me. Living among them in upland Thailand in the 1980s, Deborah Tooker (1992) observed that people do not care very much about whether spirits ultimately exist or not. They relate to their customs in terms of ‘practice’ rather than ‘belief’. Though there is an Akha word for ‘belief’ (*jan*), normally used to describe whether one believes what someone said (i.e., whether or not someone is lying), this word is not used to express one’s relationship to spiritual practices. Ancestral customs are *carried*

(*tawq*) - an action, not an internal mental state. As far as spiritual practices are concerned, “for the Akha, truth and falsehood are not an issue” (Tooker, 1992:805). What matters is their correctness. I have emphasised in the previous paper that spiritual presence is integral to the fabric of Akha everyday life, but conversational contexts that favour metaphysical reflection can give way to doubts about whether spirits really exist, out there, independently of people’s imagination. This doesn’t stop people acting *as if* spirits really were out there, especially during ritual. These two attitudes coexist, and Akha life oscillates between deep engagement with spirits and moments of dismissal and scepticism, without any felt sense of contradiction.

This capacity of shifting across ‘multiple orderings of reality’ (Tambiah 1990), which we also enact, for example, when we play games, is itself a facet of constructivism. It is perceived as contradictory only from the standpoint of the all-encompassing naturalism that has dominated the modern psy- and social sciences including psychiatry.<sup>iii</sup> It is not perceived so elsewhere, which means that this feeling of contradiction is defined less by logical constraints than by cultural sensibilities. And as such, it is amenable to historical change. Attempts at working towards an externalist psychiatry should embrace the idea that social constructivism is not incompatible with the naturalism that underpin biological and psychological psychiatry, a point that aligns with the ‘integration challenge’. Psychiatry will then be free to explore and play with ‘belief’, or act as conduit for patients to do so outside the clinic, keeping in mind that the act of ‘believing *with*’ other people is a far more crucial aspect than the content of what is ‘believed *in*’. Unbinding the naturalistic grip on the ‘social’, new avenues for therapy become possible.

### **A tension between constraints and construction**

It will be necessary to highlight once more the inherent limitations of the therapeutic possibilities of social construction. To someone depressed because in the throes of poverty or exploitative work, coming up with social explanations other than the ones they most directly



experience due to oppressing systemic conditions would be nothing but insulting. Sometimes, it is solely on constraints put in place by structural conditions that an externalist psychiatry can hope to be effective. There is a tension, in short, between social determinants – backed by power and the threat of violence – and the therapeutic possibilities of social construction. If the former get too crushing, there is no other way of framing them but for what they really are: as unequivocal social causes of illness defined by exploitation, oppression, and violence that must be tackled at their roots.

There is nuance to this tension, though.

Let me explore it by going back to the Akha once again and consider the phenomenon of ‘shamanic illness’ as an illustrative case. The reader might recall that this consists of an anomalous illness that ‘calls’ certain individuals into the shamanic profession. From that point on, the apprentice learns the shamanic craft but is also bound to periodically chant within the circle of shamans and ‘tread on the path’ to preserve her good health. It is a journey of healing and personal transformation that takes her to a more consequential relationship with spiritual beings.

Now, it is not accidental that in this patrilineal, patrilocal, in some respects patriarchal society, which places great emphasis on the continuity of the patrilineal line, it is mostly women who join the shamanic circle, often over issues of infertility. It is possible that cases of ‘shamanic illness’ are to some degree related to power asymmetry between genders in Akha society. This interpretation would align with Lewis' (2002) observation that in many male-dominated societies women join spiritual cults that affords them alternative and counter-hegemonic forms of power. Under this view, Akha shamanism might ‘obscure’ human tensions and inequities that underlie distress. And it is possible that casting social illness in terms of spirit affliction might serve as an ideological force that instead of turning the social into the psychological (as happens in modern psychiatry) turns it into a different form of social. In sum,

‘shamanic illnesses’ might have their ultimate origin in gender inequality, a well-known social determinant of mental illness (anthropologists have sometimes commented on the potentially conservative effect of healing traditions (e.g. (Sax et al., 2010)).

Still, this interpretation – a sociological rather than phenomenological one – would be one step removed from people’s direct experience of their social world (and Lewis admits as much). Akha women engage in shamanism out of a multitude of concerns, desires, expectations that ultimately leads them to engage with spirits, experienced as these are as meaningful social agents in the Akha world. They do not do so out of a conscious intention to oppose male power. Relevant to this observation is the fact that spirit afflictions in general, ‘shamanic illnesses’ included, tend to manifest themselves somatically without being articulated psychologically. They register at the site of the body (e.g., back pain, joint pain, headaches or, indeed, infertility), even if there might be a clear connection between symptoms and preceding negative life-events or emotional troubles.<sup>iv</sup> In other words, it is hard to elicit any psychological elaboration of distress from people; distress is lamented in the body at first, then socialised as spirit affliction.

This ethnographic observation requires a brief aside on somatization. Because rates of somatization show great cross-cultural variation, anthropologists have been interested in the cultural reasons behind the phenomenon. One popular interpretation has seen somatization as an intentional strategy serving the purpose of avoiding stigma around psychological symptoms and finding a more effective route to healthcare (Kleinman, 1982). While this certainly happens in some contexts, there is also a ‘functional’ kind of somatization (Kirmayer & Young, 1998), whereby social forces etch themselves directly in the body without any wilful intention to present them as such. In other words, people genuinely feel the brunt of these conditions in their back, head, joints, or other bodily sites.

I suggested (Ongaro, 2019) that, when considering *general* emotional discourse among the Akha, not solely in the context of illness, but in ordinary life, most cases of somatization lend themselves more easily to this second ‘functional’ interpretation. The whole argument would require more space, but it suffices to say that Akha emotional discourse lacks, relatively speaking, a strong emphasis on internal states of mind. Tooker (2019) has argued that this stems from a deeply rooted attitude to seeing ‘interiorization’ as dangerous because paying attention to the bounded individual risks breaking a person’s connection to other beings in the cosmos. Psychologization, which in places such as Europe or America is promoted, is here discouraged, to the point that it might facilitate a somatization of symptoms that bypasses conscious elaboration.

But while it might be accentuated among the Akha for cultural reasons, somatization can be seen as a more universal and natural response to social distress. As O’Sullivan (2021) argues, we can somatise distress because it is unviable and detrimental to psychologise it. Sometimes, the complexity of human emotions cannot be distilled into a well-thought-out analysis. Embodying conflict becomes either more manageable or more practical than intellectualising it. The point I am driving at is that there might be an under-explored connection between somatization and the engagement in socially constructed externalised narratives. The therapeutic potential afforded by the latter is only possible when the condition is not psychologised (for expressing distress through internal psychological idioms forecloses externalist explanations). The phenomenon of somatization could then be seen as the flip side of people’s intrinsic yearning for externalising narratives.

In the process, social construction carries overriding power over social determinants.

Then again, whether social construction proves therapeutic will be a matter of degree and context. Were Akha gender asymmetry to turn overtly violent, it would be much harder for women to couch distress in terms of ‘shamanic illness’; in any case, shamanic healing wouldn’t

be effective. Similarly, phenomena such as war trauma are hardly frameable as spiritual afflictions, and we know that in situations where a people's world is shattered by violence semblances of the 'transcendental social' like ritual systems tend to wither away (e.g. Hickey 1993). An externalist psychiatry must strike a balance in focus between these two ends of the continuum. It must study and act on social determinants of illness, as well as on ideologies that disguise illness as non-political, while recognising that to the extent in which illness is causally indeterminate, the naturalistic approach that has dominated its practice does not offer much in terms of therapeutic potential. It should, in these cases, turn to methodological constructivism.

On what grounds should we expect this approach to succeed? In this outline, I have refrained from delving into quantitative discussions about the rates of efficacy of externalist systems, largely because studies can be so sparse and incommensurable, and the debates so fragmented that doing so would have made for a completely different set of papers. What I have tried to do instead is providing evidence of presence, among the Akha and elsewhere, of cultural elements that are likely beneficial to healing, and absence of cultural elements that are clearly counterproductive. But when it comes to considering certain therapeutic communities that are free to externalise distress outside the paradigm of modern psychiatry the differences in efficacy can be so striking that they can't be ignored. Consider, for example, how patients with dissociative seizures can have a virtually guaranteed chance of recovery when integrated in communities that allow them to externalise their condition, while, in comparison, only about 30% of them recover in biomedical settings (O'Sullivan, 2021). Or the evidence of dramatically lower rates of developing psychosis in certain non-Western contexts where treatments are spiritual in nature (Luhrmann & Marrow, 2016). Particularly when 'transformative efficacy' is taken into account, externalist systems afford a kind of therapeutic potential that seems alien to modern psychiatry.

## **Conclusion**

The exploration of alternatives in psychiatry should be justified by the fact that the yield of the mainstream internalist paradigm has been so negligible that even its main contemporary advocates had to admit it:

“I spent 13 years at NIMH really pushing on the neuroscience and genetics of mental disorders, and when I look back on that I realize that while I think I succeeded at getting lots of really cool papers published by cool scientists at fairly large costs—I think \$20 billion—I don’t think we moved the needle in reducing suicide, reducing hospitalizations, improving recovery for the tens of millions of people who have mental illness” (WIRED, 2017).

This was Thomas Insel, former head of the US National Institute of Mental Health and one of the minds behind the RDoC biologically based framework for understanding mental illness. About 13 years earlier, Insel argued that “psychiatry’s impact on public health will require that mental disorders be understood and treated as brain disorders” (Insel & Quirion, 2005:2221). All things considered, it is now clear that Insel was looking at the wrong place. Though manifesting themselves in the brain, psychiatric conditions can have social causes that need to be addressed externally to have any chance of therapeutic and preventative success. This externalist shift in perspective does not mean giving up on the brain. On the contrary, it should be viewed as the consequence of knowing more about it as an ‘organ of mediation’ (Fuchs 2011). A goal for the ‘integration challenge’ explored in paper #1 is to understand more precisely how integration works, particularly with reference to specific conditions. With more evidence and theory coming in the way of the integrative view, it will be a matter of time, I expect, and hope, until neurocentrism turns into outdated folklore.

Rejecting neurocentrism only to gesture at the importance of the ‘psychosocial’ brings no clear advantage, however. A real shift in psychiatric practice will likely occur when a distinction is made between psycho and social dimensions of illness, and when, in turn, social causes and treatments are externalised to the point that recovery will follow a change in the environment. What I think anthropological evidence hints at as the way forward is a twofold approach on the ‘social’ that combines political action with ontological revision. On the one hand, it will simply be logical for an externalist psychiatry to fight the ‘social determinants of illness’ directly, aligned with political projects that aspire at a world that produces less distress en masse. Such psychiatry could create the conditions for political debate to take place within it.

On the other hand, externalism entails a constructivist stance on social aetiology aimed at creating a language that is itself therapeutic. Practically, this means building communities that share a social ontology within which illness becomes entangled and can be overcome. Rather than being researched scientifically, the causes of illness must be established depending on their meaning, and it is in outcome, rather than method, that the value of such project should be assessed. Outcomes, of course, should still be assessed scientifically. It would also be a boon to develop more sophisticated criteria to evaluate them, particularly in the context of ‘transformative efficacy’. This outline comes with the wager that, from a public health perspective, lending resources to externalist projects will make the psychiatric profession exceptionally more effective than it has been in its short modern history.

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## Endnotes

<sup>i</sup> It should be noted that, at least within post-war American social psychiatry (before the assault of neoliberal policies in the 1980s), it was the prospect of preventing mental illness by drawing from social epidemiology that was seen as key in granting scientific legitimacy to the discipline (Smith, 2023).

<sup>ii</sup> If this sounds outrageous just remember that the DSM has been defended for years on the sole basis of its practical value, despite lack of scientific validity (capacity of identifying legitimate, clear-cut disorders; i.e. to carve nature at its joints) and a relative lack of reliability (consistency of diagnosis given symptoms). From a constructivist standpoint, it doesn't matter whether the system lacks validity or reliability, at least to the degree in which a condition is sociogenic. What matters is the practical value of its categories. The problem with the DSM isn't that its categories are social constructs; it's that they are very bad social constructs: they are symptom-based rather than aetiological, internalising rather than externalising.

<sup>iii</sup> This cognitive flexibility has been recently thrown into sharp relief by the discovery of the 'open-label placebo' effect, in which patients respond to placebo treatment despite being told they are receiving a placebo (Kaptchuk, 2018). The phenomenon is generally perceived as counterintuitive. But it is so only if the 'placebo effect' is construed as the effect of 'belief' in the actual reality of treatment. The counterintuitiveness dissipates once we understand it as a process in which patients act as if they are receiving an effective treatment, detached from the everyday indicative knowledge about the placebo as an inert substance (Hardman & Ongaro 2020; Hardman forthcoming).

<sup>iv</sup> For example, when my adoptive Akha sister-in-law developed sickness after a stillbirth, she never reported being emotionally distressed. She reported being in pain in the head and legs, being tired, and having poor appetite ('food not tasty'), namely somatic symptoms. These pains lasted for almost a year until, by her own account, a combination of medicine and ritual brought her back to health.

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