Postcolonialism and (Anti)psychiatry: On Hearing Voices and Ghostwriting

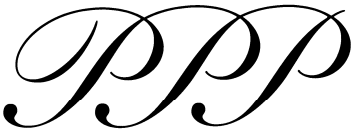
Sarah R. Kamens

Philosophy, Psychiatry, & Psychology, Online Advanced Publication, (Article)

Published by Johns Hopkins University Press
DOI: https://doi.org/10.1353/ppp.0.0018

Postcolonialism and (Anti)psychiatry
On Hearing Voices and Ghostwriting

Sarah R. Kamens



> I can only speculate about the echo of slavery and its impact upon how theories of race are disconnected from theories of mental illness.
> —Colin King (2007, p. 13)

> Haunting belongs to the structure of every hegemony.
> —Jacques Derrida (1993)

Abstract: This article offers some observations about the contemporary state of psychiatric discourse and discursive power by drawing on critical and postcolonial theories. In doing so, it is an attempt to demonstrate the crucial contemporary relevance and value of postcolonial scholarship for the clinical 'psy' professions, in particular psychiatry and clinical psychology. Focal examples are two discursive phenomena in which an addressee experiences the originator of communication as ethereal or absent: hearing voices and ghostwriting. Drawing on the works of Bhabha and Spivak—as well as Derrida and Foucault—I argue that a postcolonial lens reveals hierarchical assumptions within the psy discourses that subjugate content (messages) to the media (or mediums) by which they arrive. A critical analysis of these topics has the potential to inform the ways in which we think about experiences of social marginalization, stigma, discrimination, and oppression in the clinical encounter and broader mental health work. In addition, these topics highlight the thematic centrality of mourning, haunting, authorship, and voicelessness to contemporary psychiatric discourse and practice. Through these reflections, I also posit a means of reconsidering the relationship between psychiatry and its own critical or antipsychiatric specters.

Keywords: Clinical discourse, hauntology, psychosis, subaltern, subjugated knowledges, unhomely

Why might psychiatry need postcolonial theories? Critical discourse on psychiatry and clinical psychology—itself quite heterogeneous across the humanities and the so-called psy disciplines—has intermittently focused on the redress of power in clinical encounters, which are often constituted by an interaction between persons in very different life circumstances and with divergent positions in relation to authority and privilege, or social capital and capital itself. Postcolonial theories are relevant to this topic because they have emerged precisely in response to legacies of violence and appropriation, and they constitute explicit attempts to level these histories by recovering and elevating the voices of the oppressed. Despite increasing focus among mental health communities on issues of diversity, racism, and structural oppression, mainstream clinical scholarship has not broadly incorporated the postcolonial literature long dedicated to these focal topics. Active dialogue with postcolonial

theories has the potential not only to enhance the interdisciplinarity and intellectual diversity of psy scholarship, but also to provide tools for critical interventions in situations of structural oppression—as well as tools for recognizing oppression's anomalous, historical reverberations.

Postcolonial theory is, of course, a diverse and pluralistic set of scholarly arenas that address the sociocultural, political, psychological, and literary/artistic extensions of imperial events and history. The present article addresses only a fraction of this vast scholarly arena—ignoring what are arguably some of its most important facets. For example, it does not explore the crucial topic of how colonial rule affects its subjects psychologically (but would refer interested readers to the oeuvre of revolutionary psychiatrist Frantz Fanon [1952/2008], whose work painstakingly details the psychological fallout of internalized racism and what he called *epidermalization*, which happens when that internalized racism is expressed in relation to skin color). This article does not address the ways in which we might understand psychosocial cultures in (post)colonial societies, as many medical anthropologists, sociologists, and others have detailed (e.g., Good, Hyde, Pinto, & Good, 2008; Said, 1978). It also does not address the *mis*use of psychiatry for concretely political, colonial, and/or violent purposes, for example in prewar Germany (Documents on the "T-4" and "14f13" Programs, 1939–1945/2009), apartheid-era South Africa (Burke, 1985), and the former Soviet Union (van Voren, 2016). Instead, here I take much narrower focus on how postcolonial thought might apply specifically to consensual uses of contemporary psychiatry primarily in the Western or high-income world, and even more specifically to critical and reflexive discourse about psychiatry and its more ethereal affinities.

One final qualification: This article uses the word "psychiatry" metonymically, in reference to a broader family of psy disciplines that utilize psychiatric theory to guide their work. So the word "psychiatry" in this text also refers to discursive practices within clinical psychology (my own profession), as well as in other professions that are partially grounded in psychiatric ideas and practices, such as counseling and social work. I have framed the article with this qualification in part owing to a personal unease about a relative risk when producing scholarship that takes psychiatric practices as epistemic and/or conceptual objects; I return to this uneasiness elsewhere in this article.

Initial Definitions

Voice Hearing

First, some brief definitions of our two focal phenomena: hearing voices and ghostwriting. "Hearing voices" is a descriptive, value-neutral term that is increasingly used to describe a specific set of phenomena that clinical lingo sometimes dubs "auditory hallucinations." At present, auditory hallucinations are classified in the psychiatric nomenclature as a symptom of "schizophrenia" and other psychotic disorders (e.g., American Psychiatric Association, 2013; World Health Organization, 1992), and recent scientific trends have attempted to plot auditory hallucinations as transdiagnostic experiences that cut across diverse types of emotional distress (e.g., Ford et al., 2014). It is important to note that recent phenomenological research has raised questions about the discreteness, coherence, and validity of "auditory hallucinations" as classically defined (e.g., Jones & Luhrmann, 2015; Rosen et al., 2016). Moreover, the definition of voice hearing is broader than the classical definition of auditory hallucinations (both verbal and nonverbal) in the clinical literature, encompassing the perception of diverse types of anomalous sounds that may or may not be experienced as distressing (Hearing Voices Network, 2018b; Jones & Shattell, 2013, 2016; Longden, 2017; Wilkinson, & Anderson-Day, 2016; Woods, Jones, Alderson-Day, Callard, & Fernyhough, 2015; Woods, Romme, McCarthy-Jones, Escher, & Dillon, 2013). Put simply, a person who hears voices, or a voice hearer, experiences sounds (e.g., human speech), messages, and/or other meanings that others do not.

Ghostwriting

Now onto ghostwriting. The term broadly refers to the practice of writing a text to which someone else ultimately claims authorship. Ghostwriting has diverse purposes and exists in many

fields, including creative literature, memoirs, and nonfiction. Here, I focus on a specific subset of ghostwriting practices, namely, medical ghostwriting in psychiatric research. Medical ghostwriters often work for pharmaceutical companies or medical education companies seeking to support a specific product or highlight the downsides of competing products (Gøtzsche et al., 2009; Minasi, 2017; Sismondo, 2015). The ghostwriter is not named as an author in the text; instead, another person, typically a physician or other scholar, affixes their name to the published result. The named author or authors may or may not contribute to the text; indeed, the extent to which the ghost author contributes varies from substantial input to complete shaping and composition of the article. Sometimes, the ghost author is acknowledged as having a different, minor (e.g., editorial) role, while the extent of their actual contribution is unstated.

The prevalence of ghostwriting within the medical sciences is unclear (Kassirer, 2009; Stretton, 2014)—in large part because the phenomenon is de facto so difficult to trace—but it is believed to be quite widespread. In a 2011 survey of more than 600 corresponding authors in high-impact medical journals (Wislar, 2011), 11.9% of research articles had ghost authors. Another overview from the same year (Leo, Lacasse, & Cimono, 2011) claimed that "[a]lleged ghost authors haunt the clinical trial literature of virtually all the recent blockbuster drugs, including medicines like Vioxx, Avandia, Paxil, Zoloft, Zyprexa, hormone replacement therapy, and Fen-phen" (para. 2).

There are ongoing debates in bioethical, clinical, and critical scholarship about the ethicality and legality of ghostwriting (e.g., Fusch, Ness, Booker, & Fusch, 2017; Minasi, 2017). To some, the practice is an anathema to science—especially medical science—(e.g., Gøtzsche et al., 2009) and to others (e.g., Woolley, Water, Jacobs, Gertel, & Hamilton, 2009), it is a mere failure to disclose "professional medical writers" who would otherwise be helpful in producing research efficiently. As a specific form of plagiarism, medical ghostwriting is often considered to be specifically dangerous owing to the potential public health implications of physicians implementing recommendations shaped—or even invented—by non-experts, as well as the potential impact on patient–doctor trust (e.g., Almassi, 2013; Nerli, Magdum, & Ghagane, 2016). Although not all biomedical journals specifically name ghostwriting in their authorship policies, many require adherence to the International Committee of Medical Journal Editors (n.d.) authorship criteria, which outline specific contributions that are considered sufficient for authorship (Bosch, Hernández, Pericas, & Doti, 2013).

Why Hearing Voices and Ghostwriting?

Now that we have the basic definitions, why this strange juxtaposition between hearing voices and ghostwriting? Here are two phenomena that bear an amorphous thematic similarity in their allusion to something metaphysical, but otherwise appear as utterly *in*comparable—not apples and oranges or even apples and automobiles, but belonging to completely different taxonomic ranks, like comparing apples with the superordinate category motor vehicles. Put differently, these are two phenomena hailing from distant teleological and experiential realms. Hearing voices is an experience, often (but not always) involuntary, often reported by psychiatric patients diagnosed with so-called psychotic disorders, often conceptualized as empirically enigmatic and mysterious, and often (when addressed within the context of psychiatry) the target of pharmaceutical interventions and the object of psychiatric research and inquiry. It is the experience of an addressee who receives a communication from a seemingly distal, invisible, or otherwise anomalous source. In contrast, ghostwriting is a practice, often voluntary, often viewed as systematic and unambiguous in both means and effect, often (at least in medical realms) the activities of pharmaceutical corporations, and often a means of producing—and ultimately publishing—psychiatric research and inquiry. It is the action of an author whose identity disappears under the delivery of a message. Despite these glaring differences, I would like to suggest that, if critically interrogated, the seemingly loose thematic similarity between hearing voices and ghostwriting extends beyond the incidental and

bridges onto a broader structural positioning of authorship, agency, and voicelessness that lies at the core of clinical discourse and practice. Indeed, in exploring the similarities between the two phenomena, we might ask why *both* have been claimed by psychiatry and the other clinical psy disciplines as specifically falling under their practices and purview.

Apparent Similarities

One apparent similarity that we might note between these two phenomena—the tip of the iceberg, if you will allow—is their structural resemblance as discursive occurrences in which an addressee experiences a source of communication that is ontically concealed, absent, ethereal, or otherwise ambiguous. The person who hears voices may surmise that they (the voices) are being projected, broadcasted, inserted, intuited, telepathically delivered, or otherwise communicated by a source that is not within visible proximity, that is, through a means other than the usual face-to-face communicative actions of humans within eyeshot and earshot of each other. They (the voices) come from a source that is somehow invisible, or out of range. At times, and in line with the perspectives of mental health professionals, that source is believed to be the human brain or mind itself (see Luhrmann, Ramachandran, & Tharoor, 2015). At other times, the person might believe the voice to originate from a spiritual entity or otherworldly force, a technological device, or another human who is unseen at the time of utterance. Although the many determinants and meanings of heard voices are beyond the scope of this article, it is important to note that heard voices are not (even within conventional definitions) necessarily or always a signifier or so-called "symptom" of "psychopathology," as is commonly assumed (see Woods, 2015), but rather—as extensive epidemiological work (see van Os, Linscott, Myin-Germeys, Delespaul, & Krabbendam, 2009) and the efforts of grassroots movements such as the Hearing Voices Network have demonstrated (e.g., Hearing Voices Network, 2018a; Jones, Marino, & Hansen, 2016; Jones & Shattell, 2013, 2016; see also Watkins, 2000)—a diverse, heterogeneous group of experiences that are more often than not meaningfully related to the person's life history and contexts (e.g., Longden, 2017; Wilkinson & Anderson-Day; Wilkinson & Bell, 2016; Woods, 2015), can (as aforementioned) be pleasant or friendly as well as distressing (Woods et al., 2013; Woods et al., 2015), are frequently transient or intermittent, and quite often occur in nonclinical populations—in other words, in persons who do not seek clinical care and do not meet criteria for a psychiatric diagnosis (van Os et al., 2009). Voice hearing is increasingly investigated and conceptualized outside of conventional biomedical arenas (e.g., Watkins, 2000; Waugh, 2015)—especially in international and interdisciplinary scholarship—and is currently the focus, for example, of large multidisciplinary study in the United Kingdom (see Hearing the Voice, 2019). Moreover, voices are only sometimes—and perhaps less often than commonly assumed—experienced as literally auditory, like the voice of an interlocutor who is physically present and speaking; at other times, heard voices are experienced as thought-like and/or minimally auditory in the literal sense, but otherwise definitively external to the experiential self (Jones & Luhrmann, 2015; Watkins, 2000; Waugh, 2015).

In the case of ghostwriting, we have something different: an author who willingly (and for a profit) self-effaces after producing a communication, which is then disseminated under the name of another "author" from whom the text did not originate. The new author sometimes makes some changes to the text, but their primary role is to authorize it—to bestow the text with perceived authority by affixing their name. The original author or authors are aware of and consenting to this process, which is highly systematized and often monetized, albeit private and intentionally rendered unseen by the public. It is important to note that ghostwriting is not a distinctly academic phenomenon—in fact, there are no other academic disciplines that allow such a practice—but it *is* a distinctly medicoscientific one. It might even be said that, paradoxically, ghostwriting is one of the many means by which psychiatry asserts its own identity as a medical profession. Notably, psychiatric research is among the medical subdisciplines that make the most liberal use of ghostwriting.

For example, in a recent (but unpublished) review of 92 ghostwritten articles that were published between 1997 and 2008 (Gorry, 2015), one-third were psychiatric articles concerning mental disorders.

So, to summarize this review thus far, we might say that hearing voices and ghostwriting are two distinct phenomena in which an absence, hiddenness, facelessness, and/or other obscurity of origins is both ontic fact and—when compared with other auditory and textual activities—also essential ontological constituent. Put differently, there is a movement in which an originator, or an origin of communication, is partially cloaked—perhaps foreclosed, in Lacanian terms—but yet still signifies. In this way, both phenomena might be said to fall under the purview of what the late Jacques Derrida (1993) called "hauntology," in his own words, "the presence of a specter, that is, of what seems to remain as ineffective, virtual, insubstantial as a simulacrum" (p. 10). In other words, both hearing voices and ghostwriting might be viewed as forms of haunting or being haunt*ed*. Of course, in psychiatry, haunting is a theme that extends far beyond our two focal phenomena (it is present, for example, in predominantly affective states such as the mourning that bridges onto depression), and we might note here that the spectral world is not uncommon as a theme or cultural trope in popular discourse about and representations of psychiatry.

Haunting and Hegemonies

Here we might pause on another quote from Derrida (1993), who once wrote that "[h]aunting belongs to the structure of every hegemony" (p. 46). Put in different words, hegemonic structures inherently comprise not only the oppression of certain epistemic forms, but the return of these knowledges in the form of specters. Foucault (1972–1977) similarly wrote about the "insurrection of subjugated knowledges," or the revolutionary return of knowledges that are cast by dominant social structures as low-ranking or disqualified in terms of validity or value. In his own words, they are:

> a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity. I also believe that it is through the reemergence of these low-ranking knowledges, these unqualified, even directly disqualified knowledges (such as that of the psychiatric patient, of the ill person, of the nurse, of the doctor—parallel and marginal as they are to the knowledge of medicine—that of the delinquent, etc.) [. . .] that criticism performs its work. (p. 82)

Notably for our purposes, Foucault named the scientific institution as a potential subjugating power and the psychiatric patient as the potential possessor of a type of subjugated knowledge.

Returning now to Derrida's quote, "[h]aunting belongs to the structure of every hegemony." In the context of the present focus, we might ask: What is the hegemonic structure (or structures) to which hearing voices and ghostwriting belong? The full answer to this question is far beyond the scope of this project, and it lies in the work of previous humanistic scholars who have addressed discursive and marginalizing practices in psychiatry—scholars including R. D. Laing (1960), Foucault himself (1972–1977), and the contemporary Brent Dean Robbins, Karter, and Gallagher (2015), among others. Here I offer a brief beginning to an answer, drawing on postcolonial scholarship, where haunting is a prominent theme, especially in texts that directly address the sequelae of colonial violence, expansion, and other forms of forceful oppression.

Postcolonial Theories and Haunting

Postcolonial scholarship posits the lived experience of haunting not only as a form of suffering exacted on a place, or a people, but also as a way of remembering atrocities, a kind of collective refusal to mourn that is also an act of resistance (see Ronell, 2006), a refusal to undergo ritualistic psychic processes that might otherwise normalize, neutralize, or subsume the memory of trauma into familiar social structures and discourse—into the past, as it were. The unsettled, perpetual memories of victims, in other words, are a kind of unsanctioned memorial to the untimeliness of their deaths, a memorial constituted by a kind of

psychic timelessness of that subjugated truth. As O'Riley (2007) writes, "Haunting is pervasive in postcolonial thought precisely because of its affective dimension, a dimension that creates a sense of the imminently important, present, and disruptive" (p. 1).

The Unhomely

One postcolonial theorist whose work addresses haunting is Homi Bhabha, originally from Mumbai. Bhabha draws on the title of Freud's classic go-to text on the psychopolitics of ghosts, *unheimlich* or, as it is often translated into English, "the uncanny." Emphasizing the denotation of *home* in the German *Heim* (which Freud also recognized), Bhabha emphasizes that the "the uncanny" is more accurately "the unhomely," the *un-heim-lich*, and in doing so he reminds us that the unhomely involves a dimension of culture, and of place, and of worldly (un)familiarity that is not captured by the usual English term "uncanny." Unhomeliness is produced by violence that is wreaked by imperialism on postcolonial subjects, including violent dislocation, forced migration, and mass incarceration. Unhomeliness happens, in Bhabha's (1992) words, when "suddenly the home turns into another world" (p. 143). And further:

> [T]he border between home and world becomes confused; and, uncannily, the private and the public become part of each other, forcing upon us a vision that is as divided as it is disorienting. . . . [A]nother world becomes visible. . . . The unhomely is the shock of recognition of the world-in-the home, the home-in-the-world. (p. 141)

Bhabha's examples of the unhomely in literature include the well-known haunting figure of slavery in Toni Morrison's *Beloved*. In the unhomely, historical understanding—what Foucault called genealogy—is *unintentionally* carried in the signifying process. Or as Bhabha puts it, racial and cultural histories are "represented in a language that is *somehow beyond control*" (p. 147). Unhomeliness is precisely this unintentional, involuntary representation, here a representation of a history of oppression—what Derrida called the haunting that belongs to every hegemony. We might say that, in the case of heard voices, it is the involuntary representation of psychological and life-historical meanings, as well as an opening onto wider meanings in the world at large, an unhomely exposure to place—at times a collective and historical place, some might say—that is at once familiar and unfamiliar. Those voices are not separate from one's home-in-the-world, as Bhabha puts it, but part and parcel of it, unintentionally represented within it just as they contribute to its constitution.

Turning back to ghostwriting, we have something different: A practice that is intentional and purposefully concealed. The haunting that belongs and is eponymous to ghostwriting is not a spectral percept; ghostwriters are not typically seen or heard—indeed, their identities and unique voices are purposefully and by definition hidden, suppressed. Rather, ghostwriting sets the stage for or inscribes haunting via a signifying process by which the original author *unintentionally* inscribes life historical meanings—including their own—into the body of the published text.

But how can a ghostwritten text be haunted? What kinds of unhomely elements could possibly be present in a text that was ghostwritten by a pharmaceutical company? I would here like to propose that there are several forms of unhomely, subjugated knowledges in psychiatric texts that are written by unnamed authors. To introduce them, let's take a look at the opening sentence of *Recognition and treatment of psychiatric disorders: a psychopharmacology handbook for primary care* by "Drs. Charles Nemeroff and Alan Schatzberg" (1999)—now known to have been written by GlaxoSmithKline, maker of Paxil, a popular antidepressant. "Mental health is an important public health issue," the ghostly authors write, "as evidenced by the prevalence of psychiatric problems that are associated with the tremendous disability, *immense personal suffering*, and *heavy economic burden*" (p. vii, emphasis added). The unhomeliness of one type of subjugated knowledge, life history, is right there lurking in the text, which requires only a small reversal to be recognized. Indeed, we might reformulate this sentence to read, "[H]eavy economic burdens are an important public health issue, as evidenced by the prevalence of so-called psychiatric problems, or immense personal sufferings, that are associated

with them." Another form of unhomeliness here relates to the ghosted labor of the original author behind the names Nemeroff and Schatzberg. We do not know his, her, or their particular history, but we do know that those same economic structures led them to seek employment at a pharmaceutical company, where they were offered a means of living in exchange for veiled authorship. Both forms of subjugated knowledges in ghostwriting, we might pause here to note, bear a similar content, the meaningful experiences of a life (and indeed life history) that include human suffering, a suffering that is connected to global structures of labor and economic exchange.

The Subaltern

To understand more about the processes of discursive subjugation that can result in the haunting of lives and life histories, we can consider the postcolonial concept of the "subaltern," a term that originated in the work of the Italian Marxist Antonio Gramsci, but has taken on a life of its own in postcolonial scholarship, signifying diverse persons and groups who are excluded, again in various ways, from hegemonic power structures—and thereby rendered ontically deprived (or without basic resources) as well as voiceless within the dominant discourses of the "first-world West."

A postcolonial scholar whose work on the subaltern has been widely influential is Gayatari Chakravorty Spivak. In her classic text on the topic, "Can the subaltern speak?" Spivak (1988) analyzes the now-outdated Hindu practice of *sati* or suicide after the death of one's husband. In doing so, she addresses the possibility (and ultimately the impossibility) of revolutionary and insurgent subaltern voices existing within Western ideological and intellectual (including academic) enterprises that seek to perpetuate themselves as subject. "Some of the most radical criticism coming out of the West today," she writes, "is the result of an interested desire to conserve the subject of the West, or the West as Subject" (p. 66). As a result, the subaltern is narrativized as the object, and not the *subject* of scholarship—denied a platform from which to speak or gain voice—thereby discursively perpetuating, via what Spivak termed *epistemic violence*, the voicelessness at the core of subaltern status. This work draws attention to the necessity of reflexive, critical reflection on the discursive implications of textual production; we might, for example, problematize the ways in which the present text—although a call for elevating subaltern voices—maintains and manifests its own privileged, academic status via dissemination at conferences and as a journal article.

Discursive Hierarchy

The approach to postcolonial experience outlined in the texts of Bhabha and Spivak suggests a kind of reflexivity that focuses not only on the psychological impact, but also structures of the colonial production—not the spectrality of the ghost, but the originary oppressive structures that produce haunting in the first place—the unhomeliness of the world in Bhabha and the institutional structures of social oppression in Spivak. What happens when this reflexivity is applied to our analysis of hearing voices and ghostwriting in psychiatry? The first task is to hesitantly turn the analytic lens on psychiatry itself. With their focus on the possibilities or impossibilities of elevating marginalized narratives, postcolonial theories might seem mostly irrelevant to contemporary psychiatry, *ipso facto* a project of translating suffering and marginalization into universal (or quasi-universal) clinical terms. However, viewed from the lens of postcolonial history, universalizing discourses are themselves often anachronistic and oppressive—thus risking a kind of repeated or doubled marginalization. From this perspective, we might suggest that both phenomena—hearing voices and ghostwriting—demonstrate the existence of hierarchical, universalist, and indeed hegemonic and discursively colonizing practices in psychiatry that subjugate the interpretation of content (messages) to the media (or mediums) through which they arrive (see also Watkins, 2015). An extreme form of McLuhanism, so to speak. Although interpreted and perhaps misinterpreted in various ways, the crux of McLuhan's (1964) (in)famous statement that "the medium is the message" is that communications are inseparable from the media—and for the present purposes med*iums*—on which they arrive. In other words, in

perceiving and understanding a message, the form of that message is as, if not more important than its content. From this perspective, the presence of a television in someone's bedroom provides more information about that person's likely socioeconomic status, cultural leanings, habits, and hobbies than the particular TV show it might be playing at any given time.

We see a similar interpretive and discursive hierarchy, I am arguing, in the clinical psy discourses. On the nominally "lower" or underprivileged end of this hierarchy are communications or narratives that are typically distrusted, ignored, and silenced by virtue of their modality—subaltern or subpsychiatric communications, we might say. Voice hearing is one example; from a traditional biopsychiatric perspective, the form of auditory hallucinations (in other words the factical presence of their reported existence over the period of time necessary to meet criteria for a diagnosis) renders their content epistemologically irrelevant or meaningless. Indeed, from most conventional accounts, the contents of a hallucination are superficial and interesting, but arbitrary variations between signifiers for a core pathological process. In other words, when reported to a mental health professional, voices, interpreted as symptoms, act as signifiers for their own lack of discursive power; the professional is concerned only with their presence or absence, regardless of whether the person reporting them also views them as the referents of an illness. The person is cast, as put by an inspiring service-user I once worked with (who was also a graduate student in literature at the time), as an "unreliable narrator"—what Lowenstein (2017) calls a "lack of epistemic credibility" and Hamilton (2018), following Fricker (2017), has noted as a form of "epistemic injustice." Moreover, the report of the voices is interpreted as a signifier within a discursive realm that is often new or unfamiliar to the person, now rendered patient—namely, the realm of clinical discourse. Put again differently, when a person reports hearing voices, the content of those voices is often viewed as less relevant than the fact of the voices themselves, viewed as a sign of psychosis—a signifier for a break from ideological consensus concerning social reality.

Now, what about ghostwriting? In contrast with hearing voices, ghostwriting exists on the "upper" or privileged end of this discursive hierarchy. Ghostwritten texts are elite and colonizing communications in which the originator's identity vanishes as the message is disseminated through a more authoritative modality. Ghostwritten texts are considered relevant by the very fact of their existence in or on an elite medium, typically an academic publication of sorts. The nameless origin of the text and the foreclosure of authorship are rendered irrelevant—as well as hidden from public view—by the medium's privileged status. Yet the doctor's name on article, like the television in the bedroom, conveys an unhomely message that is just as much about that doctor and his profession as it is about the Paxil or Zoloft promoted within. We might say that this message is the factic existence of power as such. So on the one end of our hierarchy, we have a message that signals its own powerlessness or subaltern status (hearing voices), and on the other, a message silently conveying its own authority and power (ghostwriting). In other words, within this extreme version of McLuhanism, both poles signify their relative privilege or disadvantage—the medium is the message, and the message is the existence of the discursive hierarchy itself.

Postcolonial and Humanistic Convergences

We might pause for a moment to note some convergences between Bhabha and Spivak's writings and the work of three contemporary humanistic psychologists, Brent Dean Robbins, Justin Karter, and Kevin Gallagher (2015), who have written about the ways in which psychiatric diagnosis can function as a collective societal scapegoating mechanism. Robbins et al. draw on the work of Foucault, Erich Fromm, Ernest Becker, and Rene Girard to describe the theory and practice of psychiatric diagnosis as a way in which society isolates and absolves itself from those elements that, although by this mechanism of exclusion positioned as different, are actually variations on the selfsame, that is, not variations at all. Consonant with Girard's description of the devaluation and subsequent mythologization of scapegoats through mimetic desire (desire learned through imitation of others), persons with anorexia and addictions,

according to Robbins and colleagues, embody extreme forms of Western sociocultural trends (objectification of thin female bodies and materialist consumer culture, respectively). The disavowal and social stigmatization of the "anorexic" and "addict" is thus a means of scapegoating exorcising collective shame, as well as defending against the death anxiety and mortality salience thematized by their conditions. In the authors' own words:

> The model described . . . can be summarised, in Girard's (1999) terms, as the interpretation of psychiatric diagnosis as a potential mythologising, cultural force. By 'myth,' Girard means a cultural narrative that protects the cultural value system through the scapegoating of marginalised others, by way of creating a story that simultaneously blames and stigmatises the victim, while, on the other hand, in the myth, raising him or her to a god or goddess. This process, in effect, conceals the scapegoating mechanism, which, without exposure, is perpetuated in an endless cycle of repetition. (p. 94)

Juxtaposing Robbins et al.'s "narrative of differentiation" with Spivak's work, we might note the ways in which it is not only the exclusion of marginalized persons that generates social power disparities, but also the appropriation of the narrative of that exclusion from the hands of the excluded, even by well-intended allies. In Robbins et al., the scapegoating ritual narrativizes the exclusion of "anorexics" and "addicts," eclipsing their own lived experiences of their conditions as well as the marginalization that ensues. In Spivak, similarly, subaltern status is a function of both oppression as such and of voicelessness in the face of oppression. Both texts highlight the importance of wariness in the face of seemingly benevolent efforts to give voice to the voiceless, especially when those efforts involve a rewriting of narratives—an exclusion not only of the person, but also the ways in which persons tell their own histories. Psychiatric theories and practices exact this exclusion by interpreting the expression of subjugated knowledges as symptoms, and the person who experiences them as, in the words of my former client, "an unreliable narrator." But often—as what was arguably one of the central tenets of psychoanalysis—we will find that these subjugated knowledges are meaningfully related to life-historical experiences, and in particular life-historical experiences of marginalization and discrimination.

In consideration of our focus on hearing voices, we might turn to a small but growing body of literature suggesting that social marginalization may have itself been a long-subjugated truth of experiences commonly known as "psychotic." This literature, collectively known as the "social defeat" literature (Selten, van der Ven, Rutten, & Cantor-Graae, 2013), indicates that the experience of exclusion from a dominant social group is the common psychological denominator underlying the various social risk factors for psychosis, including homelessness, forced migration, racial/ethnic segregation, multiple deprivation, and childhood trauma (see also Longden, 2017; Longden, Madill, & Waterman, 2012; Rosen, McCarthy-Jones, Jones, Chase, & Sharma, 2018; Kamens, in press, 2018). (Social defeat theory also suggests that these risk factors lead to alterations in the mesolimbic dopamine system, thus positing a wholly biopsychosocial model that acknowledges both neurological changes and psychosocial risk factors.) Examined from the lens of postcolonial theories, social defeat theory helps us to connect structures of hegemony with the subaltern subjects living under them, and in particular the subaltern and unhomely experience of psychosis. That is not to say that all experiences commonly labeled as psychotic, hearing voices included, are the direct or even indirect result of social marginalization and oppression, but that they *can* be—and in populations already subjected to mental health systems and institutions, more often than not, they already are. However, it is problematic to conceptualize these experiences as symptoms or other signifiers of victimhood. As some postcolonial scholars (e.g., O'Riley, 2007) have identified in the theme of haunting, the resurgence of subjugated knowledges via alternative media can be viewed as a kind of discursive resistance, that is, as a way in which subaltern subjects can, by remaining elusive and ethereal, have a voice or signify within dominant power structures that are founded and perpetuated on their very exclusion.

Returning once again to the comparison between our two focal phenomena: if in voice hearing the person is haunted, in ghostwriting the person haunts. This is a distinction between not

only activity and passivity, but also—when we are referring to voices that are meaningfully related to the lived experience of adversity—between the anomalous temporality of traumatic memory and the amorphous anonymity of capitalist economic structures. Put differently yet again, whereas voices haunt the individual, the ghostwriter haunts modern society by promoting corporate agendas about healing and illness in the guise of unbiased science. And yet the ghostwriter, quite literally, also haunts the science of psychiatry. As China Mills (2014) has pointed out when writing about the dissemination of psychiatric discourse from high-income to low-income countries, "[p]sychiatry provides the networks for the pharmaceutical industry to colonise more and more areas of modern life in order to expand the market for psychotropic drugs" (Moncrieff, 2007, p. 192). In fact we might wonder if the pharmaceutical industry has colonized psychiatry" (p. 7; see also Watters, 2010). Notably, among those to bear the direst consequences of ghostwriters' activities are voice hearers themselves. Indeed, there is now a growing body of research demonstrating that, although helpful for some people in the short term, antipsychotic medications may increase the severity and longevity of psychotic experiences in the long term (e.g., Whitaker, 2016). And in this way, ghostwriting exacts a kind of double haunting, extending the lives of the voices themselves.

(Anti)psychiatric Specters

We are now a position to offer a few reflections on psychiatry and its antipsychiatric specters, and in doing so I return here to my personal unease concerning the risk that one takes when writing *about* psychiatry. Until the emergence (or we might say coagulation) of the "philosophy of psychiatry," this unusual and hybrid academic arena, most discourses that took psychiatry as their object (other than psychiatry itself) became already suspect as "anti." Owing in part to the discursive hierarchy described about, the same message from different sources is variously cast as center conservative or "antipsychiatric." Again, within this hierarchy, the medium is the message, the message of authority itself. That is why Thomas Insel (2013), former head of the National Institute of Mental Health and arguably one of the world's most well-known and leading psychiatrists, can make statements comparing categories in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) to the Bible and a dictionary without any risk to his status on the hierarchy.

Future Directions

For these reasons, there is a great need to advance historical and philosophical work that problematizes the notion of "antipsychiatry." As researchers and scholars, one of our responsibilities is to think not only about psychiatry, but also about its critics and reformers. The call for applications for the 2017 Association for the Advancement of Psychiatry and Philosophy conference posed the question "[i]s Critical Psychiatry best conceived of as a contemporary incarnation of "Anti-Psychiatry" or as a resource for psychiatric reform?" Yet as Daniel Burston (2014) has pointed out, with the exception of David Cooper and perhaps Foucault, many so-called "antipsychiatrists" (including R. D. Laing and Thomas Szasz) actually rejected and even "vigorously repudiated" the term (p. 109), instead viewing their work as a means of reforming psychiatry. In light of this fact, we might pose the following questions for future scholarship: Can we, and should we, respect self-identification as "pro" or "critical" or "anti" psychiatry? Can one "lack insight" with regard to one's stance vis-a-vis psychiatry as such? Or could the label "antipsychiatric" function, as some have suggested, as a way to malign opposing theories, thereby maintaining epistemic monopolies on interpretations of human suffering? What is the role of philosophy, which has historically functioned as a disciplinary site for psychiatric and antipsychiatric thinkers alike? Finally, is it at all possible that discursive hierarchies in psychiatry result in the underprivileging and eventual disavowal of narratives *within psychiatry itself*, such that what we've historically known as "antipsychiatry" is nothing more than the unhomely haunting of a selfsame specter—the specter of scientific doubt? Might we understand "antipsychiatry," in other words, as the heard voice of psychiatry?

Conclusions

In this article, I have suggested ways in which we can draw upon postcolonial theories to understand the relationship between hearing voices and ghostwriting—two phenomena that, when falling within the purview of psychiatric theory and practice, reveal a discursive hierarchy that subjugates certain communicative modalities while elevating others. In the case of heard voices, the orthodox biopsychiatric narrative forecloses the experience of social exclusion, of life history, just as it perpetuates, repeats, or redoubles that very exclusion by further marginalizing the marginalized. In the practice of medicating heard voices, we also have an attempt to quiet and interpret the resurgence of personal and collective histories as individual illness or disease. Likewise, with ghostwriting, there is an attempt to maintain and instrumentalize that hegemony by exacting rigid control over the origins of writing and discourse. And in both cases, we have a discursive erasure of origins that effectively prevents, in Foucault's terms, the insurrection of subjugated knowledges. Both phenomena highlight the centrality of mourning, haunting, voicelessness, and authorship to psychiatric discourse—itself arguably indistinct, at least in its mainstream forms, from the theorization and implementation of this very hierarchy. Further, we might say that psychiatry's vested interest in dealing in phenomena related to ghosts and ghosting might belie an implicit recognition of its historical roles in hegemonic enterprises of social exclusion (e.g., Metzl, 2009). Postcolonial scholarship offers a framework not only for examining themes of haunting and voicelessness inherent to this hierarchy, but also a means of rectifying discursive privileging practices in the clinical psy disciplines such that self-definition and first-person histories (and the individual right to share or withhold both [see Costa et al., 2012]) are not only respected, but valued alongside—and where relevant above—expertise based on privilege and medico-clinical training. More specifically, the works of Bhabha and Spivak demonstrate the critical evaluation of colonial narratives and the attempted elevation of voices that those narratives subjugate. Might it ever be possible to exact such an elevation with the voices of psychiatric service users? As articulated by Kalathil and Jones (2016), this elevation is a crucial step in the disciplinary and sociopolitical disruptions necessary for transforming oppressive power structures—for structural transformation towards social justice *within* psychiatry and clinical psychology. In doing so, we might just gain a better understanding of those "antipsychiatric" voices that have haunted psychiatry for all of these years.

Acknowledgment

The author would like to thank Mary Watkins, Nev Jones, and Jeremy Northup for their feedback.

References

Almassi, B. (2013). Medical ghostwriting and informed consent. *Bioethics, 28*, 491–499.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Bhabha, H. (1992). The world and the home. *Social Text, 31/32*, 141–153.

Bosch, X., Hernández, C., Pericas, J. M., & Doti, P. (2013). Ghostwriting policies in high-impact biomedical journals: A cross-sectional study. *JAMA Internal Medicine, 173* (10), 920–921.

Burke, A. W. (1985). Mental health and Apartheid: World Psychiatric Association conference report. *International Journal of Social Psychiatry, 31*, 144–148.

Burston, D. (2014). Anti-psychiatry. In T. Teo (Ed.), *Encyclopedia of Critical Psychology* (pp. 109–115). New York: Springer.

Costa, L., Voronka, J., Landry, D., Reid, J., Mcfarlane, B., Reville, D., & Church, K. (2012). "Recovering our stories": A small act of resistance. *Studies in Social Justice, 6* (1), 85–101.

Derrida, J. (1993). *Specters of Marx: The State of Debt, the Work of Mourning & the New International*. New York: Routledge.

Documents on the "T-4" and "14f13" Programs. (1939–1945/2009). In: G. Eghigian (Ed.), *From Madness to Mental Health: Psychiatric Disorder and Its Treatment in Western Civilization* (pp. 299–303). Piscataway, NJ: Rutgers University Press.

Fanon, F. (1952/2008). *Black Skin, White Masks*. (Trans. R. Philcox). New York: Grove Books.

Foucault (1972–1977). *Power/Knowledge*. (Trans. C. Gordon, L. Marshall, J. Mepham, & K. Soper). New York: Pantheon Books.

Ford, J. M., Morris, S. E., Hoffman, R. E., Sommer, I., Waters, F., McCarthy-Jones, S., . . . Cuthbert, B. N. (2014). Studying hallucinations within the NIMH RDoC framework. *Schizophrenia Bulletin*, *40* (Suppl. 4), S295–S304.

Fricker, M. (2007). *Epistemic Injustice: Power and the Ethics of Knowing*. New York: Oxford University Press.

Fusch, P. I., Ness, L. R., Booker, J. M., & Fusch, G. E. (2017). The ethical implications of plagiarism and ghostwriting in an open society. *Journal of Social Change, 9*, 55–63.

Girard, R. (1999). Are the gospels mythical? *Quadrant, 43* (12), 46–51.

Good, M.-J. D., Hyde, S. T., Pinto, S., & Good, B. (Eds.). (2008). *Postcolonial Disorders*. Oakland: University of California Press.

Gorry, P. (2015). *Medical literature imprinting by pharma ghost writing: A scientometric evaluation*. Available at: https://pdfs.semanticscholar.org/5528/9bbf436abb9d1ecdd53ec8062a5d89188c60.pdf.

Gøtzsche, P. C., Kassirer, J. P., Woolley, K. L., Wager, E., Jacobs, A., Gertel, A., & Hamilton, C. (2009) What should be done to tackle ghostwriting in the medical literature? *PLoS Medicine, 6* (2): e1000023.

Hamilton, N. (2018, January). *Epistemic Injustice and Using Civil Commitment to Treat Eating Disorders*. Presented at the American Philosophical Association Eastern Division Conference, Savannah, Georgia.

Hearing the Voice. (2019). Interdisciplinary voice-hearing research [Website]. Available at: https://hearingthevoice.org. Accessed May 17, 2018.

Hearing Voices Network. (2018a). *About us*. [Press web log]. Available at: www.hearingvoicesusa.org/about-us.

Hearing Voices Network. (2018b). *Basic Information About Voices & Visions*. [Press web log]. Available at: https://www.hearing-voices.org/voices-visions/.

International Committee of Medical Journal Editors. (n.d.). *Defining the Role of Authors and Contributors*. Available at: www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html.

Insel, T. (2013). *Transforming Diagnosis* [Web log post]. Available at: www.nimh.nih.gov/about/directors/thomas-insel/blog/2013/transforming-diagnosis.shtml.

Jones, N., & Luhrmann, T. M. (2015). Beyond the sensory: Findings from an in-depth analysis of the phenomenology of "auditory hallucinations" in schizophrenia. *Psychosis, 8*, 191–202.

Jones, N., Marino, C., & Hansen, M. C. (2016). The Hearing Voices Movement in the United States: Findings from a national survey of group facilitators. *Psychosis: Psychological, Social and Integrative Approaches*, *8*, 106–117.

Jones, N., & Shattell, M. (2013). Engaging with voices: Rethinking the clinical treatment of psychosis. *Issues in Mental Health Nursing*, *34* (7), 562–563.

Jones, N., & Shattell, M. (2016). Not what the textbooks describe: Challenging clinical conventions about psychosis. *Issues in Mental Health Nursing*, *37* (10), 769–772.

Kamens, S. R. (in press). De-othering schizophrenia. *Theory & Psychology*.

Kamens, S. R. (2018). Extreme states and extreme conditions: On homelessness and the ontico- ontological difference. *Journal of Humanistic Psychology*: *Special Issue on Extreme States*. Available at: http://journals.sagepub.com/doi/abs/10.1177/0022167818763734?journalCode=jhpa.<

Kassirer, J. P. (2009). Viewpoint: Ghostwriting is difficult to define, and we need more evidence of its frequency and impact. In: P. C. Gøtzsche et al., "What should be done to tackle ghostwriting in the medical literature?" *PLoS Medicine, 6* (2), e1000023. Available at: http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000023.

Kalathil, J., & Jones, N. (2016). Unsettling disciplines: Madness, identity, research, knowledge. *Philosophy, Psychiatry, & Psychology, 23* (3/4), 183–188.

King, C. (2007). They diagnosed me a schizophrenic when I was just a Gemini. "The other side of madness." In M. C. Chung, K. W. M. Fulford & G. Graham (Eds.), *Reconceiving Schizophrenia* (pp. 11–28). New York: Oxford University Press.

Laing, R. D. (1960). *The Divided Self*. New York: Penguin Books.

Leo, J., Lacasse, J. R., & Cimono, A. N. (2011). Why does academic medicine allow ghostwriting? A prescription for reform. *Society, 48*, 371–375.

Longden, E. (2017). Listening to the voices people hear: Auditory hallucinations beyond a diagnostic framework. *Journal of Humanistic Psychology: Special Issues on Diagnostic Alternatives, 57*, 573–601.

Longden, E., Madill, A., & Waterman, M. G. (2012). Dissociation, trauma, and the role of lived experience: Toward a new conceptualization of voice hearing. *Psychological Bulletin, 138*, 28–76.

Lowenstein, K. (2017, May). *Rethinking Insight: What Does It Mean To Be Aware of Illness When Awareness Doesn't Map to Concept of Illness?* Presented at the Association for the Advancement of Philosophy and Psychiatry (AAPP) Conference, San Diego, CA.

Luhrmann, T. M., Ramachandran, P., & Tharoor, H. (2015). Differences in voice-hearing experiences of people with psychosis in the USA, India and Ghana. *British Journal of Psychiatry, 206*, 41–44.

Metzl, J. M. (2009). *The Protest Psychosis: How Schizophrenia Became a Black Disease*. Boston: Beacon Press.

McLuhan, M. (1964). *Understanding Media: The Extensions of Man*. Cambridge, MA: MIT Press.

Mills, C. (2014). *Decolonizing Global Mental Health: The Psychiatrization of the Majority World*. New York: Routledge.

Minasi, D. (2017). Confronting the ghost: Legal strategies to oust medical ghostwriters. *Fordham Law Review, 86*, 299–333.

Moncrieff, J., (2007). Co-opting psychiatry: The alliance between academic psychiatry and the pharmaceutical industry. *Epidemiologia E Psichiatria Sociale, 16*, 192–196.

"Nemeroff, C. B., & Schatzberg, A. F." (GlaxoSmithKline). (1999). *Recognition and Treatment of Psychiatric Disorders: A Psychopharmacology Handbook for Primary Care*. Washington, DC: American Psychiatric Association.

Nerli, R., Magdum, P., & Ghagane, S. (2016). Medical ghostwriting. *Journal of the Scientific Society, 43*, 61.

O'Riley, M. F. (2007). Postcolonial haunting: Anxiety, affect, and the situated encounter. *Postcolonial text, 3*(4). Available at:: http://postcolonial.org/index.php/pct/article/view/728/496.

Robbins, B. D., Karter, J. M., Gallagher, K. (2015). Big pharma(kos): The stigmatised scapegoat of medicalisation and the ethics of psychiatric diagnosis. *British Psychological Society Psychotherapy Section Review, 56*, 84–96.

Ronell, A. (2006). *Dictations: On Haunted Writing*. Champaign: University of Illinois Press.

Rosen, C., Jones, N., Chase, K. A., Gin, H., Grossman, L. S., & Sharma, R. P. (2016). The intrasubjectivity of self, voices and delusions: A phenomenological analysis. *Psychosis: Psychological, Social and Integrative Approaches*, *8* (4), 357–368.

Rosen, C., McCarthy-Jones, S., Jones, N., Chase, K. A., & Sharma, R. P. (2018). Negative voice-content as a full mediator of a relation between childhood adversity and distress ensuing from hearing voices. *Schizophrenia Research*. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29580740.

Said, E. (1978). *Orientalism*. New York: Random House.

Selten, J., van der Ven, E., Rutten, B. F., & Cantor-Graae, E. (2013). The social defeat hypothesis of schizophrenia: An update. *Schizophrenia Bulletin, 39* (6), 1180–1186. doi:10.1093/schbul/sbt134

Sismondo, S. (2015) Ghostwriting. In: ten Have, H. (Ed.) *Encyclopedia of Global Bioethics*. New York: Springer. Available at: https://link.springer.com/referenceworkentry/10.1007%2F978–3–319–05544–2_215–2#howtocite.

Spivak, C. (1988). Can the subaltern speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the Interpretation of Culture* (pp. 271–313). Chicago: University of Illinois Press.

Stretton, S. (2014). Systematic review on the primary and secondary reporting of the prevalence of ghostwriting in the medical literature. *BMJ Open,* 4:e004777.

van Os, J., Linscott, R. J., Myin-Germeys, I. M., Delespaul, P., & Krabbendam, L. (2009). A systematic review and meta-analysis of the psychosis continuum. *Psychological Medicine, 39*, 179–195.

van Voren, R. (2016). Ending political abuse of psychiatry: Where we are at and what needs to be done. *BJPsych Bulletin, 40*, 30–33.

Watkins, M. (2000). *Invisible Guests: The Development of Imaginal Dialogues*. Woodstock, CT: Spring Publications.

Watkins, M. (2015). Psychosocial accompaniment. *Journal of Social and Political Psychology, 334–341*.

Watters, E. (2010). *Crazy Like Us: The Globalization of the American Psyche*. New York: Free Press.

Waugh, P. (2015). The novelist as voice hearer. *Lancet, 386* (10010), e54–55.

Whitaker, R. (2016). The case against antipsychotics: A review of their long-term effects. *Mad in America Foundation*. Available at: https://www.madinamerica.com/wp-content/uploads/2016/07/The-Case-Against-Antipsychotics.pdf.

Wilkinson, S., & Anderson-Day, B. (2016). Voices and thoughts in psychosis: An introduction. *Review of Philosophy and Psychology, 7*, 529–540.

Wilkinson, S., & Bell, V. (2016). The representation of agents in auditory verbal hallucinations. *Mind & Language, 31*, 104–126.

Wislar, J. (2011). Honorary and ghost authorship in high impact biomedical journals: A cross sectional survey. *BMJ, 343*:d6128

Woods, A. (2015). Voices, identity and meaning-making. *Lancet, 386* (10011): 2386–2387.

Woods, A., Jones, N., Alderson-Day, B., Callard, F. & Fernyhough, C. (2015). Experiences of hearing voices: Analysis of a novel phenomenological survey. *Lancet Psychiatry, 2* (7), 585.

Woods, A., Romme, M., McCarthy-Jones, S., Escher, S., & Dillon, J. (2013). Special edition: Voices in a positive light. *Psychosis: Psychological, Social, and Integrative Approaches, 5*, 213–215.

Woolley, K. L., Wager, E., Jacobs, A., Gertel, A., & Hamilton, C. (2009). Professional medical writers can be legitimate contributors to manuscripts, but ghostwriting is dishonest and unacceptable. In P.C. Gøtzsche et al., "What should be done to tackle ghostwriting in the medical literature?" *PLoS Medicine, 6* (2), e1000023. Available at: http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1000023.

World Health Organization. (1992). *The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines*. Geneva, Switzerland: Author.