

University Seminar #703: Modern Greek Studies

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Speaker: Dr. Elizabeth Ann Davis, Columbia University

Topic: “A System in Doubt of Freedom: Responsibility and Reform in Greek Psychiatry”

Presiding Chair: Vangelis Calotychos, Columbia University

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Attendees: Nikki Leger, Columbia; Christine Philliou, Columbia; Eleni Gage, Columbia, Nayia Frangouli, Barnard; Laurie Hart, Haverford; Karen Van Dyck, Columbia; Despina Hadjikyriacou, Columbia; Eleni Tzelepi, Columbia; Neni Panourgia, Columbia

Summary of Presentation:

As the scope of democratic liberalism expands globally, and its “rights and duties” are conferred to increasingly varied kinds of subjects, mental illness remains a resistant, troubling, unaccountable experience—generating confused claims of responsibility for a “vulnerable population” on the part of government, doctors, patient advocates, and patients themselves. In her presentation, Davis examined this problem of responsibility in light of the “democratic experiment” of psychiatric reform in Greece, officially carried out from 1981-1995, whose aim was to shift treatment from custodial hospitals to outpatient settings, cultivating patients’ personal responsibility outside the clinic through daily practices of self-medication, self-examination, and self-control, devised to enhance their health and dignity, and to help them avoid relapse and hospitalization. Davis’s presentation discussed the ways in which, in this process, an ethical project of responsibility diverges from therapy in the obligations and the remedies it presents to patients. In the context of reform, mental illness poses freedom as a special problem for this ethics of responsibility—since freedom is a legal condition of the decision to undertake treatment, but also the normative goal of that treatment. She used the case study of Ilias, a young, highly articulate patient with obsessive-compulsive disorder who had been treated in both inpatient and outpatient settings, whose history of treatment thus dovetailed with the narrative of psychiatric reform in Greece, to explore this nexus of problems.

Summary of Discussion:

Q: Can you tell us where Ilias is now?

A: The last time I had any communication with the clinic was a year and a half ago; but to my knowledge Ilias never went to a monastery, and is still living at home and suffering from OCD.

Q: There’s so much incredibly rich material in this presentation, I hardly know where to begin. But I’m wondering about this utopian moment at the end, where you seem to be suggesting that the monastery would be a kind of answer for him.

A: I actually don't think it's an answer. I mean, first of all, it wasn't an answer because they rejected his application. There is certainly a structure at work here that traces a homology between the asylum of the monastery and the clinical asylum, which has to do with the patient's desire for submission. But it's precisely the utopic promise of the asylum in its formulation as the monastery that gave such a grim character to this case, because this patient had been through years of treatment, with psychoactive drugs and with therapeutic treatments of various kinds, without satisfactory results, and had pinned his hopes on this utterly utopic scenario that ultimately failed him, too.

Q: I ask because paper seemed rather open at the end, when you run into him again, and he's given up hopes of entering the monastery, but is headed back into the clinic.

A: Yes, well, he was going back to therapy. Nothing had changed. So in that way I see it as a rather grim end. Largely what I'm trying to do, in discussing his particular case, is to sketch the nature of the ethical mandate and the ways in which certain expectations are delivered that don't contain the therapeutic, legal, ethical material that would allow for the transformation that mandate demands. His going back to the clinic is a moment of desperation at the end, not of utopic achievement.

Q: Could you talk more about Ilias's family, and the role that the psychiatrists expect the family to play? And also how this plays into the shift of responsibility involved in the change from an inpatient to an outpatient system?

A: His parents definitely shoulder the burden of responsibility in this case. His mother, as I said, washes him, sleeps in his room at night, accompanies him anywhere he goes in the village. As for your other question, I can't really trace the historical transformation in the legislative domain into this case, because OCD wasn't a diagnosis that existed before the period of reform; back then the state was taking care of patients that were psychotic. So this is novel terrain, to see the emergence of severe neurosis, someone who *would* be institutionalized if those institutions still took in as many patients as they once did. And yet there are simply no institutional spaces for patients like him right now, and so his parents are undertaking that responsibility. The space of the asylum, which might have been for some an actual space of refuge, just doesn't exist for these patients. So with patients like Ilias who are truly unable to take on responsibility for themselves, responsibility just keeps floating in these therapeutic encounters and never really landing on anyone.

Q: And there are no intermediate asylum spaces, like collective homes?

A: There are, but Thrace presents a kind of special case here. Remember, the closest state psychiatric hospital is in Thessaloniki, and community-based residential facilities such as halfway houses and hostels, shelter residences—well, according to the law most spaces are reserved for people who are being deinstitutionalized, so new patients aren't entitled to those spaces. This is one of the main preoccupations of staff meetings in these clinics: the doctors and residents are trying to parcel out these extremely precious spaces in

community facilities, and they're required by law not to give them to people who are not being deinstitutionalized. And in Thrace, unlike in Athens where there was a pretty good saturation of services earlier, even though there has been a lot of investment in facilities, it doesn't mean that they're anywhere near to meeting the existing need.

Q: As a historian, I'm wondering why you chose to deal with Thrace in particular. It's a borderland, a unique place within Greece, with a substantial Muslim minority, and so on. Were those things you were thinking about at all?

A: Definitely. Thanks for that question, it helps me contextualize this within the framework of my larger project. There are a few major topoi in the manuscript: one is this question of autonomy, on legal, ethical, and existential levels; another is the question of culture. I look at freedom or autonomy as a parallel to culture, and explore the ways in which cultural minorities, or traditional cultural populations, have pathologies mapped onto them—and in the clinic that mapping participates paradoxically in a humanitarian ethos of cultural sensitivity. This humanitarian ethos of sensitivity to cultural difference gets transformed into a freezing of the meaning of culture in the therapeutic setting. I spent a lot of time on the gypsy community, whose members tend to be diagnosed in a generic way with antisocial personality disorder, rather than with “legitimate” clinical disorders like OCD, which are harder to read as bearing the moral imprint of the patient. So in this particular segment of the manuscript I focused on Ilias because he's an educated, Greek-speaking Orthodox Christian, and thus these cultural dynamics aren't really at play in the encounter between therapist and patient. Thus with Ilias, the questions of autonomy and freedom were crystallized in a different way, in a way that allowed me to deal with them on their own, without this issue of cultural mapping.

Q: Can you tell us briefly what his treatment was like? Was it a psychoanalytical approach? And how good, how systematic was the treatment?

A: None of the clinicians were psychoanalysts. Certainly they would have read some Freud in their curriculum, but they weren't psychoanalysts. He was given standard treatment for OCD. He had gone through more or less every medication on the market, and in addition he was given supportive counseling, cognitive-behavioral therapy, the works. As for whether or not he was treated with unsystematic, bad therapy, I'm really not in a position to determine that.

Q: We should recognize, of course, that the overmedicalization of psychiatric disorders doesn't mean that he was being treated unsystematically. The fact that there are no psychoanalysts on staff doesn't mean it's not systematic, it's just a different approach to treatment than he would be getting in the US.

A: Though his treatment actually was of the kind called the “American style.” I can tell you what they did for him, but that doesn't answer the question of whether or not the treatment was good. There is systematic outpatient treatment, depending on the patient, but because Ilias lived in a village fairly far from Alexandroupolis it was hard for him to get there, he wasn't there all the time. But he did seek out care, and was given cognitive-

behavioral therapy; the resident I spoke of, Zevs, worked with him for two years, practicing some form of cognitive-behavioral therapy with him. But though it was systematic, it wasn't effective. I just note that, I don't try to answer the question of why.

Q: Given this proliferation of psychical disorders and diseases, the “new maladies of the soul,” do you think that psychiatry describes or invents them? Can we speak of a social definition of the psychical, in your terms?

A: Well, all of these diagnoses, the severe neuroses that have come to the fore now that chronic schizophrenia has been managed better now than it was before—all of these diagnoses participate in a fairly standard international nosology, using the DSM-IV. So when I'm looking at the def of these disorders I'm really referring to that discourse, to a discursive expertise continually influenced by international medical conferences, psychiatric literature, pharmaceutical reps who visit the clinic. This kind of redefinition is happening all the time, from all kinds of sources. I'm trying for methodological reasons to restrict my analysis to the way these disorders are dealt with therapeutically; the rest, the ontological question, is beyond what I'm prepared to discuss. I don't know if that even approaches answering your question, but this is a study that is very much limited by the parameters of the clinic.

Q: When the psychiatrist you quote at length in your paper makes a distinction between cooperation and responsibility, is that all derived from any particular school of psychiatry?

A: It's part of the discourse of social psychiatry, which is very much the therapeutic face of psychiatry in Greece, with Sakellaropoulos, whose formulation of social psychiatry in the Greek context is very interested in moral terms like cooperation. This is part of the discourse, to confront the power discrepancy between clinician and patient and to use that discrepancy for therapeutic purposes. Sakellaropoulos has actually written an article on the extent to which psychoanalysis can be practiced in such a heterogeneous context as Thrace presents. Psychoanalysis is a very prestigious but peripheral expertise in this context.

Q: I don't know if the monasteries in Greece keep historical records, but wouldn't you think that there are probably people going back for centuries with OCD going to monasteries?

A: I've never been to a monastery and don't know anything about archives.

Q: There are no archives.

A: But there is literature on the link between ritual behavior and OCD, and certain people do want to talk about how a cultural penchant for OCD has something to do with the construction and consolidation of these kinds of behaviors.

Q: But why do you assume at the end that the monastery fails? What about the possibility that substituting his own personal ritual behaviors for those that are socially acceptable, even socially proscribed within the monastery context, would have been curative?

A: Well, he never goes to the monastery; they refuse his application. Maybe it would have been a good space for him, but he had this stigma written all over him, from his application, the letter the village priest wrote for him. His senior therapist actually thought it would be a bad idea; he thought the ritual structure of the monastery would fuel rather than mitigate the obsessive-compulsive behavior, which is also a possibility. There's no way of knowing, because he never went.

Q: I'm interested in what you said a little while ago about the different populations and the different kind of diagnoses they carry, and how there's a social responsibility or social stigma assigned to someone who is antisocial. I got a sense that for the antisocial there was more personal responsibility attached than for the person with OCD, and then for the schizophrenic there was even less. I'm also interested in that moment when we found out that Ilias's father was an alcoholic, and how that ties into the notion of personal responsibility. Was that alcoholism secondary to some kind of primary disorder? And how is alcoholism socially imagined in the clinical context.

A: At that time there was no AA in Alexandroupolis, and many of the psychiatric residents had lots of alcoholic patients. In fact, alcoholism competed with schizophrenia for being the most common complaint: there was a lot of alcoholism that was not being addressed by private-sector initiatives toward personal responsibility, and among the residents there was definitely talk of starting an AA chapter. But remember the social context here: Ilias's father went to Thessaloniki for detox because if he had gone to any local hospital everyone would have know, and he would have been stigmatized, with that moralizing gesture that takes a person to task for failing to be a responsible member of the community. In this sense alcoholism and antisocial personality disorder are not that distant from one another, whereas schizophrenia and OCD are considered clinical disorders rather than personality disorders: there's been a great deal of research into neurological accounts of the disease, it appears to respond well to medications, it's closer to psychosis than to the domain of personality disorders. I'm very interested in this and deal with it in the manuscript, the way in which the personality disorder is a heavily moralized pathology, whereas the clinical disorders (depression, schizophrenia, OCD) are much less easily moralized. Of course there are some dynamics of moralism even in Ilias's case, but he was so reflective about his own responsibility—you see this discourse of responsibility emerging in the symptoms themselves. So he didn't encounter heavy moralism on the part of his therapists; he wasn't outright blamed morally the way lots of other patients were, because he partook in that discourse of responsibility. In that sense he's kind of on a pivot between these two possible cases of moralism in clinical work.

Q: I'm interested in the notion of asylum here, what sorts of differentiating discourses you might be seeing in the cases of the two asyla that we have, the medical asylum and the monastery. The term itself carries a kind of dialectic with it, because we understand

an asylum to be both a place that provides shelter and care and a place where one goes to avoid persecution. Could you talk about that?

A: This is one of the things I'd really like to develop more. I think Ilias's own description of his situation shows precisely what you're saying: he would never have been considered for asylum in the legislative sense, but the context for the treatment he was given was so heavily determined by the history of the asylum, that I've been thinking about this in terms of the absolute necessity on the legislative level to destroy the asylum as a crutch and as a failure on the part of the state to treat people. After all, it's both a space of refuge and a dark, depressing, repressive place, and the tension between those two understandings of the asylum emerges only through the point of view of this patient, who might also see the asylum as a good, as a place of refuge. It's almost a structural impossibility to recognize the desire on the part of the patient to be cared for in that way by the state. This is why the example of Mt Athos is so interesting, because it has its own discourse about refuge and the movement towards the good, towards the purification of the soul.

Q: Linguistically one could even say that one could run away from a psychiatric asylum and seek asylum from a monastery, that one could seek asylum from an asylum.

Q: I also think that the dynamic at work in the notion of a cure, even when the psychiatrist says she knows people go in and out, can take responsibility for themselves but then lose it again—that rhetoric mitigates against the recognition of the need for asylum. There are other contexts in which you might see this as a permanent condition that needs to be relieved periodically: I'm thinking about certain programs in Japan that recognize this pattern of intermittent asylum, in which the function of the asylum is not to fill a desperate need, nor is it considered a permanent solution. It's an intermittent refuge. And that involves a different construction of the notion of cure.

A: There has been some reflection on that in dealing with chronic schizophrenia. Greece has quite a large national population of chronic schizophrenics who do have the right to a place in institutions when they need it, according to the family dynamics and so on. But the clinical resources are so determined by the legislative history of different diseases.

Q: And Ilias falls through the cracks because he's not disabled, his disease isn't considered a debilitating one.

Q: I want to say something to the credit of Basaglia, who is being used as the paradigm or the icon of liberal humanitarianism. I don't think he's quite how you describe him to be.

A: I wish I were authorized by this context to engage more with Basaglia, but in this context he's invoked as the liberator, the reformer.

Q: As an amateur reader of these things, I have the basic question of how these psychological illnesses manifest themselves. Is it just the occasional antisocial behavior, the violence Ilias displayed against his parents, for instance?

A: Are you asking about OCD specifically?

Q: I think she's asking for precisely what's missing in your paper, this phenomenological dimension, the experience of the patient. You're not really addressing this issue, not really giving us the patient's experience of his illness.

A: I think perhaps I did this too quickly. There are so many dimensions of the experience of this patient that can't just be reduced to antisocial behavior, though that did serve as the point of extremity that landed him in the clinic again and again. But on a day to day basis he was assailed by fragments of memories, scenes that he experienced as projected on his "internal screen," compulsive washing up to 8 hours a day. And it wasn't just that; when we spoke, those conversations would last three or four hours because he would talk that much. The talking was a symptom, too. That didn't happen with other patients. And of course there were lots of things about his experience that he wouldn't discuss with me, things he would hint at, the specter of some kind of sexual relationship, possibly incest, that many of the clinicians hypothesized might be going on in the home. But his own explicit concerns were washing, to the point of doing physical damage to himself. He also thought of himself as a continuing student, and would try to read but continually find that he couldn't concentrate. His room was full of stacks of books and he would put himself to the task of reading, and always inevitably fail. So that was his day to day life—on medication, in therapy. As a description of his experience, that's the level of extremity we're talking about, and it wasn't resolved by medication or therapy. He thought it might be relieved by replacing these rituals by the structural rituals of the monastery. Of course in the house his mother was taking care of a lot of those rituals for him, both in the house and outside in the village. So there was constant....

Q: Reinforcement of the symptoms.

A: Yes, if you want to put it that way.

Q: But the question still remains, what makes people recognize the fact that someone's behavior has gone over the boundaries of accepted eccentricity?

A: Well, he was not considered "crazy," according to the clinical language. He landed in the clinic because he was dangerous.

Q: But you were also saying that he was denied, by the clinical structure, the right to be considered crazy.

A: You mean that if his pathology had a different symptomatic expression, he might have been able to find a place within the asylum?

Q: You're actually saying he's crazy, right? And if you wanted to see a critique of liberal humanitarian reform of psychiatry in that, you could.

A: But because he's not delusional, not psychotic, he can't be considered crazy.

Q: But in some other theoretical framework it might be understood differently.

Q: Did he believe his washing to be crazy?

A: No. It was undesired, he certainly wanted to eject it from his existence, he knew what he was doing was completely irrational, but he didn't see himself as crazy, or delusional.

Q: But the question is why he wanted to "eject it" from his existence—because everyone else was reading it as part of a disorder, or because he himself saw himself as having this disorder?

A: He certainly expressed guilt for his behavior; he felt responsible for his behavior, in a way that psychotics would never do, viewing their behavior from that kind of external vantage point. He was in a sense the author of his own compulsions, in that he felt himself to be. There's a cycle of self-reproach and self-reform, and the institution is pushing him gently towards psychosis. Ilias never blamed his therapists for bad treatment, but he and his therapists were acutely aware that the treatment was not being effective.

Q: But when you said he had such extreme treatment as to leave him physically unable to redress his problems, is that his opinion, or yours, or whose?

A: Ilias had a prehistory with the state psychiatric hospital, where he was subjected to electroshock and thorazine for about three weeks. He left there feeling like he had been physically damaged by the treatment. So there was definitely the failure of that institution, the asylum, which was distinct from the clinic. And his personal history charts the development of the Greek psychiatric world in the past 25 years, with the institution slowly being phased out.

Q: I just wanted to mention that this whole story, with the possibility of refuge at the end, being poised between insanity and the monastery, reminded me of Papadiamantis, "The Murderess."

Q: And there's also Vizyinos. You must know Vizyinos? He was from Thrace, and wrote his Ph.D. in Germany on psychiatric reform in the 1880s, and was later institutionalized, ended his life in an institution. There might be some kind of material for you there.

Q: And I keep thinking of Vita, where he's got hold of the files, and is riding his bike down to see Katerina in Vita, hoping that she isn't crazy. The whole time I kept thinking about Bael and Katerina and the intersubjectivity that comes through in cases where we redraw lines so that one is or is not responsible for his insanity.

A: And there's the question of where the ethnographer draws lines, too, and how much information I give, and background about how I got the information. Ilias was a very

special case, because of the dynamic of this particular encounter, when he would talk for three or four hours at the time. I suppose I need to do more to flesh out the context in which both the therapeutic and the ethnographic encounter took place.

Q: In the case record, to what extent did they delve into issues of sexuality?

A: Only hermeneutically. It was pretty clear that there was some question of violence or abuse within the patient's home, beyond just the question of poverty, but this never amounted to clinical action on behalf of the patient in that sense. The clinicians limited themselves to treating what they understood to be the clinical entity. So when it came to Ilias's own symptomatic expression, they speculated a lot about incest without ever making specific accusations or trying to remove Ilias from the home. But that had partly to do with the fact that there was no other space for him.

Q: But with you, he was setting up a fence in his encounters with you, sharing certain information but avoiding other conversations?

A: Yes, though of course there were times when he crossed that fence, asked me out, wanted to see me outside the clinic. I didn't know what to do with those moments; I certainly didn't want to step outside the safe space of the clinic and of our encounter there, in which I was protected by institutional protocol.

Q: What does that mean for you as an ethnographer?

A: It means that my own critical space is very fragile. Those dynamics were not contained by the clinic, so to my mind the information that was given to me at those times are outside the deal I made with Ilias that he would talk to me as a patient. But in terms of the critical position I took of being a somewhat-external yet somewhat-internal critic, that critical position has a kind of empty center, and at certain moments Ilias was located at that empty center. But that's ethnography for you.