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A Conversation with Paul Brodwin

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By Talia Gordon



[Paul Brodwin](#) is Professor of Anthropology at the University of Wisconsin-Milwaukee and Adjunct Professor of Bioethics and Medical Humanities at the Medical College of Wisconsin. He is the author of [Medicine and Morality in Haiti: The Contest for Healing Power](#) (Cambridge U Press, 1996), editor of [Biotechnology and Culture: Bodies, Anxieties, Ethics](#) (Indiana U Press, 2000) and coeditor of [Pain as Human Experience: Anthropological Perspectives](#) (U California Press, 1992).

Below is a conversation conducted over email between Talia Gordon and Paul Brodwin about his new book, [Everyday Ethics: Voices from the Front Line of Community Psychiatry](#) (U California Press, 2013), in which he explores the ethically charged and often deeply challenging experiences of mental health clinicians working with marginalized individuals in a community psychiatric system. Through his ethnographic account, Brodwin demonstrates the tensions and rifts in the on-the-ground enactment of Assertive Community Treatment (ACT) and, ultimately, offers insight into the everyday practices of caring for those most vulnerable among us. The Introduction to Everyday Ethics is available [here](#).

Talia Gordon (TG): Although there has been a fair amount of ethnographic research on community psychiatry, less attention has been given to the experiences at the “front line” of care provision. Your research explores the everyday experiences of mental health clinicians working within the Assertive Community Treatment (ACT) system and examines the ethical and moral challenges they face in therapeutic practice. How does your ethnography of Eastside Services shift the kinds of questions anthropologists have asked about community psychiatry and what lines of inquiry do you hope to open up with your research?

Paul Brodwin (PB): In planning this research, I decided to focus on the experience of providers, not service users. I also wanted to listen closely to providers with the most intimate and extensive front line experience. The field of community psychiatry is changing rapidly even now, and the ACT model (devised in the late 1970s) was decades ahead of its time. In this model, one psychiatrist oversees the work of many social workers/case managers. In fact, psychiatrists are expensive to hire, and very few of them enter the unglamorous field of community work. In the first week of fieldwork, I learned that the psychiatrist may see a given individual for 20 minutes every two months. Case managers, by contrast, may spend one hour a day, five days a week, with the same person. Sadly, the education of case managers (at most a master’s degree) ill-prepares them for the challenges of working with poor, socially marginalized and episodically quite ill individuals. In such work conditions, frustrations and ethical anxieties always lie close to the surface.

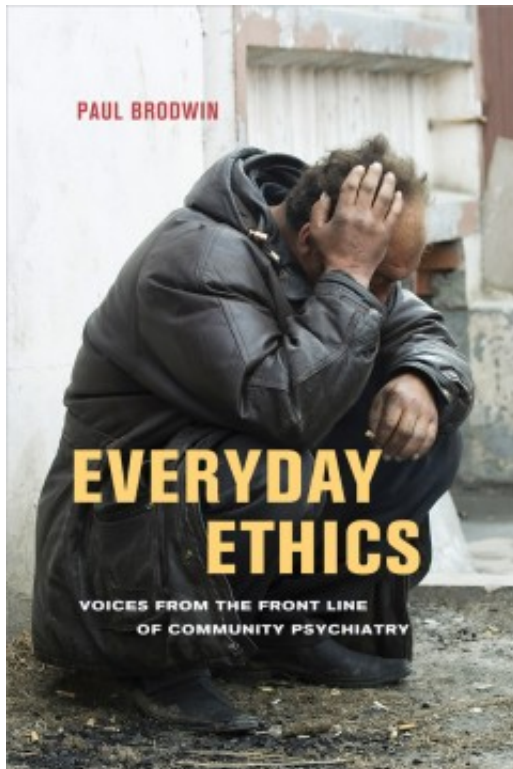
My methodological choice was also dictated by considerations besides the ACT model. I was inspired by Charles Bosk’s focus on workers at the bottom of the medical hierarchy in [All God’s Mistakes: Genetic Counseling in a Pediatric Hospital](#). Bosk’s genetic counselors knew they had little prestige and that they were a “mop-up service” performing the “dirty work” handed to them by more powerful players in the hospital. Their low status gave them a critical distance from the official story – the pieties and rote justifications – that usually accompanies their work. Behind Bosk’s choice, of course, lies a whole sociological tradition stretching back to Everett Hughes’s commandment to humble the proud and elevate the humble. Although Bosk does not mention it, his approach also recalls Gramsci’s emphasis on organic intellectuals who stand at odds with the usual strategies of legitimation.

I do not subscribe in doctrinaire fashion to methodological programs derived from Bosk, Hughes or Gramsci. Nevertheless, centering my ethnography on clinicians with the least power, training and status makes

sense for two reasons. First, I suspect that community psychiatry in the United States participates in some of the same trends driving global mental health. In the “collaborative model” of global mental health, the professional chiefly trains and supervises community health workers, who actually deliver the services ([New England Journal of Medicine 2013; 369: 66-73 \[July 4\]](#)). My book describes the frustrations, ethical anxiety, and rapid turnover in lower-ranked front line providers in the US. Such problems may well afflict mental health services worldwide.

Second, my long-term project is to develop a fully ethnographic analysis of ethical sensibility in health care. The discipline of bioethics – its categories and conceptual models – permeates ordinary clinical routines as well as the ways that providers talk about their jobs. When I started fieldwork, I gambled that lower-ranked providers are less likely to mimic (or even consciously know) the formal bioethics justifications for their work. I was eager to capture people’s experience-near and indexical expressions, so I focused on people less exposed to (and perhaps less convinced by) the confident analyses and categories of psychiatric ethics. I hope my gamble paid off.

TG: Modes and experiences of power and control are key themes in your discussion of the institutional structure and therapeutic ethos of Eastside Services. You describe the Assertive Community Treatment model as “paternalist by design.” How is paternalism deployed and legitimated by clinicians in everyday practice? How do the “ethics of dependency” intervene in the prescribed approaches to case management set out by the ACT model?



PB: What are the pre-requisites for an ethnography of ethical sensibility? The first is to reclaim our vocabulary. Paternalism and dependency are key words in bioethics. Indeed, much of the impetus for that field in the 1960s and 1970s came from defining and decrying paternalism. Feminist bioethics – such as Eve Kittay’s work that continues to inspire me – fundamentally aims at revalorizing dependency. These words have an aura that accompanies their use in ethnographic description and analysis. We can never cleanse words like paternalism and dependency from the meanings they have acquired in bioethics, nor should we try. But we must use the words carefully and not let normative judgments slip in unacknowledged.

In community psychiatry as in many other branches of health care, ethical considerations are engineered into the very tools and mandatory routines of work. In this regard, I remain hugely indebted to the work of Annemarie Mol and Jeannette Pols. I will therefore dissent a bit from the phrasing of your question. I would not say that clinicians “deploy paternalism,” for that phrasing sidesteps the most important questions. To what extent is paternalism inherent in the very blueprint of ACT? To what extent do clinicians self-consciously justify their power over clients as the benevolent protection of weaker individuals? In other words, what does “paternalism” look like from the perspective of the presumably paternalist clinician? What forms do “paternalism” or “dependency” take in the short-term trains of action at the clinical front line, and in the imagination of policy makers or designers of new schemes of service delivery? Asking those questions allows us to hone our distinctively anthropological vision onto areas of human life usually left to bioethics.

TG: You write that “stability is a key term for the ethos of work” and that, despite articulations of “progress” as the desired objective for those in Assertive Community Treatment programs, stability is often seen by case managers as the only possible goal for their clients. How do case managers negotiate or reconcile the tension between adherence to an idealized “trajectory of progress” and the everyday practice of maintaining clients’ stability?

PB: In today’s world of manualized mental health care, paperwork protocols and web-based checklists govern all the major clinical gestures (assessment, diagnosis, devising a plan for treatment, intervening via different treatment modalities, evaluating therapeutic progress, etc.). The development has many causes, including changes in the culture of psychiatry and reimbursement schemes. Not surprisingly, so-called “checkbox psychiatry” is enormously frustrating and even insulting to psychiatrists (whose voices animate the wonderful recent book [Shattering Culture: American Medicine Responds to Cultural Diversity](#), edited by Mary-Jo DelVecchio Good and her colleagues).

Because of this development, the right strategy for analyzing my fieldnotes rapidly became clear to me. To oversimplify, I wrote this book by comparing what the manual says and what clinicians actually did on a daily basis. The work of an ACT agency is structured by innumerable explicit guidelines and rationales, such as the template for treatment plans. Staff members must use them, but given their rigidity and “one size fits all” quality, staff members must also ignore, reformulate, or bend them to fit the realities of the job. In the end, they can become jaundiced about the rhetoric of progress and the metrics demanded by the written treatment plan (e.g., “in the next six months, client must formulate one relevant goal for socialization and attend at least two meetings of group therapy for his alcohol use, as indicated by weekly progress notes”). The opposition between “stability” (a minimal goal of simply not relapsing and not trying to evade treatment) and “progress” emerges from this quagmire of rigid paperwork and deskilled and demoralized mental health workers.

TG: Many of the clinicians and case managers at Eastside Services arrive with only minimal training and a limited skill set for working with clients. How is expert knowledge and clinical intuition constructed and embodied on the front line? How do the personal ethical and moral registers of individuals working at Eastside Services shape the development of strategies and tactics of care?

PB: This question resonates with one of my own lingering doubts about my research. To be blunt: I was not sure how, and how much, to delve into people’s “personal ethical and moral register.” In planning the research, I drew guidance from the sociology of the professions (via Bosk

and Good, for example) and, indirectly, practice theory. For that reason I chose not to burrow deeply into the personal roots of people's ethical sensibility. I could easily have made another choice and drawn my guidance from the recent exciting work about morality in psychological anthropology (see Jarrett Zigon's overview [Morality: An Anthropological Perspective](#)). Intellectual choices have consequences, and I ended up without much information about the deep biographical or subjective dimensions of people's everyday ethics.

Put another way: Carrying out an ethnography of ethics continually poses the question, why do people ferret out this issue, but not that one, as raising ethical stakes? Why do they puzzle over the rightness or wrongness of this particular clinical maneuver, but pass over that maneuver in silence? I still insist that this is an enormously productive question for fieldwork. I decided, however, to answer the question on the basis of people's occupational identity and training, the specific texture of work, the types of embodied presence and encounter that the job demands, and their idealized self-image as mental health professionals. Plumbing the personal ethical register of particular individuals (their religious commitments, for example, or experience with family members with mental illness) would demand a different orientation from the start.

TG: In chapter five, you describe the development of outpatient commitment in the United States in the 1980s, in the wake of deinstitutionalization. How has the shift to outpatient commitment and the Assertive Community Treatment model affected the practice of care on the parts of clinicians and case managers? How are ethical considerations reflected in the use of commitment as a therapeutic tool? Finally, what is the role of fieldwork and ethnography in opening up space for critical conversations about ethics among those working the front lines of community psychiatry? What changes do you imagine for the practices of care?

PB: Over the past 50 years, lawyers, psychiatric survivors/advocates, philosophers, and psychiatrists have thoroughly mapped out all the possible positions about commitment. As an ethnographer in this project, I chose neither to mediate among these (sometimes incommensurable) claims nor to adopt a single ethical standpoint as my own. Instead I traced the chain of mediations from yesterday's explicit debates and arguments to the fluid practical logic and literal pieces of paperwork by which today's clinicians orchestrate commitment. I again emphasize again the way that ethical considerations get embedded in the tools for work. I therefore query the embedded ethics of commitment, the bits and pieces of formal arguments that reappear in staff meetings, and the genealogy of the mental health court. I query the divisions between people even on the same treatment team over the legitimacy of forced treatment. I follow the

way case managers effectively reinvent (or half-remember) ethical rhetoric about patient rights and the obligation to treat. Viewed through the lens of practice theory (enacted through in-the-trenches ethnography), the “ethics of commitment” is an assemblage composed of wildly disparate elements. It is unsystematic and half-conscious, and yet people rely on it address their undeniable anxiety over their disproportionate power.

Finally, I have presented my research to many practitioners in the field of community psychiatry, via in-service presentations to local agencies, presentations at national meetings of case managers, and several grand rounds talks in departments of psychiatry and of bioethics. To be frank, I am still trying to break through the techno-rational approach and the therapeutic pragmatism of such audiences. In formal presentations, these audiences look for usable research results. My goals are quite different. I wish to inaugurate reflection on the human difficulties of care in ACT-like programs. Such reflections could lead to innovations such as more time for staff members to process the trauma of their work, or better ways to mediate ethical impasses. As I currently serve on several local mental health advocacy groups, I introduce these ideas at the grass roots level.

Talia Gordon is a graduate student in the medical anthropology program at Wayne State University.

Further resources:

- [Paul Brodwin's faculty website](#)
- [Paul Brodwin's academia.edu website \(with many articles available\)](#)
- “[Introduction: The Terrain of Everyday Ethics](#),” *Everyday Ethics: Voices from the Front Line of Community Psychiatry* (U California Press, 2013).
- “[Futility in the Practice of Community Psychiatry](#).” *Medical Anthropology Quarterly*, 25(2), 2011: 189-208.
“[The Assemblage of Compliance in Psychiatric Case Management](#).” *Anthropology and Medicine*, 17(2), 2010: 129-143
“[The Coproduction of Moral Discourse in U.S. Community Psychiatry](#).” *Medical Anthropology Quarterly*, 22(2), 2008: 127-147.

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