# THE ANTISOCIAL PROFILE: Deception and Intimacy in Greek Psychiatry

**ELIZABETH ANNE DAVIS**
**Princeton University**

> What the patient says about himself is very important, *most* important. . . . Now, psychiatrists see many patients who lie. But there's no scientific way to know if someone is lying—only ways to "sense" it. You just get a feeling that you're being deceived.
>
> —Dr. Filalithi, psychiatrist, General Hospital of Alexandroupolis, July 2003

> What types of knowledge are you trying to disqualify when you say that you are a science?
>
> —Michel Foucault, "Subjugated Knowledges," *Society Must Be Defended,* 2003

## CLEARING THE RECORD

In his implacable critique of psychiatry, proceeding from *The Myth of Mental Illness* in 1961, Thomas Szasz delivered a severe dual diagnosis: of psychiatric science as a "tissue of lies" (1979:124), and of lying as an essentially normal, nonpsychopathological practice. I recall Szasz here not to reiterate his denunciation of psychiatry, but, rather, to borrow his focus on lying as a pragmatic mode of sociality, pervasive not only within but also outside the clinic—a strategy for managing the social and emotional risks of interpersonal relations that, on a foundation of deception, may develop into gratifying functional collusions:

> The value of lying derives not so much from its direct, communicative meanings as it does from its indirect, meta-communicative ones. By telling a lie,

*CULTURAL ANTHROPOLOGY, Vol. 25, Issue 1, pp. 130–164. ISSN 0886-7356, online ISSN 1548-1360.*  *DOI: 10.1111/j.1548-1360.2009.01054.x*

> the liar in effect informs his partner that he fears and depends on him and wishes to please him: this reassures the recipient of the lie that he has some control over the liar and therefore need not fear losing him. At the same time, by accepting the lie without challenging it, the person lied *to* informs the liar that he, too, needs the relationship and wants to preserve it. In this way, each participant exchanges truth for control, dignity for security. Marriages and other "intimate" human relationships often endure on this basis. [1974:227]

This essay is about lying, and the forms of ambivalent intimacy it fosters in clinical encounters—the paradoxical dynamic it inaugurates, of knowing and not-knowing; of stabilizing and destabilizing communication. Lying has engaged some version of this dynamic in psychiatry and psychology for as long as clinical care has depended on unreliable accounts from patients about their own experience and behavior. Psychoanalytic theory in particular has developed a preoccupation with lying, understood as an expression of the play between unconscious motives and conscious intentions that defines the discursive material to be worked through in therapy[1]—and that attests, as Lacan contended, to an "ethical" rather than an "ontic" status for the unconscious.[2]

Without presupposing any such psychical theory of lying—or any objective clinical truth against which lying as such could be gauged—I aim in this essay to trace suspicions of lying, by patients and therapists, across multiple terrains of Greek psychiatry. I begin with a case that arose at the outpatient psychiatry clinic of the General Hospital of Alexandroupolis, in Greek Thrace, where I conducted field research between 2001–04. I was working at the outpatient clinic one afternoon, with a senior psychiatrist and a nurse, when a man in his late twenties pushed his way into the consultation office. The nurse immediately identified him to me as a Gypsy, noting his complexion, his broken Greek, and his aggressive demeanor. The doctor told us under her breath that she knew his face but not his name; she had seen him the previous week, when he asked her to "clear" his psychiatric history. Today, he handed her two medical files that he had retrieved at the reception desk: the one this doctor had started the previous week, and an older one, dating back nine years. Notes from the older file indicated that this patient had "reported hearing voices," but refused to be admitted for clinical evaluation.

The psychiatrist asked the patient about this event, but he said he had no recollection of it: "I never had mental problems—that's why I came here today, to clear my record!" The doctor told me later that, very likely, this man had reported

hearing voices nine years before to be disqualified from army duty. Now, for some reason—perhaps because he had children, and wanted to show them that "he's a man who can stand up"; or perhaps because his lack of a service record was blocking his access to jobs or property—now he regretted his lies. "I've seen this many times," she said.

In the session, the doctor showed the patient that his two files coincided in all the personal details of birth date and place, parents' names, educational record, residence. The man admitted the old file might be his, but still insisted that he had never heard voices. The doctor said she had no doubt about this, but she made it clear that she believed him for different reasons from the one he was offering. To catch him in the lie she suspected he was telling now about his past, she pretended to believe the lie she suspected he had told in the past, and asked him a series of questions about those voices he had heard. Their exchange developed into a game of mutual dissimulation.

The doctor's main tactic was a moral defense of her role as an expert: "I can't sign a certificate that says you have no psychiatric history, because I know from your file that you do! Do you expect me to lie, too? And break the law? If I put my signature on this paper it's a pledge to the state that I'm telling the truth. Do you want me to destroy that pledge? If you want me to clear your record, I'll have to see you ten more times, so that I can get to know you, and do a thorough examination, and gather information from witnesses. Only after all that can I honestly say you don't present the medical problems that got you this certification nine years ago."

With this line of argument, the doctor was articulating to the patient a bureaucratic protocol for credibility and transparency in clinical knowledge, to model honesty for him, and to explain her own motive for refusing his request—at the same time that she herself was lying, about both the content and the urgency of that protocol. In fact, it was well within the parameters of her professional discretion to grant his request outright, as I had seen other clinicians do in similar cases. Instead, she turned to the language of responsibility to summon an injunction to honesty that apparently governed them both.

The patient grew irate: "You're a hard woman! I can tell you don't have any children." This was true, and for the doctor perhaps carried a glimmer of the Gypsy's legendary second sight; although she stared impassively as the patient stormed out of the room, she let on afterward that she was chastened by his unexpected insight. He had broken the *illusio* of her bureaucratic role. She adopted a more self-critical mode, and apologized to me for the way she had handled the

case: "I have to admit he made me angry. I always get mad when these patients lie. But it's not personal."

The question of what is and is not "personal" in clinical encounters like this is what I want to explore in this essay. *Encounters like this:* where a patient supplicates a doctor, seeking help or recognition or certification, offering only his word to support his claim. Where a doctor meets this claim with suspicion—perhaps, as in this case, because it matches too closely a "cultural pattern" of deception. In this case, the patient perceived that the doctor thought she knew more about him than he had told her; that she saw beyond his self-presentation into a past he was trying to hide, and a trove of secret motives. But the patient knew something about her, too: namely, that there were other reasons for her suspicion—reasons that had no diagnostic or therapeutic function in their encounter.

This mutually intimate knowledge had none of the depth or texture this doctor indicated when she told the patient (dishonestly) what procedures she would have to follow to certify his health (honestly). It did not pass through a diagnostic frame that might have converted the patient's lies into symptoms of a mental illness. This knowledge instead arose almost instantaneously, in the almost anonymous space of a crowded outpatient office—making use, as Lauren Berlant typifies *intimation,* of "the sparest of signs and gestures," of "shifting registers of unspoken ambivalence" (2000:1, 6), whose tacit efficiency was conditioned by profound mistrust arising, first, outside the clinic. The mutual suspicion of deceit inside the clinic transformed the one-way exposure of a therapeutic relationship—in which the most secret aspects of a patient's life are revealed to a hermetic clinical authority—into a reciprocal one. If self-presentation, on the part of the patient, and diagnosis, on the part of the therapist, are distancing maneuvers by which each takes on a conventional role in the clinical encounter, then lying is the maneuver by which a more intimate, if antagonistic, relation can be recuperated from this distance in a mutual act of countertransparency.

**RESPONSIBILITY AND THE SECRET ENCOUNTER**

Although deception has long troubled the practice of psychology and psychiatry, it has taken on new clinical roles and implications in the context of psychiatric reform in Greece. The national program for reform was designed, mandated, and funded largely by the European Union, as a humanitarian condition of Greek accession in the early 1980s. Over the last 25 years, psychiatric treatment in Greece has shifted from custodial hospitals to outpatient settings, challenging the mentally ill to help care for themselves as they adapt to life "in the community" (Blue 1991;

Davis in press; Madianos 1994; Mavreas 1987). The reforms have yielded broad changes in health care policy, medical training, and institutional infrastructure in Greece—all taking shape around the mandate to verify the Greek state's capacity to protect the freedom and foster the responsibility of its most vulnerable and dysfunctional citizens.

In this recent history of Greek psychiatry, reform emerges as a universalizable technology of the state: a mobile set of policies, institutions, and practices that has accompanied political liberalization worldwide since the 1950s, with the expansion of human rights and policies of social welfare. Documents from the European Union audits of Greek psychiatric reform (1984–95) exalt this perspective, relentlessly measuring Greece's increasing approximation of a robust welfare state and its "synchronization" with European standards of humane medical care (Davis in press).

Progressive as this perspective may be, the ambitions and successes of psychiatric reform in Greece might seem obsolete to social scientists tracking the evolving relationship between psychiatry and the state since the 1980s. The nearly worldwide eclipse of psychoanalysis by statistical and pharmaceutical psychiatry in this period (Lakoff 2005; Luhrmann 2000), and of state health and social services by managed health care and private self-help movements, have been associated in the scholarly literature with the rise of technologically enhanced rational individualism diffusing through international consumer markets for psychiatric medications and expertise. For many, these developments signify a new biopolitical logic wrought by the devolution of state responsibility both to private managerial bodies and to individual subjects of care (Campbell and Shaw 2009; Castel 1981; Castel et al. 1982; Lester 2009; Rose 1989, 1999).

Although novel elements, clinical and economic, have certainly shaped the theory and practice of psychiatry since the 1980s, I suggest that the now-dominant neoliberal narrative offers a misleading and partial account of contemporary psychiatry in Greece, as in many states where the public sector remains the primary scene of medical care. This is not only a question of economy; it is also a question of ethics. The imagination of patients as responsible citizen-consumers—endowed with the capacity and the desire to uphold therapeutic agreements, and to undertake practices of self-medication, self-examination, and self-control—has impelled psychiatric reform and community-based care worldwide since the mid–20th century. The neoliberal discourses and practices of "responsibilization"—as Nikolas Rose describes emergent biopolitics in the "psy" field (1996, 2006)—are neither especially novel, nor notably more effective, in their design to produce responsible subjects.

Indeed, I find that the neoliberal moment, at least in Greece, has but protracted an enduring impasse in the ethics of responsibility broached by psychiatric reform. To the extent that patients are enrolled in psychiatric care by an agency other than their own robust and autonomous will, the responsibility they cultivate and discharge requires another ground than the liberal theory of freedom undergirding the project of reform. The paradoxical ethical task patients face here is to assume responsibility for an ideal, or duty, or desire, that is determined elsewhere than in the self, and otherwise than by the self, but that is discovered and directed through self-reflection and self-transformation.[3] This task is ethical in the sense Foucault attributes to nondecisionist yet transformative "care of the self" that produces a moral "mode of being" (1988, 1997; Rabinow 1997; see also Campbell and Shaw 2009).[4] As Foucault and commentators are careful to observe, the self that becomes an object and subject of such ethical work does so "in its relation to others" (Foucault 1997:287; Faubion 2001:96)—and this is no less the case for psychiatric patients than for the disciples of Epictetus (Foucault 1988).

In this essay, then, I focus on the relations with therapists that structure the ethical reform of patients in Greece. Like their fellow citizens, these patients are expected to function as responsible members of a community; but unlike them, many patients are "disabled" from the subjective capacities and desires that define responsible citizenship. The demand for patient responsibility thus initiates a collaborative mode of therapeutic ethics, by which therapists in a sense complete the subjectivity of their patients as they enlist them in treatment. In these relationships, designed to expand the responsibility of patients in proportion to their freedom, therapists occupy a shaky ground between ethical guidance and coercion (see Faubion 2001:97 ff.). The shakiness of that ground helps to account for why therapists and patients who undertake responsibility for psychiatric care do not always do so directly, consistently, or unreservedly.

I show in this essay how suspicions of deception in therapeutic relationships mark a limit of collaborative responsibility. When patients and therapists suspect one another of lying—about the symptoms and needs of the patient; about diagnosis and treatment options; about the effectiveness of therapy; about rules and procedures; about the reliability of judgment and commitment on both sides—they counter and yet anchor the work of "responsibilization." They counter it, by contesting their transparency to one other; they anchor it, by securing one other in something like what Spivak calls a "secret encounter": an ethical engagement characterized "on both sides" by "the sense that something has not got across," animated by the persistent but impossible desire to reveal that "secret" (Spivak 1999:384; see

also Spivak 1994). Thus, I see suspicions of deception in community-based care as strange refractions of responsibilization through a constitutive opacity in intimate ethical relations. As against the reformist goals of increasing patients' autonomy while scaling back clinical care, these suspicions actually help to secure mutual therapeutic dependencies.

The history of psychiatric reform in Greece is thus more than a story of governmentality: of how self-governance comes to be the dominant mode of population governance in the modern state (Foucault 1991; Rose 1989, 1999). It is more, too, than a story about neoliberal consumption and risk management in health care, as therapeutic contacts proliferate, outpatient services saturate local communities, and patients increasingly seek medication and counseling to enhance their self-care (Castel 1981; Cohen 1985; Ierodiakonou 1983a, 1983b,1983c; Ierodiakonou et al. 1983; Rose 1989, 1996, 1999). It is also a story about collaboration between patients and therapists, and the impasses of their collaboration. In this essay, then, I look at therapeutic contacts outside custodial institutions, exploring the reworking of therapeutic relationships through verbal negotiation—as against methods of confinement and constraint associated, in psychiatric reform, with inhumane institutional care. In these negotiations, I argue, multiple determinants of the suspicion that *someone is lying* converge and combine to sustain therapeutic relations.

It is crucial, in examining these suspicions and the relations they bind, to maintain a fundamental indeterminacy in the meaning of "Greek psychiatry," as distinct from the global science or profession of psychiatry. I write from a clinical context in which anthropological concepts of "culture" and "the local" had been appropriated and instrumentalized for diagnostic and therapeutic approaches to minority patients long before my own ethnography began.[5] The clinical encounters I describe here cannot be glossed unproblematically as *Greek,* when *Greek* has the implicit ideological function of marking minority culture in Thrace, by contrast; nor, conversely, can the standardizing and universalizing truth claims by which psychiatry realizes itself as a global science stand as transparent representations of knowledge about clinical encounters in Thrace. My aim, instead, is to express what is particular about these encounters—which may only ambiguously mean what is Greek or global about them.

**INTIMATION**

The elicitation, discernment, and evaluation of responsible speech from patients are key therapeutic techniques in community-based psychiatry (Ierodiakonou 1983c; Velpry 2008). The imaginary of the patient addressed through these

techniques is of a conscious, coherent, intentional person who communicates transparently—whose speech is understood not as an elaborate cipher of unconscious psychic conflicts, but, rather, as the realistic transcription of thoughts and feelings to which the patient has more or less open access. In this context, the pragmatic functions of speech—the positioned strategies of patients and therapists in their communication with one another—are mystified by the dominant semantic project of conveying information truthfully (see Crapanzano 1992).[6] This project, as Nietzsche describes the will to truth in modern science, always stages a moral ground: its rationality is based not in a desire not to be deceived—for "both truth and untruth constantly prov[e] to be useful" in science (1974:281)—but, rather, in an injunction not to deceive others, shored up by all the pieties and contingent objectives that mitigate against dishonesty (1974:282). This moral injunction produces a responsibility to tell the truth that weighs on therapists and patients alike, although in different regards and measures.

The role of the clinic as a space of knowledge production enhances this expectation for patients and therapists to speak honestly and transparently. Reliable speech is required for diagnosis and treatment in contemporary Greek psychiatry, on what doctors in Thrace often described to me as the "American model" of drug-based therapy that has made its way into psychiatric practice internationally, through networks comprising multinational pharmaceutical corporations, research publications, academic departments and conferences, clinical trial sites, medical training curricula, and practical manuals like the *International Classification of Diseases* (*ICD*) (WHO 1992) and the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (*DSM-IV-TR*; American Psychiatric Association [APA] 2000). The discourse of truth in this global psychiatry is oriented to corporate knowledge products in the field of psychopharmacology and, at its speculative outer limits, pharmacogenomics—secured through the increasing imbrication of these knowledge products with international consumer markets (Lakoff 2005; Lewis 2006; Petryna et al. 2006).

But these frontiers of research and marketing do not expand autonomously from clinical knowledge. The development of new medications and diagnostic techniques begins and ends with profiles of patient populations that are generated in the clinic—whether these are profiles of illness, identified through standardized diagnostic interviews, or potentially more specific medication-response profiles that suspend ontological questions about illness entities (Lakoff 2005). Clinical diagnosis remains the leading procedure for generating psychiatric truth.

It is therefore crucial to observe the provisionality of clinical diagnosis on two levels. First, diagnosis is based primarily on patients' reports about their own experience and behavior, and therefore wholly mediated by speech in all its potential ambiguity and duplicity. Second, the link remains tenuous between the clinical profiles generated through diagnosis, on the one hand, and the biochemistry, neurophysiology, and genetics of mental illness, on the other. Advances in diagnostic specificity in the clinic, or in laboratory knowledge of neurotransmission, do little to consolidate or concretize the link between them. The problem of "the unknown," rooted in the unreliability of speech, looms large in psychiatry in all its developing scientific facets.

This problem of the unknown has been posed persistently to psychiatry, both within and outside the field, at least since the political critiques and therapeutic experiments of the 1960s, now broadly associated with the antipsychiatry movement.[7] Although the backlash in psychiatry and adjacent fields has dismissed the antipsychiatry movement as simplistic, moralistic, and antiscientific, psychiatry today remains vulnerable to criticism of its nosological uncertainty and low rates of therapeutic success (Breggin 2008; Clare 2003; Hacking 1999; Healey 1997, 2002; Lakoff 2005; Lewis 2006).

This disrepute colors professional self-conceptions of psychiatry in Thrace, a comparatively underdeveloped agricultural region between the Turkish and Bulgarian borders of northeastern Greece. The poorest region in mainland Greece, the most rural and the most eastern, Thrace presented the greatest apparent need for reform in health and social services during the period of European accession, and was targeted for experiments in community-based care well before policy changes transpired at the national level. I conducted much of my field research there at the General Regional Hospital of Alexandroupolis, a small facility attached to the medical school of the University of Thrace. In 1978, its inpatient clinic was the first psychiatric ward to be established in a general hospital in Greece, with a mandate to treat patients for brief periods and sustain their well-being outside the hospital with systematic outpatient supervision. In the early 2000s, the Alexandroupolis hospital clinic, like public psychiatry settings throughout Greece, was largely biopharmaceutical in orientation; as a university clinic, it hosted frequent clinical trials for new medications, and its clinicians regularly published research articles, most often in English, in international journals. The clinic offered a wide range of therapies in addition to pharmaceutical treatment—including supportive and family counseling, group therapy, and cognitive-behavioral therapy—but few clinicians had any training in psychodynamic theory and practice.

Several of the senior psychiatrists at this hospital clinic been working there since its founding. Like many Greek doctors who had chosen the psychiatric specialty in the 1970s, after the fall of the Junta, they told me they were drawn to psychiatry because this branch of medicine had the worst reputation for abuses of power. A new "interest in the freedom and rights of the individual" (Blue 1991:339), itself partly engendered by the dictatorship, impelled doctors toward a radical reform of public health care in Greece. Clinicians came to Thrace, they told me, with an investment in the human rights of patients, and a commitment to the practice of critical psychiatry at the margins of society. But the intervening years of reform had diminished their expectations and ambitions. Decades on, when therapists in Thrace remarked that psychiatry there was "backward," they were indicating a double deficit: both the peripheral regional status of Thrace in Greece (as of Greece in Europe), and the still-unscientific and inhumane status of psychiatric knowledge and treatment.

Contributing to this professional self-disparagement was the frequency of serious relapse among patients in Thrace, despite the best efforts of their treatment teams. Therapists often pointed to deception by their patients as the main factor in these treatment failures. They strove to determine their patients' psychological aptitudes for truth, and, thus, for responsible self-care, according to clinical profiles of pathological dishonesty. In the following sections, I sketch what I have learned of these profiles: of the diagnostic and culturalist logics therapists deployed to discern lies, and to interpret them as symptomatic (or not) of particular mental illnesses.[8] But, as I also show, these logics proved to be quite limited in their capacity to contain the complexities and ambiguities of patients' speech. Local suspicions of deception in the clinics of Thrace thus speak of an insufficiency of knowledge in contemporary psychiatry globally.

The urgent problem of failure in these clinics demands a critical analysis of mental illness and therapy in terms other than the self-validating logic of diagnosis. I therefore trace suspicions of deception across multiple terrains: from (neo)liberal reform, where deception foils the ethics of responsibility; to clinical diagnosis, where lies may symptomize personality disorders; to culture, where minority patients embody perceived norms of dishonesty. In exploring these terrains, my task is not to determine and moralize the referential truth of the speech I record, but, rather, to discern the dynamics of suspicion through which that truth comes into question. It is to these dynamics that I account the continuity of therapeutic relationships even when treatment seems futile. I argue that suspicions of deception recur to implicit knowledge of a secret between therapists and patients—intimate

knowledge that has no proper clinical function, but inhabits and fortifies these relationships.

The intimacy of these relationships is perhaps most evident in long-term therapy, where secret knowledge is painfully and laboriously elaborated in recurring encounters between patients and doctors. So I turn now to the case of Feyza, a Gypsy outpatient at the General Hospital of Alexandroupolis, whose "antisocial" behavior perpetually eluded diagnosis and effective treatment, and who lived the last years of her life in a chronic impasse of mutual suspicion with her therapists.

**SHE MIGHT NEVER LEAVE**

I reencountered Feyza, by chance, in the outpatient psychiatry clinic at Komotini Hospital, about 50 kilometers from Alexandroupolis and another 20 to the Turkish border. I had been working with the sole psychiatrist on the hospital staff for about a week when Feyza appeared at the outpatient clinic. After a brief session, in which Feyza received a prescription for sedatives and 1.50 Euros for the bus, the psychiatrist told me, "She's very sweet today. But she's the kind of patient who can get really aggressive, under the right circumstances. She just turns into someone else. But we understand each other, we get on well. I look out for her." Feyza's reputation was, by then, familiar to me. I had met her the year before at the hospital clinic in Alexandroupolis, where Feyza was a regular visitor. She was known to the staff as a possibly schizophrenic drug addict with a history of violence and suicide attempts. Over the following year, I got to know her during her outpatient visits and two admissions to the inpatient clinic. But when I returned to Thrace several years later, I learned that Feyza, at the age of 28, had died recently from a drug overdose. No autopsy was performed to determine which drugs she had taken; her doctors suspected a combination of street narcotics (presumably heroin) and prescribed psychiatric medications (chiefly Hipnosedon, a sedative known in the United States as Rohypnol—the "date-rape drug"). Feyza had, in any case, always taken massive amounts of pills: "whatever she could find," as her psychiatrist in Alexandroupolis put it, informing me of her death. Months earlier, she told me, she had tried once more to cut down Feyza's medications and help her through withdrawal, but they had lost contact when Feyza began treatment at Komotini Hospital. It was unknown whether her overdose had been a suicide or an accident.[9]

Feyza had sought and resisted psychiatric treatment for many years. Her diagnosis alternated between depression, psychotic syndrome, and antisocial personality disorder. Her therapists pointed to her multiple drug addictions when they accused her of lying about her need for care. Each time she was discharged from

the clinic, she returned to a home environment of violence and poverty. Yet her case was unremarkable; it fit the most common profile for psychiatric outpatients in Thrace. At the hospital in her hometown of Komotini, up to several patients per day were hospitalized for suicide attempts, most often by drug overdose. Most often, these patients were, like her, Gypsy women. The head of the emergency ward explained to me that suicidality—along with the drug abuse and domestic violence that seemed to provoke it—were "cultural problems," rather than medical ones. This accounted for the much higher suicide rate in Komotini than in Alexandroupolis, which had a smaller Gypsy population.[10]

The psychiatrist at Komotini Hospital told me that when she had taken up her post, she was shocked by the number of suicides and attempts, but she had grown accustomed over the course of her first year. Gypsies took pills "like they're candy," she said, and often overdosed by mistake. Psychiatric medications circulated along with narcotics in the neighborhood black markets—one reason for the suspicion with which psychiatrists greeted Gypsy patients requesting sedatives and therapeutic stimulants with high street value. But these patients often had legitimate access to these medications through their own prescriptions.[11]

One morning at Komotini Hospital, as we visited three patients in the emergency ward—all Gypsy women who had attempted suicide the night before—the psychiatrist told me, "There's not much I can do to get these patients to take responsibility for their lives. Most likely they'll just slip through the cracks." She described her fellow clinicians as poorly trained to heed the "social problems" that led to suicide; most didn't stop to think, before discharging these patients, that they would be returning to the same desperate situations that had driven them to take their own lives in the first place. "The law requires us to report cases of domestic violence, but most doctors don't bother. Those who actually care are afraid that patients will stop coming to the hospital if their families are reported for abuse. Everyone's suspicious of everyone."

The Gypsy population of Thrace is one of several "cultural minorities" in the region that remain largely unintegrated into Greek society, including Muslim communities of Turks and Pomaks,[12] and a growing group of Orthodox Pontic immigrants from former-Soviet states, with claims to Greek ancestry. Since the 1990s, as these communities have expanded, and their connections to Turkey and Russia have grown increasingly politicized—ramified by a surge in illegal human traffic into Europe from the north and the east—cultural difference has increasingly come into view as a clinical problem.[13]

In the psychiatric settings where I worked, these minority groups were perceived to make disproportionate demands on health and social services. Minority patients were often disappointed in their pursuit of clinical resources, especially medications and the certificates that would qualify them for disability income. Therapists, referring to their responsibility to distribute fairly the scarce resources of the state, often dismissed the demands of these patients as cunning manipulations. Gypsy patients in particular were frequently described as "culturally dependent" on welfare, rather than mentally disabled. As one therapist told me:

> It's not illness, really; they just don't want to work. Once someone in the neighborhood figures out that you can get on permanent disability by faking symptoms of psychosis, the word spreads to the whole community. Soon everyone knows that all you need to say is that you hear voices, or you think someone's trying to poison you. So we start seeing the same generic set of symptoms, in patient after patient.

To the extent that these patients were not taken for outright malingerers, they often emerged from clinical encounters with a diagnosis of personality disorder, rather than more severe disorders like schizophrenia or acute depression that would warrant full disability.[14]

In this sense, Feyza was—or became—a typical Gypsy outpatient. She lived as an adult in the same destitute Gypsy neighborhood in Komotini where she was born. Her husband worked occasionally, but largely the couple and their two children survived on welfare and disability income. According to the husband's doctor, he was schizophrenic and "very sick," but basically "functional." One of his functional behaviors was to bring Feyza to the hospital when she got "out of control" at home.

In the five years leading up to her last visit, Feyza had been admitted to the hospital clinic in Alexandroupolis ten times, for periods of one to ten days. She told me, "I take a lot of pills because I can't handle things without them." But also: "I feel like a robot after my shots. I hate that feeling." (She usually had biweekly injections of haloperidol, an antipsychotic medication.) She often found that she could not stand to be around other people. She would run away, wander alone in the streets, rend her clothing, and scream. "I can't sleep. I'm always mad at my husband. And my kids. I love them but they get on my nerves, sometimes I'm not good to them." Notes recorded in her file over the years detailed symptoms of suicidal depression, irritability and violence, hallucinations, labored and disorganized speech, and reduced cognitive function. In clinical interviews,

Feyza described her own symptoms as "fears" [φοβίες], "nerves" [νεύρα], and a syndrome often translated from the Greek as "anxiety" [στενοχώρια]: a suffocating panic accompanied by heart palpitations and painful constriction of the throat and chest. Although Feyza's native language was Turkish, these terms were Greek; artifacts of her experience in the clinic, they expressed highly conventional symptoms that, in transcultural psychiatry, hold the status of Greek "culture-bound syndromes" (APA 2000:899; Blue 1991; Low 1985). When Feyza spoke these words, she was already employing a vocabulary understood clinically to be distinctive of the local culture. Yet this local culture was one to which Feyza, as a Gypsy, was marginal. To many therapists at the outpatient clinic, her claims to hear "strange voices" [παράξενες φωνές] suspiciously indexed her own culture more directly.

Feyza normally saw her doctor at the outpatient clinic every couple of weeks. Although she usually seemed to me cheerful and pliable on these visits, one morning in midwinter she arrived in tears, begging the psychiatrist to admit her to the inpatient clinic. She was having trouble speaking; her limited fluency in Greek was aggravated by a terrible slur; she mostly spat and gestured. It slowly came out that she had woken up in the middle of the night before and attempted to strangle her younger child, who was sleeping next to her. "I didn't know who he was, I was terrified. I panicked." Her husband stopped her from killing the child, and kicked her out of the house. "I wandered the streets until I could catch a bus to the hospital." She told us that lately she had been hearing voices coming from the blades of her ceiling fan at home. "Sometimes my husband finds me talking to myself. He snaps me out of it, I don't know what I'm doing."

Feyza's prescription booklet showed that, even though no pharmacy should have allowed it, she had filled her sedative prescription six times in the last month. She swore to the psychiatrist that she had not sold the pills: "I took them all myself! I need that many just to survive!" She had run out the previous week, and came to the outpatient clinic to have her prescription renewed, but the resident who saw her refused to write it. (At a staff meeting the following week, this resident told us he could tell that Feyza had been lying about her meds: she was very likely addicted to them, he said, but she was also likely selling them in her neighborhood.)

The psychiatrist told Feyza that all of her symptoms were due to withdrawal from these sedatives, to which she was obviously addicted. She showed impatience with Feyza's crying and pleading, insisting, "Whether you're admitted to the clinic is up to you! You'll have to agree to certain conditions. No pills. No phone calls. No asking for leave." This regime marked a change in their therapeutic relationship:

no longer in a position to negotiate, Feyza agreed to relinquish all responsibility for her care.

At the next staff meeting, Feyza's case was presented by the resident who had recently refused to refill her sedative prescription. He said that although the patient presented symptoms of psychosis, such as auditory hallucinations and mental confusion verging on delusion, it was unclear how clinically psychotic she was, given her drug addiction and withdrawal. Another resident, who had treated her in the past, suggested that as a clinical syndrome, Feyza's drug use was actually secondary to her anxiety and dysphoria—themselves typical of her "cultural environment" [πολιτιστικό περιβάλλον]. But this same environment also made it difficult to know whether she was presenting an "honest" picture of her symptoms. This comment sparked the following discussion:

| | |
|---|---|
| staff psychiatrist: | *It's indiscriminate drug addiction! She'll take whatever pills are in front of her.* |
| Feyza's psychiatrist: | *Eighty percent of the minorities who come to the hospital are addicted to these drugs, the benzodiazepines.* |
| clinic director: | *That's true of minority communities in general, under such extreme conditions. Think about alcoholism on those Indian reservations in the U.S.* |
| staff psychiatrist: | *Let's not be fooled. These patients are looking for disability papers and they know all they have to say is, "I hear voices." That's what's going on here.* |
| Feyza's psychiatrist: | *But even if we know these patients aren't really psychotic, we have to understand that the papers help in other ways.* |
| clinic director: | *It's not just the papers they're after—it's a moment of recognition for them. The patient is really* ***seen*** *by the therapist who writes the paper. It's an acknowledgment that the patient has a right to social services.* |
| Feyza's psychiatrist: | *I thought we should try her on the weekly Prozac pill, since she'll have a much lower risk of overdosing on it.* |
| clinic director: | *You shouldn't just replace sedatives with antidepressants and send her on her way. That moment of recognition is very important. Still . . . it might be better to discharge her right away. If she stays any longer, she might never leave.* |

As it happened, the entire hospital was moving that month to a new facility on the outskirts of town. To expedite the move, the staff decided to discharge all but the most critical patients beforehand. Feyza was among them. She left after ten days of treatment without a prescription for sedatives, but with a new diagnosis of antisocial personality disorder.

## MORE DIFFICULT THAN SICK

The shift from psychosis to personality disorder in Feyza's diagnosis did not mark a corresponding change in treatment; her therapists continued to prescribe varying combinations of antipsychotic, antidepressant, and sedative medications. Her maintenance on habit-forming sedatives such as Hipnosedon indicates that her therapists considered her drug addictions less critical than her "antisocial" behavior—especially violence, which the sedatives helped to moderate. What the shift in diagnosis marked most fatefully, then, was the moment when Feyza became a chronic "problem patient."

Diagnostic distinctions between psychoses and personality disorders are authorized—although ambiguously—by the *DSM-IV,* a common reference point of theory and practice in the clinics of Thrace. The *DSM-IV* classifies mental illnesses along two axes. Axis I designates clinical disorders: the psychoses, mood disorders, and a variety of impulse-control disorders. Axis II designates personality disorders. According to the text, these share some features with clinical disorders—including "distress or impairment" and "deviation from cultural norms"—but have a distinct temporal course. They are defined as "pervasive" and "enduring pattern[s] of inner experience and behavior" that emerge early in life, and remain "stable" and "inflexible" over time (APA 2000:685). By contrast, schizophrenia, arguably the most severe clinical disorder, bears a typical "age of onset" of mid-twenties in men, late-twenties in women (APA 2000:308–309). Therapists I knew described schizophrenia as an illness that emerges suddenly, dividing the patient's life into a "before and after," while other clinical (Axis I) disorders, such as bipolar, would come and go during a patient's life.

The *DSM-IV* is designed to aid clinicians in the "multi-axial assessment" of their patients, who may present symptoms of clinical and personality disorders at the same time. These diagnoses are, thus, by no means mutually exclusive. Yet, in practice, therapists in Thrace often associated the axes with different types of patients. The director of the hospital clinic in Alexandroupolis, for example, used the term *clinical* to denote "real" illnesses—whereas patients with personality

disorders, he said, were "more difficult than sick." He explained the trouble of diagnosing these disorders:

> It is very difficult [to make such a diagnosis] because these disorders don't comprise clinical symptoms that make the patient suffer. When someone is suffering, ok, you always know that he has some real problem. Or when there are symptoms and it's absolutely clear [that] a month ago he was just fine, and then suddenly, something appeared.
>
> By contrast, personality disorders have features that will follow the patient around throughout his life. And most often these features are types of behavior—for example, someone is very timid, or very violent, or he needs a lot of order in his environment. And precisely because it's this, it's not symptoms but more like elements of his character, . . . it's extremely difficult to discern where the normal ends and the pathological begins.

If patients with personality disorders were indeed "more difficult than sick," their difficulty was due to at least partly their apparent dishonesty. I asked one of Feyza's therapists about what I called *the theory,* put forth in the *DSM-IV,* that lying was a symptom of certain mental illnesses. She told me, "It's not a theory; [lying] really is a symptom. Whether a patient lies is one of the ways of diagnosing a personality disorder." What patients with these disorders "really want" when they lied was often unclear to therapists, she said: their dishonesty seemed intentional, but lacked any obvious motive, and often thwarted the patients' own requests for help. As another psychiatrist explained it to me, "these patients have no regard for truth, but no real reason to lie, either."

As enumerated in the *DSM-IV,* lying is symptomatic of all the subtypes of personality disorders.[15] According to the text, patients of the paranoid, avoidant, and dependent types may cultivate restraint or aloofness, hiding their thoughts and feelings out of fear and mistrust. The borderline and histrionic types evince a different kind of dishonesty, distinguished by the attention-seeking exaggeration of pain or need, including self-destructive behavior. The most deceitful type of personality disorder in this taxonomy, however, is the antisocial. The Feighner criteria for clinical diagnosis, the basis for the *DSM-III* (APA 1980), specify "persistent and repeated lying" as a defining "manifestation" of antisocial personality (Feighner et al. 1972:60). According to the *DSM-IV,* a person with this type of personality disorder, unlike others, is often deliberately manipulative in pursuit of desired objects (money, sex, drugs), and may engage in "criminal" deceit, such

as theft or malingering.[16] The "external incentives" of "personal gain" that would otherwise permit a clinician to distinguish a malingerer from a symptomatically dishonest patient (APA 2000:513, 705, 739) are, thus, at work in antisocial personality disorder; indeed, the manual counts malingering as a diagnostic criterion for the disorder. What distinguishes symptomatic deceit in antisocial personality disorder from the nonsymptomatic deceit of malingerers is not the absence of external incentive, then, but the impulsiveness and compulsiveness by which the incentive motivates the deceit (APA 2000:702–703; Cleckley 1941:208), and the "maladaptive" persistence of deceit despite the functional impairment and distress it causes the patient (APA 2000:705–706).

The clinical profile of antisocial personality disorder is outlined in a textbook on social psychiatry published by Panayiotis Sakellaropoulos, a renowned leader of Greek psychiatric reform in the 1970s–80s, and now the president of a mental health association in Thrace. According to his text, "antisocial" or "psychopathic" traits include instability, impulsivity, and disorientation.[17] But this personality type, he says, can also be "charming," "persuasive," and "misleading," either by cognitive fault or by conscious pretense; antisocial men and women alike are "entertained" by "deluding" themselves and others, and given to "mythomania" in their avoidance of reality. Although in some people, this personality bears a destructive aspect that delights in scandal and provocation, Sakellaropoulos insists that "the psychopathic is more *amoral* than deviant" and displays, rather than malice, a "general avoidance of responsibility" (2005:241, 240). Patients with this type of personality disorder do not "open up," but instead "externalize" their conflicts in behavioral symptoms; lacking an introspective tendency, they stand incapable of honesty and of moral responsibility generally (Sakellaropoulos 2005:240, 241).[18] Antisocial personality disorder, thus, in theory, presents a complete riposte to the demand in Greece for transparency and self-responsibility on the part of patients.

## THE UNDERLYING PROBLEM

The moralism inherent in designating patients with personality disorders "more difficult than sick" is not unique to the clinics of Thrace. Luhrmann, for example, describes the feelings of guilt experienced by a cohort of American psychiatric residents in their work with patients diagnosed with personality disorders (2000:112–118). These residents often blamed the patients for their own suffering—this, in stark contrast to patients with clinical disorders who, as one therapist put it, "c[o]me by their diagnosis *honestly*" (2000:115, emphasis added). Luhrmann notes that these residents learned to diagnose personality disorders not

through the "disease model" of mental illness, but through the "interaction model" of psychodynamic therapy, by analyzing their countertransference with patients (2000:112). Lester, also working in a U.S. clinical setting, likewise observes the recourse made by therapists to the dynamics of transference and countertransference in their "borderline talk," when deciding on treatment for "difficult" patients whom they suspected were manipulating them with self-destructive behaviors that came to seem "incurable" in the rationality of managed care (2009:33 ff.).

At the hospital clinic in Alexandroupolis, however, residents and clinicians rarely referred to transference and countertransference when discussing their personal reactions to "difficult" patients. Rather than naturalizing their suspicion or hostility toward these patients as products of challenging clinical encounters, they often—as in the staff meeting quoted above—phrased these reactions in terms of cultural difference. As one senior psychiatrist exclaimed in another staff meeting, during an argument over a Gypsy patient's care: "Half the Gypsies we see have personality disorders—it's all theater, in their culture!"

The year I began working at the hospital clinic in Alexandroupolis, the training curriculum for the new cohort of psychiatric residents included a textbook on culture and psychiatry just published by Miltos Livaditis, a professor of psychiatry at the local medical school, with 20 years of clinical experience in the region. In the text, he notes the unique obstacles to therapeutic relationships between Greek psychiatrists and patients from Thrace's minority communities. Among these communities, he attributes to Gypsies the most severe social problems, including poverty, lack of education, criminality, drug addiction, and violence (Livaditis 2003:594 ff.).

The clinical implications of these social problems are charted in a research paper that Livaditis coauthored on psychopathology among Gypsy outpatients treated at the General Hospital of Alexandroupolis (Livaditis and Vorvolakos n.d.). Gypsies had been chosen for the study for several reasons. According to the text, they composed roughly seven percent of the regional population, but 60 percent of those visiting the hospital's outpatient psychiatry clinic. The Gypsy outpatient population presented "disproportionately prevalent and severe problems" of psychiatric illness and stability "independent of diagnosis," although the most common diagnosis was personality disorder. The erratic attendance of these patients at scheduled appointments, their poor adherence to medication regimes, and their "hysterical behavior . . . and hostility" toward therapists translated into dire prognoses. In fact, the data showed that the health of these patients often worsened on exposure to psychiatric care. The authors note that "very obvious cultural differences in

behavior and appearance" presented by Gypsies in clinical settings often "cast doubt on their credibility."

In an interview, the director of the hospital clinic in Alexandroupolis offered me what he described as "speculative theories" about the prevalence of personality disorders in Gypsy communities. The *biological theory,* as he gave it, held that Gypsies, as an evolutionary breeding population, had developed a genetic disposition to aggressive behavior. The *materialist theory* proposed that the chronic social and economic deprivation suffered by Gypsies forced them to adopt antisocial behavior as a means of survival. On the *relativist theory,* which the director said he preferred, the cultural conditions of Gypsy life were considered a normative context for behavior that only appeared pathological to outsiders. He referred me to a passage from the textbook by his colleague, Dr. Livaditis, highlighting this source of misunderstanding between Greek therapists and their Gypsy patients in Thrace:

> Gypsies often express themselves in dramatic or aggressive ways, which the un-sensitized therapist too readily judges as antisocial or dishonest behavior, in the service of some strategy for seeking advantage. However, in reality, [this behavior] is often a matter of idiomatic ways of expressing distress or despair. [Livaditis 2003:594–595]

It was on the basis of such misunderstandings, the director explained, that Greek psychiatrists often made errors in diagnosing Gypsy patients. He said it was crucial to gather information about the patient's "cultural background" (in English) before making a diagnosis. Most important in this regard was the opinion of other members of the patient's community as to whether the behavior in question was strange, crazy, or dysfunctional. In the director's view, pathology was often a matter of the degree rather than the type of behavior in question. For example, he said, in a Gypsy man who beat his wife, pathology might be identified only by the extremity and frequency of the assaults.

It is unclear, in this relativist theory, whether the normativity of antisocial behavior in Gypsy communities entails a psychological etiology, or whether its normativity is only a matter of behavioral expression. What is clear is that only some cultural conditions are ripe for antisocial normativity. According to the clinical profile, the crises of aggression that erupt in antisocial personalities appear to have a peculiarly collective aspect: Sakellaropoulos remarks in his textbook that these crises "provoke in people with similar personalities a chain-reaction of irritation or aggressive rage," directed at oneself or others, as in "epidemics of suicides

or self-mutilation," which are "well known in communities that shelter antisocial persons" (Sakellaropoulos 1995:242). The disorder thus presents itself more as a "community problem" than a therapeutic one in such environments (1995:239). The clinic director confirmed this view when I asked him to compare pathological violence in an individual patient with extreme but widespread violence in that patient's community: "Well, at that point, we're talking about a social problem. We can't address that with psychiatry alone."[19]

The concept of culture invoked in the director's "relativist" theory of minority pathology attributes the disordered behavior of individuals to a moral code, and ascribes cross-cultural conflicts to incommensurabilities between such moral codes. Culture thus provides an account of mental pathology in the context of diagnosis, which may be skewed by a clinician's inadequate attention to the cultural background of the patient. This relativism, however, directly contradicts the alternative "materialist" view also presented by the director—an etiological account, in which pathogenic social, economic, and political conditions are understood to cause standard mental disorders such as reactive depression and personality disorder, which can be accurately diagnosed without reference to the patient's cultural background.

This materialist specter hovered over every clinical encounter between Greek therapists and minority patients in Thrace. The local minority groups reputed to be "culturally dependent" on state welfare also subsisted under conditions of deprivation that could easily drive patients to lie deliberately and strategically, rather than symptomatically. Therapists in Thrace could understand and often, in fact, articulated in straightforward political-economic terms the needs motivating these patients to seek psychiatric care.

It is well, then, to query the evident concern on the part of these therapists to preserve a clinical perspective in their encounters with "suspect" patients from cultural minorities—that is, to preserve culture as a framework for diagnosing and treating mental pathology.[20] Even those patients openly accused of fraud usually emerged from their clinical encounters with a diagnosis, albeit of a "cultural pathology" like antisocial personality disorder. In making claims on clinical resources, these patients pushed psychiatrists to decide how the state would mediate their clinical relationships: to determine how they would balance their therapeutic and their bureaucratic obligations, and how they would link and separate pathology and poverty in that work. Were they bound to the scientific discourse of psychiatry by which the state authorized their power to find a personality disorder—rather than a clinical disorder, or malingering? Did they acknowledge the state's role in

the deprivations that might dispose their poorest and most marginalized patients to develop personality disorders? If so, would they distribute the resources under their control in ways unauthorized by state policy?

For the patients diagnosed, antisocial personality disorder described an equally ambivalent relationship to the state. Its symptoms took the form of disregard for the law: chronic unemployment leading to welfare fraud, evasions of compulsory education and military service, customary divorces and remarriages not recognized by civil law, and outright criminal activity. More than merely demonstrating the clinical and bureaucratic means by which pathology is rendered from poverty, then, antisocial personality disorder coupled a rejection of the norms of liberal citizenship with a claim, even a dependence, on state care.

In this sense, antisocial personality disorder among Gypsy outpatients in Thrace bore a robust resemblance to the "political personality" Wendy Brown has observed of liberal subjects formed through the "wounded attachments" of identity politics:[21] the disorder secured affective, corporeal, and psychical dependencies on a state that declined responsibility for their welfare. The entitlements for which patients with more severe clinical disorders could qualify through their disability were largely unavailable to the antisocial. Yet a claim to these entitlements persisted in the intractability of this disorder. A psychiatrist at the hospital clinic in Alexandroupolis drew a connection between the difficulty of people with personality disorders and the difficulty of treating them, noting their resistance not only to psychotherapy but also to pharmaceutical treatment:

> These patients are the least liked by psychiatrists. They're considered the most difficult, because it's much harder to see the results of treatment—compared with schizophrenia, for example. . . . Patients with personality disorders do take psychiatric medications, but they're less effective. They're given to control the symptoms, like violence, but they don't deal with the underlying problem.

Antisociality did not, then, present a seamlessly pathological face in the clinic. Yet neither can it be dismissed as an instrumental guise or a psychical allegory for the politics of dispossession. If Gypsy patients addressed moral claims to the state through the antisocial behaviors they presented to their doctors, this does not mean that their strategy was a form of deliberate resistance. The rejection of liberal citizenship embodied in these behaviors is more obviously a form of dependency on the state than of contestation.[22]

This dependency was facilitated by the clinical imagination of culture in Thrace. In the relativist sense, "culture" offered suspicious clinicians a way to marshal their medical authority against the deceptive tactics of patients who addressed them as gatekeepers of state resources. The diagnosis of antisocial personality disorder as a cultural pathology in these patients, I would argue, thus constituted a refusal—not only to accede to these deceptive tactics and falsely certify a more severe disorder that would warrant full disability income, but also to acknowledge the deceptive tactics as such. This culturalist diagnosis stood as an assertion of psychiatric purview over a broad spectrum of deceptive behaviors, from deliberate fraud to severe disability.

The refusal on the part of clinicians either to accept or to reject outright the suspected lies of their patients smacks of the bureaucratic "fear of responsibility" [ευθυνοφοβία] in Greece that Herzfeld has explored (1992:passim). Herzfeld presents this "logic" of "buck-passing" (1992:122) as a legal principle as well as a conventional rhetoric of excuse in everyday encounters between supplicant citizens and public servants. He reads the stereotypically Mediterranean attitude of fatalism in regard to bureaucracy as a "secular theodicy," by which citizens seek transcendent accountability in the state—and symbolize its failures in national(ist) stereotypes of self and other. One of the main "tactical uses" of these stereotypes inheres in the "ethical alibis" they offer for all parties to deflect personal responsibility (Herzfeld 1992:77, 81).

But the logic of ευθυνοφοβία offers only a partial account of the impasse I observed between Greek psychiatrists and Gypsy patients seeking prescriptions or disability papers. Certainly, this impasse describes a conflict of rhetorical strategies: psychiatrists presented themselves as impersonal guardians of scientific truth, as of the common interest of the body politic entrusted to them as state employees; Gypsy patients presented themselves as the personal victims of medical and state neglect embodied, personally, by their therapists. Yet the conflict of these strategies was not resolved by the "ethical alibis" provided by the symbolic logic of self–other stereotyping. What is distinct about these clinical encounters, in comparison to the bureaucratic ones that Herzfeld examines, is the irreducibility of pathologies to social dynamics. Therapists were concerned to retain a clinical purview over the antisociality of their Gypsy patients, legitimating it as a mental pathology even if they also recognized it as a pragmatic strategy. I therefore see the state psychiatric clinic as a bureaucratic institution in which self–other stereotypes do not function only as "the idiom in which social and cultural exclusion become mutually convertible" (Herzfeld:73). These convertible exclusions, while clearly

operative in clinical encounters between Greek psychiatrists and Gypsy patients, are nonetheless secondary to the intimate relationships generated there—relationships that are primarily and fundamentally ethical, in the perpetual mutual dependencies they sustain.

**CONCLUSION**

Three months after her discharge from the old hospital, Feyza's husband brought her to the new outpatient clinic in Alexandroupolis. She had overdosed on sedatives the day before and he found her on the couch at home, "cold, as if dead." He rushed her to the hospital in Komotini, where she was discharged the same day. But when she got home, she took more pills. Her husband didn't know what they were or where she had found them, but they made her angry and violent. She set to beating their children until he intervened.

That morning at the clinic, Feyza was still drugged; she was slow and clumsy in her movements, and barely able to speak. "My brain isn't working," she told us. Her husband seemed desperate for her to be admitted. He implored the psychiatrist, "Keep her this time until she's well and don't throw her out after a few days!" The psychiatrist parried:

> Feyza is always the one who decides to leave! Usually because she gets a phone call from your father [πεθερός της], yelling at her to come home and take care of the children, since you can't do it without her. Besides, Feyza causes a lot of trouble when she's here. She fights with the other patients and steals their pills. She always begs for admission, but once she's inside she makes no effort to get better. The clinic is only for people who can be helped—and Feyza will never be helped until she learns to help herself!

I had heard other therapists say outright what this one implied here: that Feyza only sought admission to the clinic when she needed to escape her family. That, on those occasions, she exaggerated or feigned symptoms to create a sense of urgency—or overdosed to create a real emergency. That she was not truly "open" to therapy. But, despite her well-entrenched suspicion, the doctor eventually yielded to Feyza's pleading and admitted her to the inpatient clinic.

Several days later, this psychiatrist presented the case to the rest of the staff. Feyza, she said, was still suffering the effects of "toxic delirium" from her recent overdose, and had "admitted" she was suicidal. But they had reached an agreement about her treatment: Feyza would stay at the inpatient clinic for an extended

detoxification. Excessive drug use and withdrawal could explain all of her symptoms, the doctor said—but so could psychosis, suicidal depression, or personality disorder: "If Feyza has a clinical psychopathology, it's certainly comorbid with her drug use. We need to put a stop to the vicious cycle [φαύλος κύκλος]." She wanted to clear Feyza's system of all drugs and medications to clarify her diagnostic picture, to render transparency from the persistent opacity of her illness. The clinic was the safest place for this, in the doctor's view; the nearest specialized detox facility was located in Thessaloniki, some 400 kilometers away, and Feyza would never make the trip.[23] "She'll stay in the clinic until I decide her treatment is complete. If she leaves against medical advice, we'll never let her back in." The doctor hoped that this regime of incentives and consequences, reinforced by close and continuous supervision, would motivate Feyza finally to relinquish her manipulative tactics and face her problems "sincerely" [ειλικρινά].

The resident who had treated Feyza during her last admission objected to this plan. He said he was offended by her manipulative behavior: "She sells drugs, she fakes her illness. She thinks we'll do whatever she wants, and so far she's been right. We can't let her treat us this way anymore!" He proposed that, rather than continuing treatment "in the community," they send her instead to the state psychiatric hospital at Thessaloniki—the only custodial facility left in this part of Greece, and a last resort for cases in which community-based treatment had failed. Her husband had already signed the order to have her committed, but Feyza was scared to go, and he was reluctant to force her.

Feyza's doctor rejected this solution: "It's the responsibility of those of us who've treated her here to provide her care." The state hospital was for truly disabled patients who had no hope of functioning "in the community," and that was not the case with Feyza, she said. "It's *our* fault that Feyza is addicted to sedatives. We've promised to help and we haven't. We've let her go on for years without a clear diagnosis or consistent treatment. If she were a Christian rather than a Gypsy, she'd have gotten better care."

This staff meeting, at which the prospect of Feyza's internment at a state hospital was raised and rejected, inaugurated the period of her final "starvation" from drugs. She abandoned this regime after a week, against her doctor's advice, to reunite with her family and begin outpatient care in Komotini. From that time until her death two years later, she never again sought treatment in Alexandroupolis—although I heard that she did show up from time to time at the outpatient clinic, for refills on her many prescriptions.

Feyza's case, which unfolded through treatment sessions, staff meetings, and negotiations with family members at two hospitals over many years, was composed of unreliable speech; the norms of transparent communication were repeatedly misunderstood or broken, by all parties. The truth of her affliction was periodically deemed by those authorized to speak it, in the paradigmatic form of diagnosis; but that truth did not effect a resolution to her case. Suspicions of deception marked not only what was unknown but also what was unresolved in Feyza's encounters with her therapists.

The truth of mental illness wrested from these suspicions depended on the mystification of the pragmatic determinants of deceit on the part of both the patient and her therapists. I have therefore traced the pragmatic as well as the semantic functions of speech in these encounters. In theory, the semantic conventions of communication in the clinic—by which patients achieve transparency, and their efforts at communication intelligibly express their interior motives—make it possible for therapists to diagnose "antisocial" behaviors like dishonesty as symptoms of mental illness, and to understand their patients' motives for lying in terms of their medical needs for care. But, as in Feyza's case, antisocial behaviors may disrupt the clinical ambition to contain them within these semantic conventions. Lying, in particular, creates a pragmatic space to depart from these conventions, to angle around the clinical exchange of symptoms for diagnoses and treatments—like the active protest effected by silence in response to a normative demand for speech, as Susan Gal observes (1991; see also Herzfeld 1991).

In the context of psychiatric reform in Thrace, which counts on continuous and truthful communication, deception speaks instead of an entitlement to non-transparency shared by patients and therapists. The clinic can function here as an intimate space, where ethical relations may develop indifferently to cultural and class barriers. Even if they arise from these barriers, the suspicion shared by a Gypsy patient and a Greek psychiatrist that the other is lying trace the latent positivity of a secret "subjugated," as Foucault has phrased it, by the scientific discourse of psychiatry.

The difference between suicide and accidental overdose does not register in the antisocial profile of Gypsy outpatients in Thrace. But that difference does register in the ways Feyza experienced the conditions of her life, imagined its possibilities, and sought to realize those possibilities through treatment; in the ways she and her therapists shared, and deflected, responsibility for her care. In her unreliability, her opaque instrumentality, her distrust and disappointment in her therapists, we can see an appeal for intimacy: a demand that her therapists know and

help her, despite her manipulations; an entitlement to place that intimate demand on them. And we can see, in her therapists' perpetuation of treatment—despite the ambiguity of its diagnostic basis, and the failed promise of its therapeutic regimen—an acceptance of that burden. For a time, Feyza's life was sustained by this relation, through the bureaucratic disbursement of medication and disability income, but also through the temporality of clinical care: a temporality of expectation and satisfaction that perhaps made a future appear out of her unlivable present. The suspicions that bound the patient and her therapists in this temporality of care perhaps convey their refusal, against the incitements of (neo)liberal reform, to take full responsibility for themselves—in the interest of keeping a relation going.

**ABSTRACT**

*Based on field research in Greek Thrace, this essay examines the problem of deception in psychiatric care, in the context of national psychiatric reform. Over the last 25 years, psychiatric treatment in Greece has shifted from custodial hospitals to outpatient settings, challenging the mentally ill to help care for themselves as they adapt to life "in the community." I explore the consequent reworking of therapeutic relationships outside custodial institutions through verbal negotiation, as against methods of confinement and constraint associated with inhumane institutional care. I argue that an ambivalent intimacy is fostered in these relationships by suspicions of deceit, which speak as well to a problem of knowledge in contemporary psychiatry globally. Working through the case of a Gypsy outpatient diagnosed with antisocial personality disorder, whose life ended in a drug overdose, I trace suspicions of deceit across multiple terrains: from (neo)liberal reform, to clinical diagnosis, to constructions of minority culture. On these terrains, I do not attempt to determine the truth of speech in the clinic, but to discern the dynamics of suspicion through which that truth comes into question. Rather than clear refusals of responsibility, I show suspicions of deception in community-based care as refractions of psychiatric reform through a constitutive opacity in intimate ethical relations between patients and therapists.*

**Keywords:** Greece, psychiatry, ethics, responsibility, neoliberalism, Gypsies, deception, intimacy

**NOTES**

*Acknowledgments.* I am very grateful to Selvinaj and Dr. S. for allowing me to collaborate briefly in their relationship; and to many others at the Alexandroupolis hospital clinic for their invaluable help and tolerance. I also want to thank Anne Allison, Kathy Ewing, Anne-Maria Makhulu, Megan Moodie, Anand Pandian, and Rebecca Stein for their attentive reading and insightful comments on drafts of this essay, as well as Kim and Mike Fortun and anonymous reviewers at *Cultural Anthropology*. Early versions of this essay were presented at the AAA panel, "Anthropology of Intimacies"; the Faculty Work-in-Progress Seminar of the Program in Women's Studies at Duke University; and the Gender and Disability lecture series of the Program in Culture, Health, and Medicine at the University of Michigan. I thank Rebecca Stein, Ranji Khanna, Ara Wilson, and Jonathan Metzl for organizing these events, and the participants for their very helpful questions and comments. Research and writing

for this essay were supported by the German Marshall Fund of the United States, the Social Science Research Council, the Woodrow Wilson Foundation, the Mellon Foundation, the Robert H. Lowie Endowment, and the Institute of International Studies at the University of California, Berkeley.

1. Lacan developed a theory of desire as the truth of the subject, and charted Freud's invention of the psychoanalytic procedure to discover this truth through a strategic reduction of symptoms to signifiers. For Freud, Lacan says, the dread "other" situated in this field of truth is not the deceiving God of the Cartesian nightmare but a "*deceived* Other" (1978:37)—the analyst himself, whom the patient fears misleading, and who can indeed be misled. The patient's unconscious desire to deceive the analyst is "that truth which makes it perfectly possible, contrary to the supposed paradox, to declare, *I am lying*" (1978:37–38). This deception does not undermine analysis, because the patient's speech is granted symbolic value in its signification of motive, rather than its semantic reference.
2. Lacan makes this assertion in a discussion of deception, which characterizes the "reality of the hysteric" that impelled Freud's invention of the analytic procedure (1978:32–33).
3. This task is what Saba Mahmood, with Judith Butler, cites as Foucault's "paradox of subjectivation" (Butler 1993:15; Mahmood 2005:17, 20 n. 35): "The very processes and conditions that secure a subject's subordination are also the means by which she becomes a self-conscious identity and agent" (2005:17). Mahmood's departure from Butler is to consider, as ethical, practices that find a *telos* other than liberation in the terms of progressive liberal politics (2005:14). This departure dislodges ethics from the mutual entailment of freedom and agency—a set of values to which, as Mahmood points out, liberalism and feminism make exclusive political claims, against other "value systems" such as Islamism. Yet the ethics in which patients are engaged by psychiatric reform insistently repose that entailment. Freedom in this context both requires and produces agentive responsibility: it is a legal condition of the decision to undertake treatment, but also the normative goal of that treatment—a liberation from mental illness and institutional life. Psychiatric reform thus poses freedom as a special problem for the ethics of responsibility that cannot be reduced to cultural or political conflicts over values.
4. I see this "care of the self" as consistent with psychoanalytic ethics—even if those ethics describe a deontology (in which the subject's duty or obligation is bound to his desire, as against normative social goods), rather than a nondecisionist practice of the sort genealogized by Foucault. Lacan, offering psychoanalysis as an empirical practice, rather than an axiomatic moral system, suggests it is an "open question" whether psychoanalysis has an ethics, which he defines as the judgment of actions that themselves "contain" judgment (1992:311). If psychoanalysis does have an ethics, it is because the practice restores focus to the "meaning of an action," revealing the desire that "inhabits" the action (1992:312, 313) in a "catharsis" of self-knowledge that permits the patient to assume authorship of his own desire. If psychoanalytic ethics conceive responsibility as precisely this authorship of desire—discharged therapeutically but discovered hermeneutically—then responsibility transpires within the field of truth, enrolled in its laborious progression from concealment to revelation. This procedure, with its commitment to "deep" and "hidden" meaning (Lacan 1992:312), exemplifies the "hermeneutics of suspicion" to which Foucault turns a critical eye (Dreyfus and Rabinow 1982; Foucault 1998). Although Lacan theorizes the ethical task of self-knowledge for the patient along with the professional ethics of care for the analyst, he does not trouble the will to truth in which these ethics are mutually constituted—and which forms the "substance" of the ethics of care of the self that Foucault pursues (Rabinow 1997). As far as the patient's work on the self is concerned, however, I suggest that Foucault's and Lacan's formulations of ethics converge on the same paradox of subjectivation (see N. 3).
5. See Ewing and Hoyler (2008) for a parallel discussion of appropriations of the culture concept in political discourse on Islam in the United States.
6. See Crapanzano's critique of "linguistic ideology" in interpretive social science (1992:12 ff.). Crapanzano is concerned with the interpretation of communicative phenomena in the sociocultural field that can be described as either semanticoreferential (in the form of propositions that convey information), or pragmatic (having an efficiency in the fields of power and desire that they reflect and create). On his account, western social science uses only

semanticoreferential language to interpret both semanticoreferential and pragmatic communication, with their radically different functions and orientations to truth. He argues that the dominance of the semanticoreferential at the meta level obscures these differences, generating a closed interpretive system whose pragmatic determination is constantly reinforced by the "truthful" interpretation of data that only apparently exists independent of pragmatic context. Social science thus "represses" the pragmatics of its own metapragmatics, as it develops a metalanguage in the semanticoreferential mode—obfuscating the location of its truth claims in a field of power and desire.

7. The foundational thought of Franco Basaglia (in Italy), R. D. Laing (in Great Britain), and Thomas Szasz (in the United States), among others, denounced the construction of psychiatric truth through coercive power, and sought both to liberate patients from their institutional domination and to develop new therapeutic avenues to the truth of madness. Neither Basaglia nor Laing, however, identified himself with the antipsychiatry movement, which is perhaps rather a retrospective label for a disparate array of critical theories and experimental practices emerging across Europe and the United States in the 1950s–70s. See Scheper-Hughes and Lovell (1987) and Foucault (2006) for histories of the movement.
8. In the clinical imagination I examine here, lying cannot be adequated to other forms of unreliable speech on the part of patients, such as confusion or delusion. Velpry, in her analysis of group therapy in a community-based setting in France, notes that because "what a patient says may be considered a symptom of mental illness" instead of informative speech on a par with what therapists say, the disqualification of delusional speech is a crucial therapeutic mechanism in community-based care that aims to produce responsible patients (2008:241:passim). In light of this suspicious orientation to clinical discursive material, Velpry finds psychiatry to be a "privileged setting" for studying the active construction of "the patient's view" as a factor in treatment (2008:243). What I show in this essay is a misstep in this process of construction, where the unreliable speech of patients cannot be pinpointed as symptomatic of a mental illness, and comes instead to impugn the reliability of therapists' own speech.
9. There are profound resonances between Feyza's story and that of Alma, a heroin addict in New Mexico, written by Angela Garcia (2008). Garcia carefully evokes the chronicity of Alma's addiction—a temporal structure of returning to pain and loss, a "structure of endlessness" (2008:725), which coincides with and yet contravenes the liberal discourse of personal autonomy and choice dominating medical and legal–penal approaches to substance abuse in the United States (i.e., to relapse and recidivism, respectively). What Garcia sees at the heart of this temporal structure—the site of the melancholic subject's return: the rush of a heroin dose, or the personal reencounter with communal pain—is, I think, what I see in the secret encounter of therapeutic relations themselves. Like Feyza, Alma died of a drug overdose that may not have been accidental; even if not suicides, these women's deaths were overdetermined—by devastating deprivations of land, legitimacy, and well-being in the marginalized communities to which they (ambivalently) belonged; but also by gender—in ways that demand a more complex understanding of "accidental."
10. In this text, I use the term *Gypsy* [Γύφτος/Γύφτισσα] advisedly: like many designators of minority identity, this term has pejorative and positive connotations, depending on its use. Here, I use the term for Turkish-speaking Muslim people who composed approximately seven percent of the population (and about 20 percent of the Muslim population) of Thrace at the time of my research. This community bore an ambiguous identification with both the Turks of Greece and the Roma of Eastern Europe; these identifications had strong but very different political resonances in Greek political discourse. On the Roma side, the precarious citizenship of Gypsies in Thrace evokes the classification of Gypsies as a criminal population seen explicitly in the Berlusconi administration's census and fingerprinting scheme, introduced in Italy in 2008 (echoing similar policies in Bulgaria, Romania, and Serbia—not to mention the Nazi extermination).
11. When I began fieldwork, measures had recently been taken at the national level to control the prescription of sedatives in Greece. Doctors were now required by law to write these prescriptions on special "red-line" forms, intended to alert pharmacists to the date and duration of the prescription; duplicates were kept in consultation offices so that doctors could track

their chronicity. Most sedatives were supposed to be prescribed only for seven–ten days at a time; in practice, however, they were prescribed and taken for years at a time, with the same chronicity as other types of psychiatric medications.

12. "Turk," "Pomak," and "Gypsy" were all fraught and contested identifications in Thrace. See Demetriou (2004) for a thorough discussion of "Pomak" and its shifting relation to "Turk" in Greek and Turkish nationalist discourses on the Muslim minority of Thrace, as well as emergent multiculturalist discourses. See also Hart (1999) for a parallel discussion of Albanian and Greek communal demarcations in regard to the politics of blood, culture, Islam and Christianity, in the borderland between northwestern Greece and southwestern Albania.
13. See Fassin and d'Halluin (2005, 2007) and Ticktin (2005) for discussions of this overdetermined nexus of suspicion developing around immigration and asylum between the legal, medical, and policing organs of the state at the borders of Europe.
14. Patients with a range of medical conditions could qualify for disability certification. Qualifying mental illnesses were not restricted by law, but social workers and psychiatrists alike told me that therapists were encouraged to write certifications only for highly dysfunctional patients, which usually meant those with psychoses or severe depressive or bipolar illness. To gratify their claims, or simply to silence them, many psychiatrists continued to write "papers" for patients with personality disorders, postponing the moment of refusal to their encounter with petty bureaucrats in the welfare office.
15. In the *DSM-IV,* personality disorders are delineated in three descriptive clusters and ten subtypes: (1) the "odd or eccentric" cluster of paranoid, schizoid, and schizotypal personality disorders; (2) the "dramatic, emotional, or erratic" cluster of antisocial, borderline, histrionic, and narcissistic personality disorders; and (3) the "anxious or fearful" cluster of avoidant, dependent, and obsessive-compulsive personality disorders (APA 2000:685–686).
16. See Rhodes (2004) for an incisive discussion of the nexus between antisociality and criminality, as between the medical and penal systems, in the United States.
17. In some diagnostic systems, antisocial personality disorder appears as "psychopathy" or "sociopathy," with slightly different clinical emphases. Rutherford and colleagues (1999:849, 851) point out that, although the socio- or psychopathy diagnosis, more common in European psychiatric practice, places more emphasis on character traits, the antisocial personality diagnosis in the *DSM-IV* enumerates behaviors, thus bearing a wider scope of potential application but narrower psychomoral implications. See Gondles (1999) for a brief history of shifts in usage of these diagnostic labels in American psychiatry and popular culture.
18. Other psychiatric texts, including the *DSM-IV,* likewise identify extreme irresponsibility as a key diagnostic feature of this disorder (APA 2000; Cleckley 1941; Feighner et al. 1972; Rutherford et al. 1999).
19. Similarly, in an article on community-based therapy practiced in public schools by politicized therapists in postdictatorship Brazil, Behague notes the radical discrepancy of scale between social and individual psychological treatment, and the insufficiency of clinical models to redress social "inequities" and "conflicts" that dispose public school children to behavioral and emotional distress (2008:216).
20. Lester aptly notes the peculiarly circular and expansive way in which a generic, ungrounded concept of culture operates in cross-cultural approaches to eating disorders: "culture becomes something of a catchall term for anything not strictly psychological or biological, and . . . a way of displacing concerns that might otherwise require a more profound examination of the cultural bases of the diagnostic criteria themselves" (2004:609).
21. In *States of Injury* (1995), Brown deems "wounded attachments" those politics waged in paradoxical identitarian investments, where the "marginal, deviant, or subhuman" is recast as contestatory identity (1995:53), thus binding particularist "claims to injury and exclusion" to the universalist ideals from which these "marked" social identities deviate. Such identity politics represent to Brown a foundering project of subversion and emancipation—one animated by a desire to "inscribe in the law" the "historical and present pain" of the claimants, and to seek recognition before the law in terms of that pain, rather than in novel terms that might effect their liberation from oppression (1995:66). In *Politics Out of History* (2001), Brown again observes the tragic impossibility of surrendering the ideals that found political claims

of injury in modern liberalism. Here, she uses Freud to allegorize the formation of political subjectivity in a libidinal framework of masochistic desire: a complex oscillation between the disavowal and the satisfaction of this desire stabilizes the subject's attachment to the political order that punishes it. From this process of subject formation, Brown suggests, emerges a "political personality" wrought in paranoid paralysis—a powerlessness to dislodge the masochistic structure of desire (2001:58).

22. My analysis of this dependency takes a different direction from the critique of medicalization proposed by anthropologists of "social suffering," who seek to address suffering without personalizing it in the psychological individual, or pathologizing it in the constructions of biomedical rationality (as, e.g., Kleinman [1995:38, 177] sees the social effects of political violence treated as posttraumatic stress disorder). This critique preserves the distinction between political and medical etiologies so as not to reduce suffering to the institutional discourses of the state (as Das [1995] shows in her work on the Bhopal disaster and other events of social trauma in India; see also Kleinman 1997:318–319). This antinomy, however, establishes the condition for obfuscating equivalences: mental illness may appear primarily as an index of political crisis, while political crisis takes the social form of mental illness. These equivalences account, in my view, for a tendency in this literature to diagnose medicalization itself as a symptom of structural inequalities and social dysfunction in modern states, rather than viewing mental illness (such as antisocial personality disorder among Gypsy outpatients in Thrace) as a failure of the distinction between political and medical causes and effects.

23. By 2003, two small centers for the treatment of substance abuse (KYTHEA and OKANA) had been founded in Alexandroupolis, but both were private. Although they took some patients on referral from state services, they were under no obligation to treat such patients, and their acceptance into treatment programs depended on complex negotiations for coverage with semiprivate insurance organizations and/or welfare. At that time, very few patients had been referred to these centers from the hospital. The inpatient clinic at the hospital regularly housed, among 20–25 short-term patients, several alcoholics in withdrawal; high rates of alcoholism persisted in Thrace in the absence of adequate recovery programs or self-help groups such as Alcoholics Anonymous. Although therapists at the hospital clinic recognized the abuse of alcohol and other substances as clinical problems, they did not offer specialized treatment for addiction. The "controlled starvation" regime proposed for Feyza was typical of therapeutic approaches in this setting.

*Editors Note*: *Cultural Anthropology* has published other essays on the intersections of humanitarian ethics, expert discourse, and national policy; see Didier Fassin's essay on the increasing involvement of psychologists in the study of traumas, "The Humanitarian Politics of Testimony: Subjectification through Trauma in the Israeli-Palestinian Conflict" (2008), as well as his "Compassion and Repression: The Moral Economy of Immigration Policies in France" (2005). *Cultural Anthropology* has also published other essays on the subject of addiction, including Angela Garcia's "The Elegiac Addict" (2008) and Nancy Campbell and Susan Shaw's essay "Incitements to Discourse" (2008) on state-funded drug ethnography and public health projects.

## REFERENCES CITED

American Psychiatric Association (APA)
1980 Diagnostic and Statistical Manual of Mental Disorders. 3rd edition. Washington, DC: APA.
2000 Diagnostic and Statistical Manual of Mental Disorders. 4th edition, text revision. Washington, DC: APA.

Behague, Dominique Pareja
2008 Psychiatry and Military Conscription in Brazil: The Search for Opportunity and Institutionalized Therapy. Culture, Medicine, and Psychiatry 32:194–218.

Berlant, Lauren
2000 Intimacy: A Special Issue. *In* Intimacy. L. Berlant, ed. Pp. 1–8. Chicago: University of Chicago Press.

Blue, Amy Victoria
1991 Culture, *Nevra,* and Institution: The Making of Greek Professional Ethnopsychiatry. Ph.D. dissertation, Department of Anthropology, Case Western Reserve University.
Breggin, Peter R.
1997 2008 Brain Disabling Treatments in Psychiatry: Drugs, Electroshock, and the Psychopharmaceutical Complex. 2nd edition. New York: Springer.
Brown, Wendy
1995 States of Injury: Power and Freedom in Late Modernity. Princeton: Princeton University Press.
2001 Politics Out of History. Princeton: Princeton University Press.
Butler, Judith
1993 Bodies That Matter: On the Discursive Limits of "Sex." New York: Routledge.
Campbell, Nancy D., and Susan J. Shaw
2009 Incitements to Discourse: Illicit Drugs, Harm Reduction, and the Production of Ethnographic Subjects. Cultural Anthropology 23(4):688–717.
Castel, Robert
1981 La Gestion des risques: De l'anti-psychiatrie à l'après-psychanalyse. Paris: Éditions de Minuit.
Castel, Robert, Françoise Castel, and Anne Lovell
1982 [1979] The Psychiatric Society. A. Goldhammer, trans. New York: Columbia University Press.
Clare, Anthony
2003 [1979] Psychiatry in Dissent: Controversial Issues in Thought and Practice. New York: Routledge.
Cleckley, Hervey
1941 The Mask of Sanity: An Attempt to Reinterpret the So-Called Psychopathic Personality. St. Louis: C. V. Mosby.
Cohen, Stan
1985 Visions of Social Control. Cambridge: Polity.
Crapanzano, Vincent
1992 Hermes' Dilemma and Hamlet's Desire: On the Epistemology of Interpretation. Cambridge, MA: Harvard University Press.
Das, Veena
1995 Critical Events: An Anthropological Perspective on Contemporary India. Delhi: Oxford University Press.
Davis, Elizabeth Anne
In press Bad Souls (Κακόψυχοι): Madness and Responsibility in Greek Thrace. Durham, NC: Duke University Press.
Demetriou, Olga
2004 Prioritizing "Ethnicities": The Uncertainty of Pomak-ness in the Urban Greek Rhodoppe. Ethnic and Racial Studies 27(1):95–119.
Dreyfus, Hubert, and Paul Rabinow, eds.
1982 Michel Foucault: Beyond Structuralism and Hermeneutics. 2nd edition. Chicago: University of Chicago Press.
Ewing, Katherine Pratt, and Marguerite Hoyler
2008 Being Muslim and American: South Asian Muslim Youth and the War on Terror. *In* Being and Belonging: Muslims in the U.S. since 9/11. K. P Ewing, ed. Pp. 80–104. New York: Russell Sage.
Fassin, Didier
2005 Compassion and Repression: The Moral Economy of Immigration Policies in France. Cultural Anthropology 20(3):362–387.
2008 The Humanitarian Politics of Testimony: Subjectification through Trauma in the Israeli-Palestinian Conflict. Cultural Anthropology 23(3):531–558.

Fassin, Didier, and Estelle d'Halluin
2005 The Truth from the Body: Medical Certificates as Ultimate Evidence for Asylum Seekers. American Anthropologist 107(4):597–608.
2007 Critical Evidence: The Politics of Trauma in French Asylum Policies. Ethos 35(3):300–329.
Faubion, James D.
2001 Toward an Anthropology of Ethics: Foucault and the Pedagogies of Autopoiesis. Representations 74:83–104.
Feighner, J. P., E. Robins, S. B. Guze, R. A. Woodruff, G. Winokur, and R. Munoz
1972 Diagnostic Criteria for Use in Psychiatric Research. Archives of General Psychiatry 26:57–63.
Foucault, Michel
1988 [1984] The History of Sexuality, Volume 3: The Care of the Self. R. Hurley, trans. New York: Vintage.
1991 [1978] Governmentality. *In* The Foucault Effect: Studies in Governmentality. G. Burchell, C. Gordon, and P. Miller, eds. Chicago: University of Chicago Press.
1997 [1984] The Ethics of the Concern for Self as a Practice of Freedom. *In* The Essential Works of Michel Foucault, vol. 1: Ethics, Subjectivity, and Truth. P. Rabinow, ed. Pp. 281–301. New York: New Press.
1998 [1967] Nietzsche, Marx, Freud. *In* The Essential Works of Michel Foucault, vol. 2: Aesthetics, Method, and Epistemology. J. Faubion, ed. Pp. 269–278. New York: New Press.
2003 [1975] Society Must Be Defended: Lectures at the Collège de France, 1975–1976. D. Macey, trans. New York: Picador.
2006 [1973–74] Psychiatric Power: Lectures at the Collège de France, 1973–74. J. Lagrange, eds. G. Burchell, trans. New York: Palgrave-Macmillan.
Gal, Susan
1991 Between Speech and Silence: The Problematics of Research on Language and Gender. *In* Gender at the Crossroads of Knowledge: Feminist Anthropology in the Postmodern Era. M. di Leonardo, ed. Pp. 175–203. Berkeley: University of California Press.
Garcia, Angela
2008 The Elegiac Addict: History, Chronicity, and the Melancholic Subject. Cultural Anthropology 23(4):718–746.
Gondles, James A., Jr.
1999 The Criminal Mind: A Challenge to Corrections. Corrections Today 61(1):6.
Hacking, Ian
1999 The Social Construction of What? Cambridge, MA: Harvard University Press.
Hart, Laurie Kain
1999 Culture, Civilization, and Demarcation at the Northwest Borders of Greece. American Ethnologist 26(1):196–220.
Healey, David
1997 The Anti-Depressant Era. Cambridge, MA: Harvard University Press.
2002 The Creation of Psychopharmacology. Cambridge, MA: Harvard University Press.
Herzfeld, Michael
1991 Silence, Submission, and Subversion: Toward a Poetics of Womanhood. *In* Contested Identities: Gender and Kinship in Modern Greece. P. Loizos and E. Papataxiarchis, eds. Pp. 79–97. Princeton: Princeton University Press.
1992 The Social Production of Indifference: Exploring the Symbolic Roots of Western Bureaucracy. Chicago: University of Chicago Press.

Ierodiakonou, Charalambos
1983a Mobile Unit in the Framework of a Rural Community Mental Health Center: Experiences and Results of the First Year. ιατρική 44:225–232. [Greek]
1983b Primary Care and Mental Health Services in Greece. Publication ICP/MNH 059(1)/9, World Health Organization Regional Office for Europe, Working Group on First Contact Mental Health Care, Tampere, April 25–29.
1983c Psychotherapeutic Possibilities in a Rural Community Mental Health Center in Greece. American Journal of Psychotherapy 37(4):544–551.
Ierodiakonou, Charalambos, with A. Iakovidis and K. Bikos
1983 Mobile Mental Health Units Affiliated with a Provincial General Hospital: Comparison of First and Third 6-Month Periods of Operation. Materia Medica Greca 11(6):518–522. [Greek]
Kleinman, Arthur
1995 Writing at the Margin: Discourse between Anthropology and Medicine. Berkeley: University of California Press.
1997 "Everything That Really Matters": Social Suffering, Subjectivity, and the Remaking of Human Experience in a Disordering World. Harvard Theological Review 90(3):315–335.
Lacan, Jacques
1978 [1973] Of the Subject of Certainty. *In* Seminar XI: The Four Fundamental Concepts of Psycho-Analysis. J.–A. Miller, ed. A. Sheridan, trans. Pp. 29–41. New York: W. W. Norton.
1992 [1959] Seminar VII: The Ethics of Psychoanalysis. D. Porter, trans. New York: W. W. Norton.
Lakoff, Andrew
2005 Pharmaceutical Reason: Knowledge and Value in Global Psychiatry. Cambridge: Cambridge University Press.
Lester, Rebecca J.
2004 Commentary: Eating Disorders and the Problem of 'Culture' in Acculturation. Culture, Medicine and Psychiatry 28:607–615.
2009 Brokering Authenticity: Borderline Personality Disorder and the Ethics of Care in an American Eating Disorder Clinic. Current Anthropology 50(3):281–302.
Lewis, Bradley
2006 Moving Beyond Prozac, DSM, and the New Psychiatry: The Birth of Postpsychiatry. Ann Arbor: University of Michigan Press.
Livaditis, Miltos
2003 Culture and Psychiatry: Anthropological and Social Dimensions of Psychopathological Phenomena. Athens: Editions Papazisi. [Greek]
Livaditis, Miltos, and Theophanis Vorvolakos
N.d. Gypsies and Prejudice. Unpublished MS, Department of Psychiatry, University of Thrace.
Low, Setha M.
1985 Culturally Interpreted Symptoms or Culture-Bound Syndromes: A Cross-Cultural Review of Nerves. Social Science and Medicine 21:187–196.
Luhrmann, Tanya
2000 Of Two Minds: The Growing Disorder in American Psychiatry. New York: Knopf.
Madianos, Michalis
1994 Psychiatric Reform and Its Development: From Theory to Practice. Athens: Ellinika Grammata. [Greek]
Mahmood, Saba
2005 Politics of Piety: The Islamic Revival and the Feminist Subject. Princeton: Princeton University Press.

Mavreas, Venetsanos G.
1987 Greece: The Transition to Community Care. International Journal of Social Psychiatry 33:154–164.
Nietzsche, Friedrich
1974 [1887] The Gay Science—With a Prelude in Rhymes and an Appendix of Songs. W. Kaufmann, ed. and trans. New York: Vintage.
Petryna, Adriana, Andrew Lakoff, and Arthur Kleinman, eds.
2006 Global Pharmaceuticals: Ethics, Markets, Practices. Durham, NC: Duke University Press.
Rabinow, Paul
1997 Introduction. *In* The Essential Works of Foucault (1954–1984), vol. 1: Ethics, Subjectivity and Truth. P. Rabinow, ed. Pp. xi–xlv. New York: New Press.
Rhodes, Lorna A.
2004 Total Confinement: Madness and Reason in the Maximum Security Prison. Berkeley: University of California Press.
Rose, Nikolas
1989 Governing the Soul: The Shaping of the Private Self. London: Free Association.
1996 Inventing Our Selves: Psychology, Power, and Personhood. Cambridge: Cambridge University Press.
1999 Powers of Freedom: Reframing Political Thought. Cambridge: Cambridge University Press.
2006 The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century. Princeton: Princeton University Press.
Rutherford, M. J., J. S. Cacciola, and A. I. Alterman
1999 Antisocial Personality Disorder and Psychopathy in Cocaine-Dependent Women. American Journal of Psychiatry 156(6):849–856.
Sakellaropoulos, Panayiotis, ed.
1995 Elements of Social Psychiatry and Its *Implementation* in Greece, vols. 1–2. Athens: Editions Papazisi. [Greek]
Scheper-Hughes, Nancy, and Anne Lovell, eds.
1987 Psychiatry Inside-Out: Selected Writings of Franco Basaglia. A. Lovell and T. Shtob, trans. New York: Columbia University Press.
Spivak, Gayatri Chakravorty
1994 Responsibility. boundary 2 21(3):19–64.
1999 A Critique of Postcolonial Reason: Toward a History of the Vanishing Present. Cambridge, MA: Harvard University Press.
Szasz, Thomas S.
1974 [1961] The Myth of Mental Illness: Foundations of a Theory of Personal Conduct. Rev. edition. New York: Perennial–HarperCollins.
1979 The Lying Truths of Psychiatry. Journal of Libertarian Studies 3:121–139.
Ticktin, Miriam
2005 Policing and Humanitarianism in France: Immigration and the Turn to Law as State of Exception. Interventions 7(3):347–368.
Velpry, Livia
2008 The Patient's View: Issues of Theory and Practice. Culture, Medicine and Psychiatry 32:238–258.
World Health Organization (WHO)
1992 International Statistical Classification of Diseases and Related Health Problems—Mental and Behavioural Disorders. 10th edition, rev. Geneva: WHO.