

Pharmaceutical Self

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Introduction

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This volume addresses a critical contemporary issue, that is, the world-wide proliferation of pharmaceutical use. The purpose of this book is to analyze the nexus of culture and psychopharmacology in a globalizing world. The SAR seminar expanded on an invited executive session that I organized and chaired for the 104th meeting of the American Anthropological Association in Washington, DC in December 2005 entitled “Globalization and Psychopharmacology: Interrogating the Historical Moment of Discourse on Chemistry, Magic, and Science.” The session examined the blurred conjunction of magic, science, and religion with respect to pharmaceutical markets and global capitalism, on the one hand, and culture and lived experience of pharmacological agents, on the other. This seemed timely given that global markets have recently moved to discursively regulate subjectivities of deficiency, excess, and desire. In Malinowski’s (1954, 35) terms, disputes surrounding such moves are waged partially over the problem of how to reduce a “complex and unwieldy bit of reality into a simple and handy form.” Thus we observe culturally curious public health slogans such as “Better Living through Chemistry” and “A Flaw in Chemistry, Not Character” in America or “Defeat Depression, Spread Happiness” in India. Multivocal symbolizations of pharmaceuticals such as “magic bullets,” “awakenings,” “placebo,” “God’s miracle,” “happy

pills,” “cure,” or the scientific foundation for recent “evidence-based” medical practice seem to constitute components of a transformative magic in the form of science and almost with the aura of religion.¹ Such discourse has unsurprisingly generated disputes surrounding premodern polities and modern nation-states/bodies, rationality and risk-taking, uncertainty, and what I think of as “scientific fundamentalism” (Jenkins 2005).

TACTICAL QUESTIONS FOR THE ANTHROPOLOGY OF PHARMACEUTICALS

At the seminar I charged the group with addressing a host of questions I formulated concerning the increasingly widespread distribution of psychopharmacological drugs worldwide: How are culturally constituted selves transformed by regular ingestion of these drugs—for therapeutic, nontherapeutic, or recreational reasons; whether to alleviate suffering or enhance performance; whether awake or asleep? To what extent are *Homo sapiens* transforming themselves into pharmaceutical selves on a scale previously unknown? Does the meaning of being human increasingly come to mean not only *oriented* to drugs but also *produced* and *regulated* by them? From the standpoint of cultural phenomenology, does this reshape human “being”? How are cultures, societies, and nation-states transformed by sizeable proportions of the population regularly ingesting psychopharmaceutical compounds? Are such “biological citizens” (Petryna 2002) more socially engaged and economically productive, on the one hand, or detached and politically indifferent, on the other? Do such drugs alleviate personal and social suffering that is otherwise overwhelming, or do they merely mask and dislocate the source of such suffering and impede personal and institutional action that could more broadly transform disordered social and biological conditions? How do we differentiate between “good” or “bad” drugs given historical and sociopolitical shifts in the moral economy in which they are produced? Given the power of recognizing and defining what “counts” as effects of psychopharmacological drugs, whose accounts and language do we advantage in such accountings? Finally, how does unequal distribution and access to these drugs reproduce social inequalities in health and subjective states of suffering?

To be sure, each of these questions is intricate, and the only anthropologically valid response can come from cautious, nuanced approaches to particular human problems in particular human contexts. On the one hand, who, seeing a man feeling suicidal from overwhelming voices, would not want to offer a medication that could alleviate such suffering? Who, sitting with a woman beaten and raped by military troops, would deny her

some measure of relief from the pain she finds unendurable? On the other hand, what governmental bodies or nation-states should authorize antidepressant medications while denying other potentially effective treatments (such as women's collective organizations, individual/group psychotherapy, or rehabilitation)? What is the role of nation-states in regulating and providing public health awareness of helpful and safe compounds or, conversely, harmful, addictive, or life-threatening drugs? Which bodies determine this matter, and what is their relevance under the sway of neoliberal forces in global markets? In light of such considerations, I intend this volume as an anthropological contribution to the study of pharmaceuticals that is tone-deaf neither to human suffering nor the biological realities (Lin, Smith, and Ortiz 2001) of such affliction even though in this collection we focus on social, cultural, and political analyses of the problem. Analysis of particular issues is approached from the vantage points of subjective experience as well as global processes of production and circulation, agreeing with Sherry Ortner (2006) that discursive analysis may not justifiably bid farewell to the experiencing subject and with Jonathan Friedman (1994) that a global perspective cannot be achieved by lobotomizing experience from the cultural realm.

GEOGRAPHIES OF PHARMACOLOGICAL CIRCULATION AND CONVERSION

The extent of psychopharmacological use in the United States may be as high as 25 percent of the adult population. People are taking psychiatric drugs today more than ever throughout North America and Europe as well as parts of Asia and countries of the global South, reflecting the way treatment has been affected by the global dominance of biomedicine, sometimes in seemingly incongruous ways. The seminar participants considered, for example, what it means to dispense three days' worth of tranquilizers to a person living in a postconflict society who has lost everything in a tsunami and what it means to take medication in the poorest sectors of Brazil in the wake of social abandonment by one's family for ceasing to be economically productive.

Contributors to this volume draw on their recent work from five continents. They deploy a variety of strategies to explore the nexus of the subjective experience of psychoactive pharmaceuticals and global processes that shape psychopharmaceutical consumption. In formulating this problematic, I argued that a fusion is needed because studies of global processes that address the problem of psychopharmacology often do not consider the experience of medications for those who take them. Likewise, the limited

set of studies of the phenomenology of medication experience has thus far not given due consideration to the economic and political dimensions of the problem (Semar 2000). Uniting these heretofore separate areas of inquiry, several key issues surrounding this historically transformative global phenomenon require anthropological consideration that is simultaneously more focused and more broad-ranging.

Concerning psychopharmacology and globalizing processes, it is important to bear in mind that while biomedicine has been reasonably labeled hegemonic—and the clout of Big Pharma does not appear to be in decline—the American influence on global biomedicine in the future may shrink commensurate with a decline of economic and political power. While the extent of that process remains to be seen in coming decades, it is important in global anthropology that “while there is surely a tendency towards a local encompassment of the global in cultural terms, there is at the same time an encompassment of the local by the global in material terms” (Friedman 1994, 12). The reciprocal connections between local and global are key to what over time can be specified for an anthropology of psychotropic drugs. As for other social processes and products, the worldwide circulation of psychiatric knowledge and psychotropic drugs cannot usefully be portrayed anthropologically as entirely negative any more than it can be cast as entirely positive in relation to mental health. Gregory Pappas and colleagues (2003, 94) make this point generally with respect to health and human potential and suggest that globalizing processes need not be conceived primarily in terms of the erosion of local worlds, but also as “formative, creating new institutions and boundaries.”

CONCEPTUAL COORDINATES: PHARMACEUTICAL SELF AND PHARMACEUTICAL IMAGINARY

In this volume we are concerned with the practices and significations that shape the *pharmaceutical self*, understood in terms of the subjective experience of psychopharmaceuticals, and the contemporary *pharmaceutical imaginary*, understood in terms of the global shaping of consumption (Jenkins 2006). To be precise, if, following Hallowell (1955), we understand the self as the sum of processes by which the subject is oriented in the world and toward other people, then the pharmaceutical self is that aspect of self oriented by and toward pharmaceutical drugs (Jenkins, this volume). If, following Castoriadis (1987), we understand the imaginary as that dimension of culture oriented toward conceivable possibilities for human life, then the pharmaceutical imaginary is that region of the imaginary in which pharmaceuticals play an increasingly critical role (see Jenkins, this

volume). At issue is the question of how regular consumption of psychopharmaceuticals shapes the self and conceptions of agency in postcapitalist labor markets. In this regard, I argue that the extent to which we are all pharmaceutical selves has yet to be fully appreciated (Jenkins 2005). Also central is the problem of how pharmaceutical companies and their emissaries shape patterns of medical practice, diagnosis, and prescription. Finally, this volume is intended as a contribution to the problem of how “pharmaceutical” bodies are conceptualized in relation to power, dependency, or transformation.

Concerted anthropological inquiry into the meaning and use of pharmaceuticals was set into motion by Sjaak Van der Geest (1984) and Susan Whyte (Van der Geest and Whyte 1988). Their work probed the interest in recent decades “in Western culture and its products (such that) biomedicine came to be seen as a cultural phenomenon worthy of study. As the ‘exotic bias’ diminished, more anthropologists from both the North and the South did fieldwork in their own societies on aspects of popular culture and everyday life. Capsules, tablets and hypodermic syringes were no longer taken for granted and ignored; they could be defamiliarized (denaturalized) and analysed in terms of the meanings people attributed to them in [a variety of] settings” (Whyte, Van der Geest, and Hardon 2002, 13). With the publication of “The Anthropology of Pharmaceuticals” (Van der Geest, Whyte, and Hardon 1996) and *The Social Lives of Medicines* (Whyte, Van der Geest, and Hardon 2002), the anthropology of materia medica was launched not only as the study of the material “things” of medicine, but also as “things” with social lives in terms of pragmatic and purposeful uses, consequences, and symbolic mediums of exchange between people. Currently, medicines “with the most active social lives” and “vigorous commodity careers” (ibid., 3) are “commercially manufactured synthetic drugs produced by the pharmaceutical industry” (ibid., 14).

Whyte and colleagues call attention to pharmaceuticals, the materia medica of nearly every local society, both as a prime example of (the moving objects of) globalization and as a medium of intimacy insofar as “they are the most personal of material objects, swallowed, inserted into bodies, rubbed on by anxious mothers, used to express care and intimately empower the uncertain individual” (2002, 3–4). A key component of medicines, they argue, is their power to transform, although such transformations can be simultaneously healing and harmful given their noxious potential. While transformations target the body, these also have effects on minds, situations, and modes of understanding (2002, 4). While this corpus of work has been highly generative in anthropology as a thoroughgoing analysis of

biomedical and indigenous pharmaceuticals (Nichter and Vuckovic 1994), psychotropic drugs went largely unexamined (except as instances of non-compliance or resistance). However, a body of research more directly concerned with psychotropic medications as social phenomena from a variety of disciplinary standpoints has grown in recent years (Gardiner 1995; Comas-Diaz and Jacobsen 1995; Abiodun 1998; Breslau 2000; Cohen et al. 2001; Healy 2002; Kirmayer 2002; Ecks 2003; Oldani 2004; Schull 2006; Jain and Jadhav 2009).

Recent anthropological studies of psychopharmacology have examined sociocultural aspects of the circulation of drugs in a number of settings. Lakoff (2005, 7) has written on “pharmaceutical reason” to refer to psychiatric drug interventions that are prescribed with the intention of restoring normal cognition, affection, or volition. His work in Argentina following the financial crisis of 2001 showed that doctors’ prescription of selective serotonin reuptake inhibitors (SSRIs) was contingent neither on a diagnosis of depression nor a biological understanding of mental disorder. Drugs were prescribed for the alleviation of suffering caused by the social situation and as an aid to psychoanalytic process. Dumit (2002) provided a brief but significant identification of the new paradigm of health, illness, treatment, and normalcy in the United States that not only allows for the utilization of “drugs for life,” but also a logic that he believes generates the “Pharmaceutical Self.”² With this development pharmaceutical companies have capitalized on a paradigm of “inherent illness” that further internalizes pathology (2002, 124).

Other anthropological accounts have illustrated the economic, cultural, and political practices that contribute to the growth of the drug industry and how this expansion affects health practice (Martin 2007; Petryna, Lakoff, and Kleinman 2006) and the social shaping of what Rose (2006) recently referred to as the “neurochemical self.” Particularly generative theorizing of culture and medicine has been set forth by Mary-Jo Good (2001, 2007) in her formulation of the “biotechnical embrace” and “medical imaginary” that hold persuasive appeal for physicians and patients alike.

PHARMACEUTICAL PARADOXES OF LIVED EXPERIENCE

Ethnographic interviews and observations with persons who have long struggled with mental illness have led me to interpret their experience of pharmaceuticals as freighted with more than a few recurring paradoxes (Jenkins and Carpenter-Song 2005, 2008). First and foremost among the paradoxes is that even though they have experienced substantial

improvement of symptoms and duration of episodes, their experience is nonetheless colored by the frustration of “recovery *without* cure.” Second, for persons with long-term or recurrent mental illness, their daily lives are shaded by the ironic social experience of “stigma *despite* recovery.” Third, the pervasive cultural-clinical trope that a wide array of problems can reductively be defined as “a biochemical imbalance,” which, while no one’s “fault,” enjoins the neoliberal dictum of individual responsibility for one’s own condition even so. Fourth, taking psychotropic medications invariably causes “side effects” that are met with varying degrees of awareness or tolerance of insalubrious effects. For example, taking second generation or “atypical” antipsychotics (and many antidepressants) generally involves considerable weight gain and blunting of sexual desire such that persons must “choose” to be “crazy” or fat, sexless, and genderless. Finally, transnational pharmaceutical “management” of persons with troubled minds and situations proceeds apace despite tangible and complicated needs that require psychotherapeutic and community intercession for healing and social integration (Jenkins and Carpenter-Song 2005, 2008). Taken together, I am convinced that these paradoxical conditions of illness experience can ironically create madness and suffering for individuals and their kin.

The question of why and how it is that the experience and practice of pharmaceuticals is so distinctively laden with social and cultural conundrums was posed by one of the reviewers of this volume, who also wondered whether the answer may be related to pharmaceuticals’ place as an agent of globalization, reflecting paradoxes related to science and medicine and their claims on the universal. It is clear that considerably more work is required to determine both the source of these paradoxes and how they play out in different cultural settings. If the globalization of science and medicine assumes both universal application and uncomplicated reconfiguration of the self, does unpacking these paradoxes provide some purchase on a critique that might allow us to distinguish conditions under which pharmaceuticals spread following uniform trajectories or distinctive pathways? Such a critique could be applied to ambivalent and contradictory societal stances toward culturally defined abnormality in the form of mental disorder, on the one hand, and what can be termed hypernormality that is sought through pharmaceutical enhancement to achieve or exceed normality of functioning, on the other.³ Such a critique would also highlight the way in which pharmaceutical practice continuously reconfigures the self and thus draw attention to conceptual cracks in the notion of self, both in terms of what it might be and where it might be said to begin and end.

On a pragmatic level, these paradoxes may be amplified, suppressed, or refracted in the context of globalization not only by cultural differences in receptivity to the drugs but by uneven distribution and access to psychopharmaceutical agents. As a technology of and for society and self that presents the possibility for alleviating, controlling, or muting mental illness, programs that provide psychotropic medication are forms of both social control and treatment, culturally and morally judged to be legitimate practice.

CONTRIBUTIONS OF THIS VOLUME

My own contribution develops the theme that a pharmaceutical imaginary is operative in everyday life in global society, and that in practice we are all already pharmaceutical selves to a cultural extent we scarcely recognize. Within this framework I address the problem of how subjectivity in schizophrenia and schizoaffective illness is co-constituted by the experience of taking psychopharmacological drugs and by political economic forces that shape psychopharmacological consumption. As aforementioned, the intersection of personal experience and social forces has yet to be specified: studies of psychopharmaceuticals and globalizing institutional processes have generally not considered the experience of medications for those who take them; and thus far, the limited set of studies of medication experience has not given due consideration to the economic and political dimensions of the problem. I trace the current climate to the rise of government funding for psychiatric “services” research, aggressive marketing that expands the range of conditions targeted by psychotropic drugs, poorly controlled financial ties between psychiatrists and pharmaceutical companies, and the emergence of consumer groups advocating empowerment and personal choice. I then examine the pharmaceutical self and imaginary through the ethnography of two outpatient psychiatric clinics specializing in the treatment of psychosis. Bringing Ludwig Binswanger’s insights to bear, I identify existential dilemmas characteristic of the subjectivity of schizophrenia under the psychopharmaceutical regime and question the rhetorical impact on the imaginary of the metaphor of “biochemical imbalance” to account for schizophrenia.

In a novel application for this volume, Mary-Jo Good draws on the Parsonian theory of value to interpret the introduction of pharmaceuticals as a treatment for the sequelae of political violence in Aceh, Indonesia, following the peace agreement between Acehnese independence forces and the Indonesian government. She proposes that we consider pharmaceuticals as a “medium of exchange” alongside narratives of trauma for the

circulation of value in relation to humanitarian resources. In the context of high proportions of the population having suffered from exposure to violence and in consequence being symptomatic for depression, posttraumatic stress disorder (PTSD), and anxiety, she recounts an episode in which an international team visited a village that had been particularly strongly traumatized. The psychiatrist listened for five hours to trauma narratives, prescribing doses of psychopharmaceuticals corresponding to the severity of the reported suffering and symptomatic response. As a result, a more focused intervention program was developed that dealt with a wide variety of cases by prescribing or not prescribing psychopharmaceuticals based on a distinction between whether individuals were in need of “mental health” treatment or only in need of “psychosocial” care. She concludes by posing the question of whether trauma narratives will maintain their currency for the self and how global psychiatry will contribute to development of an enduring and durable mental health care system in Aceh while continuing to engage remainders of violence that stimulate the psychopharmaceutical imaginary.

João Biehl reflects on the case of Catarina, a Brazilian woman abandoned by her family, institutionalized in a psychiatric facility, and subjected to an intense regime of pharmaceuticals. Her experience takes place against the background of a health system under transformation by neoliberal economics in which budget allocations for psychiatric care and hospitalization have dramatically decreased while allocations for psychotropic medications distributed without charge to the poorest strata have dramatically increased. In this circumstance, Catarina was cast as a particular kind of pharmaceutical self—a madwoman. This was cruelly ironic insofar as she in fact suffered from a genetically based chronic neurological degeneration and not a psychiatric disorder. Biehl frames his consideration of this case in terms of the philosophical reflections of Deleuze on drugs in contemporary life, with additional reference to Foucault, Freud, and Lacan. The pharmaceutical imaginary is reflected through the subjectivity of a person who struggles to maintain her integrity by writing in her journal, creating poetry, and even renaming herself as a form of drug. In Biehl’s analysis psychotropic medications are moral technologies that mediate social abandonment both through creating scientific truth values and through the chemical alterations they produce, serving as mechanisms by means of which poor families and local medical practitioners do the triage work of the state health system.

Stefan Ecks continues the conversation by engaging the question formulated for this volume regarding how psychopharmaceutical practice

troubles the boundaries of the self. Ecks is particularly concerned with how psychopharmaceuticals create and re-create social spaces. He shows this “sociotopic” effect in cases of impoverished psychiatric patients in Kolkata, India, placing the transformation of domestic and community space in relation to the transformation of clinical and economic space. In his argument globalization is the common ground of neoliberal capitalism and psychiatric deinstitutionalization, facilitated by the universal spread of psychopharmaceuticals. Ecks brings to bear Sloterdijk’s distinction among metaphysical, terrestrial, and communicative globalization, arguing that while psychiatric universalism is a form of metaphysical globalization, the spread of psychopharmaceuticals consummates psychiatry’s terrestrial globalization in a way that the colonial spread of asylums did not, “flexibilizing” space by transcending the walls of psychiatric institutions and definitively moving psychiatry into the fold of global capitalism. Evidence of communicative globalization is present in the international pharmaceutical market, with drugs produced not only in Europe and the United States but also in the global South, and a philosophy of universal availability predicated on the ideal of a homogenous global space of consumption. However, Ecks suggests that the interplay of impulses toward homogeneity and heterogeneity in globalized psychiatry is in fact best described in terms of Sloterdijk’s metaphor of social reality as a heap of “foam” composed of asymmetrically related bubbles rather than as a “network” of interconnected nodes.

Byron Good examines the pharmaceutical treatment of psychosis in Indonesia, a setting in which the use of psychotropics has advanced to a considerable degree while the conceptual apparatus of professional psychiatry is by no means dominant in defining the pharmaceutical imaginary within public culture. In reflecting on his own work, Good draws attention as well to the sometimes contradictory stance of an anthropological critic of biological reductionism in pharmaceutically oriented psychiatry and an advocate of improved global mental health services that include access to psychiatric medications. He describes the prominence of global pharmaceutical companies in professional meetings of Indonesian psychiatrists, sponsoring symposia on drug treatment and providing general financial support. Nevertheless, Indonesian psychiatry is not unidimensional, with a colonial Dutch heritage and contemporary interpretations from Muslim and Hindu standpoints and a younger generation concerned with social psychiatry, cognitive psychotherapy, homosexuality, and mental health sequelae of disaster and conflict. Psychotropic medication is often dispensed in complex polypharmaceutical cocktails on the model of Chinese

herbal prescriptions, with individual psychiatrists or hospitals becoming known for their characteristic blend of medications. He describes several cases of rapid onset psychoses that are quickly treated with medication that for some is suspended as soon as symptoms resolve, even if only temporarily, and for others is continued indefinitely, all without necessarily incorporating biomedical understandings of mental illness within the contours of the self.

To probe the pharmaceutical imaginary, Jonathan Metzl examines the expansion of the diagnosis of depression, the increase in prescriptions of SSRIs, and gender stereotypes. He compares the content of medical chart notations for depressed Euro-American men and women from 1985 to 2000, a period beginning just two years before the introduction of SSRIs. The charts reveal increasing medicalization corresponding to heightened gender stereotypy in the form of a significant increase in use of terms not present in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. To describe depressed women, these were terms pertaining to marriage, motherhood, menstruation or menopause, and a language of emotion. For depressed men, an increase occurred in references to work, aggression, and athletics, apparently related to recent advertisement of the illness as a “physical” condition. Metzl attributes these changes to the interactive effects of the pharmaceutical imaginary through direct-to-consumer advertising of pharmaceuticals such as SSRIs, mass media representations of mental illness and its effects, and clinical encounters, all in cultural and historical contexts.

Tanya Luhrmann vividly describes the bleak and often harrowing world of homeless mentally ill women in a Chicago neighborhood that has been what local media labeled a “psychiatric ghetto” following deinstitutionalization in the 1960s. She describes the importance among these women of the category “crazy” understood as socially caused, permanent once it begins, and avoidable for the strong and determined, as well as the category “strong” that includes not only aggressive toughness, but also disciplined self-respect. Being crazy is associated with being weak, unlikable, and on medication for psychosis. Other medications, for psychiatric problems such as PTSD and bipolar disorder as well as for physical conditions, are neither stigmatized nor invoked in an effort to insult others, and all of these stand in a complex relation to the ubiquitous street drugs. Spanning three groups of women who resist psychiatric diagnosis and medication, who accept them, and who are ambivalent, the cultural meanings of illness and medication have pragmatic consequences for the stability of everyday life.

Emily Martin examines the phenomenology and cultural meaning of insomnia in Euro-American culture, with emphasis on sleep-aid technologies including the physical type—mattresses—and the pharmaceutical type—sleeping pills. She offers a brief history of attitudes toward sleep and the development of sleep aids since premodern Europe, as well as of the scientific study of sleep since the 1950s. Sleep medicine took off during the second half of the twentieth century, and sleep disorders were included as part of psychiatric nosology in the 1987 *DSM-III*. By the first decade of the twenty-first century, the pharmaceutical industry had responded with a number of sleep-inducing drugs. Martin presents an analysis of use of these remedies based on material posted since 1998 on a popular web site forum by people suffering from insomnia, documenting their concerns over side effects, dependence, loss of sense of control, anxiety, and phobia about sleep. The average citizen as well as the sleep-challenged shift worker and the globe-trotting corporate traveler are challenged by the increasingly convoluted cultural meaning of “natural” sleep as an ideal in an increasingly globalized world. Faced with the paradox that sleep can only be attained by ceasing to focus on one’s desire for it, some struggle for the elusive good night’s sleep while others imagine training themselves to need less sleep. Here the pharmaceutical self engages the pharmaceutical imaginary on the most literal terrain—the possibility of dreaming.

A. Jamie Saris extends the application of this volume’s formulation of the pharmaceutical self and imaginary to the social world of heroin addicts. He frames the relation between psychopharmacological agents and addictive street drugs in contemporary global society explicitly as a problem of subjectivity that encompasses will, predisposition, and choice. The boundary between these apparently distinct categories becomes increasingly blurred as Saris traces the vicissitudes of the social life of drugs in terms of whether they are conceived as tools used for positive benefit by social agents or as insidious agents that deprive vulnerable individuals of agency. The market-driven value of “free choice” implicates the notion of will at a deep cultural level with implications for the chemical remedy of deficits to the chemical enhancement of normal states. He discusses the development of a model common to pharmacological treatment of addiction and major mental illness predicated on the existence of a predisposition to these conditions that, once activated, could ultimately only be compensated for but not cured, like insulin treatment for diabetes. In this context Saris reminds us that both recreational and psychopharmaceutical drugs have as much to do with social practices and cultural meanings as with pharmacological effects and subjective experiences. He suggests an

understanding of the place for drugs in contemporary subjectivity with a novel twist on Marxist ideas of reification and fetishism and an invocation of Bateson's cybernetics to understand the systemic character of relations among drug, mind-body, and society.

In sum, the seminar participants intend the book as a novel contribution to anthropology and allied fields concerned with psychopharmacological use in the twenty-first century. For anthropology, there are four ways in which this topic is of broad import. First, the problem of the creation of the pharmaceutical self (across an array of diverse contexts) bears on the most fundamental of anthropological questions, that is, what it means to be human. Second, the manner in which the pharmaceutical imaginary structures the experience of persons taking pharmaceuticals and necessarily reinstates the classical anthropological triumvirate of magic, science, and religion as categories within which pharmaceutical discourses are rhetorically and symbolically embedded. Third, this volume brings the body into the foreground for anthropological theorizing of the different kinds of and differently valued bodies (e.g., gendered) that participate in the configuration of pharmaceutical selves. Finally, the pervasiveness of the marketing and consumption of psychopharmaceuticals globally invites an ethnographic initiative to place these phenomena firmly in cultural and historical contexts. While this volume and other anthropological works make significant strides in extending the study of psychopharmacology beyond the confines of North America and Europe, much ethnographic work lies ahead to more fully flesh out the cultural, political, and economic forces that shape the lived experience and institutional processes of production and circulation of psychopharmacology worldwide.

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Notes

1. The study of psychopharmaceuticals is anthropologically useful to highlight the blurring of boundaries among analytic categories of magic, science, and religion. Healing has medical overtones and medical practice has religious overtones. Medical care includes "ritual" and healing practice includes "treatment." Appeal to the universal power of science is an appeal to faith in science similar to a religious attitude, while religious healing is sometimes targeted toward specific disorders or symptoms, which is similar to medicine's idea of specificity of treatment. Invoking the instance of religious

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practice among Catholics, “taking” Holy Communion from a priest in full vestments is parallel in structure to “taking” a medicine prescribed by a physician in a white coat.

2. From a slightly different perspective than I have adopted here, Dumit (2002, 126) defines the “pharmaceutical self” as “an individual whose everyday experience of his symptoms is as if he is on bad drugs, too little serotonin perhaps, and in need of good drugs, like an SSRI, to balance the bad one out and bring both biochemistry and symptoms to proper levels.” In my use of the term “pharmaceutical self” the emphasis is on orientation of the self regardless of whether the individual is symptomatic, while in Dumit’s formulation the emphasis is on inherent illness and the proper level of medication to be taken.

3. Here I refer to the use of pharmaceuticals to improve academic or work performance (e.g., stimulants prescribed for attention deficit hyperactivity disorder [ADHD]).