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Special Feature Article

Psychiatry as a Technology of Subjectivity: A Perspective from Medical Anthropology

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Abstract

What happens when doctors and scientists begin to reflect on their own experience and come to regard psychiatry as a dialogic process of subjective and the objective? How is it possible to enact what Shin-ichiro Kumagaya and others have called "tojisha-ka" (becoming tojishas or users) -which comprises subjective narrativization and objective generalization? Drawing on medical anthropological perspectives, I first examine the move towards subjective narrativization in North American medical education through a focus on "illness narratives". Secondly, I examine the move towards objective generalization attempted by psychiatric users, particularly in the UK. And thirdly, I raise questions about the dialogic relationships between subjective narrativization and objective generalization through the rise of digital psychiatry as a tool of self-reflection (as in self-tracking). Analyzing psychiatry not only as a technology of objectivity but also of subjectivity, this paper explores the future implications of "tojisha-ka".

Keywords: subjectivity, medical anthropology, tojisha-ka, subjective narrativization, objective generalization

Introduction - Tojisha-ka -

How can we listen to the voices of patients (tojishas) and incorporate them into medical care? This is a question posed by psychiatrist and medical anthropologist Kleinman, A. in his classic work "The Illness Narratives: Suffering, Healing, And The Human Condition". While treating a young girl who had suffered burns over her entire body, Kleinman was unable to bear the girl's screams while supporting her body, and he found himself involuntarily asking her "How are you bearing this suffering?" She was startled for a moment, but then began to speak earnestly. The important thing here is that not only the girl herself, but also the doctor, who was feeling helpless, gained the strength to overcome the harsh treatment through this story.¹⁷⁾ The loss of narrative in medicine causes a sense of alienation not only in patients, but also in doctors.⁹⁾

What was re-examined here was the extreme objectivism of biomedical science. Biomedical science is characterized by its skepticism towards subjectivity, and its aim for so-called "uncontaminated by interpretation" pure objectivity. According to the science historians Daston, L. and Galison, P., the history of this concept of "objectivity" only goes back to the middle of the 19th century, but the rapid

development of technology that followed led to the widespread adoption of "mechanical objectivity."³⁾ In the pre-modern era, doctors relied mainly on storytelling and palpation, but from the modern era onwards, as blood tests, X-rays, EEGs, PET scans, MRI, and genomic testing were introduced, the gaze of doctors began to move away from the patient's subjective perspective at an accelerating pace.²⁷⁾ As the focus shifts to using technology to detect pathology deep within the body, the unstable and uncertain patient's subjective perspective was increasingly neglected and excluded. What was gradually lost was perhaps a more holistic perspective that captured the social interactions that make up illness, as well as the tojisha as a person living their life - it was this realization that led to the re-evaluation of subjectivity in the second half of the 20th century.

This movement is most prominent in the field of mental health, where it is never possible to complete everything through objective diagnosis and treatment. As the focus on the art of listening to the subjectivity of tojishas and the movement to place it at the heart of diagnosis and treatment has gained momentum globally, a research project to elucidate "tojisha-ka" has also been launched in Japan, led by Kiyoto Kasai.²³⁾ As discussed by Shin-ichiro

Kumagaya and Satsuki Ayaya, the aim is to elucidate "tojisha-ka" as a self-reflective process that reimagines the world as a tojisha, where everyone, not just those with disabilities or illnesses, has some kind of difficulty in living. According to them, tojisha-ka can be understood in terms of both "objective generalization" and "subjective narrativization". Objective generalization refers to the process of considering why incongruities between the laws of one's own body and brain and the laws of the surrounding world and difficulties in living arise, and how to make life easier. On the other hand, the process of "subjective narrativization" is based on an approach that reorganizes one's experience of difficulty in living as autobiographical memory and experience, and positions it as a broader social narrative within the world and history.¹⁸⁾ In the past, the former has been the domain of natural science, and the latter of social science, but this project aims to bring the two together.

By having doctors and scientists themselves reflect on their own experiences and view clinical practice as a back-and-forth movement between the objective and subjective, what exactly will be created by reimagining mental healthcare? In this paper, I would like to reexamine this trend towards the restoration of the

subjectivity of tojisha from the perspectives of (i) the doctor's subjective narrativization, (ii) the tojisha's objective generalization, and (iii) the interaction between subjective narrativization and objective generalization (in relation to data-based medicine).

I. Subjective Narrativization by Doctors

1. Explanatory Model

The focus on the patient's perspective arose from therapeutic needs. In particular, in North America and Europe, where both doctors and patients have diverse cultural backgrounds, it is not always the case that the other party's assumptions are shared, and treatment often encounters difficulties when it is based solely on one-way explanations from the doctor to the patient and demands for compliance. Therefore, the "Illness Narratives" movement in North America was an important starting point for the realization that doctors, as well as patients, have some kind of "explanatory model" for illness.¹⁹⁾

Doctors basically try to provide an objective explanation in the form of a "disease" model. In contrast, patients and their families often have their own 'illness' (phenomena perceived subjectively) model. Patients and their families often have their own views on why it happened (theory of etiology),

how to deal with it (theory of therapeutics), and what constitutes recovery (theory of recovery). For example, there are various theories of etiology, including constitutional theory, climate theory, and sometimes theories of magic as a curse or of trauma that trace back to past events, but these are rarely openly discussed with doctors. However, in psychiatry, where the cause of the disease and objective diagnosis have not been fully established, the disease model is also unstable, and if treatment does not lead to a smooth recovery, the doctor's model also suddenly loses its persuasiveness. In this way, the clinical setting becomes a space full of tension, where different explanatory models constantly compete with each other and various objective and subjective factors collide with each other.¹⁶⁾

2. Cross-cultural Competence

In order for doctors to understand the often chaotic and contradictory narratives of their patients and to empathize with their feelings, it is necessary not only to relativize the disease model, but also to pay attention to the cultural background of the patient, which they may not necessarily be aware of. With this awareness of the problem, "cultural competency" has become a focus of medical education in North America since the end of the

1990s.¹³⁾ This is said to have arisen as a criticism of the prevalence of the "one-fits-all" approach to medicine, which applies the same treatment to everyone, due to the rise of evidence-based medicine (EBM), and as a reflection on the fact that the subjectivity of patients was neglected in this process. The medical anthropology textbook "The Spirit Catches You and You Fall Down",⁷⁾ which was widely used as a teaching material in North American medical education at the time, details the events leading up to the worst possible outcome, in which a girl who shows symptoms of epilepsy falls into a vegetative state after a crisis escalates as the family and doctors continue to oppose each other over the cause of the girl's illness and the theory of therapeutics. This was discussed as an unfortunate case of miscommunication that occurred because the doctor, despite his best efforts, was too fixated on his own view of illness and did not listen to the cultural explanatory models of the patient's family, who were a minority. From this period onwards, the importance of subjectivity and cross-cultural understanding was repeatedly taught in medical education.

However, there were also clear limitations to "cross-cultural competence". The biggest problem was that this did not act as a dynamic concept that would help doctors

understand the complexity of culture and relativize their own assumptions, but rather acted as a "technology of othering" that simplified differences between patients and even fixed them in a static way as exotic beings. Furthermore, the fact that it was seen as a "capacity to memorize vast amounts of information", which is often valued in medicine, was also a cause for concern. It is said that this was encouraged by the list of culture-bound syndromes attached to the end of the DSM-IV. The list included stereotyped illnesses such as "illness X seen in tribe Y", and culture was pathologized as a strange difference that resides within the patient. There were also concerns that this kind of list-based, simplified "culture" theory actually undermined the clinical sense of experts who would otherwise be keenly aware of the complexity of the family and the relationships behind the patient.²²⁾

On the other hand, the SOAP medical record system, which was introduced with the aim of establishing holistic medical care by more accurately grasping the patient's subjective perspective and incorporating it into medical care, also drew criticism. The anthropologist and physician Taussig, M. criticizes SOAP, which analyzes from four perspectives (S: subjective, O: objective, A: analysis, P: plan), for reducing the complexity of the patient's

subjective experience to a rational explanation that doctors prefer, and for trivializing the problem through a "psychological" interpretation. Taussig is scathing in his criticism of the democratic rhetoric that sets out to resolve the differences between doctors and patients by "negotiating" as if the "explanatory models" of the two were equal, explaining that this is nothing more than a device to conceal the power relationships in the medical field and silence patients even further. Indeed, the reason for the increased focus on patient narratives during this period was the medical economic trend of incorporating patients as active consumers into the medical system and placing some of the responsibility on them.²⁾³⁴⁾³⁵⁾

3. Structural Competency

As a result of such reflection, the concept of "structural competency" is currently being actively discussed in medical education in North America. As the interactions in clinical practice are already deeply embedded in the power structure of society, even though many patients live in poverty and various disparities, the structural vulnerability of these patients is not easily visible to doctors who usually belong to the elite class. Patients' poor compliance or their continued engagement in high-risk behaviors may not be due to a lack

of commitment to treatment, but rather to their family situation or employment situation making it difficult for them to behave in a desirable way in the first place.¹⁰⁾ The introduction of a social perspective that re-examines the structural weaknesses of society, which patients are not even aware of and cannot easily talk about, as the fragility of their living networks, rather than treating them as weaknesses of will or psychological problems, is currently being attempted in the development of the "Structural Vulnerability Scale" and other projects.¹⁾²⁴⁾ This perspective, which focuses on the socially constructed concept of "sickness",³⁶⁾ provides an opportunity to reflect on the cultural values that doctors themselves hold in secret, and on the doctor-patient relationship as an existence embedded in social structures, and to reconsider subjectivity together with its complexity.

II. Objective Generalization by Tojishas

1. User-led Research

At the same time as there is a movement within medicine towards subjective narrativization, there is also a movement among users/tojishas to go beyond subjective narrativization and aim for objective generalization - in other words, the establishment of "objectivity as a bundle of subjectivities". The reason for this is that, in science (and medicine), stories are nothing more

than anecdotes, and the tojisha's narrative as such anecdotes remain in a very low position in the hierarchy of scientific knowledge. Stories of illness appeal to our emotions, and because of the morality inherent in such emotions - the denunciation of overwhelming suffering and injustice - the listener is often left speechless. Furthermore, they demand that we "believe" in them without saying a word. For this reason, stories are not easily the subject of scientific inquiry, which is based on the objectivity, neutrality, and universality that doctors value, such as the verification and comparative examination of their authenticity. In addition, even among tojishas, there is a conflict over the question of representativeness (i.e. whether the story should be that of the person who suffered the most, the person who shows the most typical symptoms, the person who can tell the story in the most intelligent and eloquent way, or the person who can tell the story in a way that deeply moves the emotions). Such conflicts can sometimes even lead to a reversal of the situation, with those who are most marginalized socially being able to speak of the purest truth. However, such moralistic hierarchies not only distance people from science, but can also lead to new power struggles among tojishas, and cause unfortunate divisions.¹⁴⁾

In the field of physical medicine, a major step forward in overcoming this kind of division was the rise of citizen science in relation to AIDS. In the 1980s, in relation to AIDS, a disease whose cause was still unknown at the time, the participation of homosexual *tojishas* (among them were PhD holders, doctors, and scientists) in AIDS research in North America led to a major change in the way science was conducted. Until then, the user movement tended to be polarized into two camps: either being subservient and deferential to science, or being negative and antagonistic towards it. In contrast, the user leaders of the AIDS movement learned the language of science, mobilized the media to develop criticism of the status quo, and at the same time, they organized user groups and promised full cooperation with clinical trials, winning the full trust of scientists. Furthermore, by bringing together researchers of rare diseases, experts in epidemiology, scientists, government officials, and experts from different fields, they established a truly interdisciplinary research system in which the opinions of the users were directly reflected. As their friends and loved ones died one after another, they came to realize that obedience and silence could lead to their own death, and their movement to sincerely question "who science is for" and "what good medical care is" was

also a movement to question the significance of the existence of scientific medicine.⁶⁾¹²⁾

2. Multi-Axialization of Evidence

At the same time, the groundwork for citizen science in the field of psychiatry was also being laid. In particular, user-led research in the UK emerged after the deinstitutionalization movement of the 1970s as a place for people to reflect on and discuss the strangeness and absurdity of the 'treatment' they had received in psychiatric hospitals. Subsequently, the users' legitimate questions about 'treatment' produced research with such an impact that it led to the rewriting of the guidelines of the UK's Department of Health and Social Care. For example, a group led by user/psychologist Rose, D. began their research with the simple question of why the results of scientific studies on electroconvulsive therapy (ECT) had such a wide range of effectiveness, from 18% to 90%, with many of the studies showing results that were far higher than the users' own experiences. Rose and her colleagues, who conducted a meta-analysis of ECT research, clarified that there were serious methodological and ethical problems with the papers that showed extremely high effectiveness by conducting interviews with users about the circumstances in which the ECT research was conducted.

In this way, their citizen science, which does not limit questions arising from the experiences of users about individual subjectivity, but instead collects and analyzes a wide range of narratives to raise them to the level of objective evidence, has grown rapidly to the point where it has even moved the government.²⁸⁻³⁰⁾

The background to this movement was also said to be a concern about the changes in the apparatus for producing scientific knowledge, in the process of the transformation of psychiatry into an area that generates huge wealth due to the expansion of the market for psychotropic drugs. At the time when clinical trials became large-scale and the initiative shifted from doctors to the pharmaceutical industry, the process of raising clinical knowledge to scientific knowledge became more complex. As the psychiatrist and medical historian Healy, D. pointed out,¹¹⁾ the fact that negative data from clinical trials was being concealed and ghost-written papers were being published with the names of famous researchers who had received support from the pharmaceutical industry led to a sudden decline in trust in science, and this also brought about a sense of crisis among users.⁸⁾ Another major factor was that, from the 1990s onwards, the pharmaceutical industry's marketing began to focus on selling disease

categories before selling drugs, and to promote them as enhancement technologies for improving oneself. As the clever rhetoric about autonomy, which suggests that consumers can become their true selves by continuing to take their medication of their own choosing, came under scrutiny, there was also a growing concern that a critical perspective was being driven out of science.⁴⁾ As a result, there was an urgent need for a place to examine questions that are truly important to users, such as the effectiveness of treatments other than psychotropic drugs, or when medication can be stopped.

In many developed countries, the participation of users in research is now a condition for receiving government funding, and there is a growing awareness that the more control is given to the users, the more politically correct the scientific research will be. On the other hand, there are also many barriers, and even Rose, who has published hundreds of papers, including in top medical journals, feels that it is difficult to raise one's voice within the hierarchy of medicine. Not to mention, it is not easy for ordinary citizens to be invited to join a group of scientists and speak their minds freely even when their opinions are sought. Moreover, in groups of scientists, important matters are often decided through informal

networks, and the opinions of minority users who do not fit in with their values are easily excluded. There are also many users who feel that they are being forced to accept the one-sided interpretations of researchers in the research papers, and some say that the participation of users has become nothing more than tokenism, used simply to fulfill the conditions for receiving grants. In this way, a place that was originally intended to be for the empowerment of users could instead become a device that deepens feelings of powerlessness.

In addition, the division among users is becoming more serious in some areas. In the field of developmental disorders, where the user movement, including citizen science, is thriving, a group of people known as high-functioning individuals have been attracting attention with their "neurodiversity movement". They see differences in the brain as a different way of being, and have talked about the characteristics of autism spectrum disorder (e.g. repetition of the same thing, high sensitivity to minute differences, and hyperfocusing) as an identity that can bring about innovation in society.³³⁾ Furthermore, there are also people who criticize the "neurotypicals" as pathological beings trapped in conformity to their surroundings, and who adhere to an anti-treatment

philosophy. However, behind their passionate arguments, there are many people with developmental disorders who do not want to change their personality, but would like to receive treatment to make life easier. Even the user/sociologist Singer, J., who is said to have first used the term neurodiversity in her book, is scathing in her criticism of those who make extreme claims, saying that they are "eternally victims, childish, seek unconditional love and approval, lack self-reflection, self-criticism and stoicism as adults, and refuse to see that there is both light and darkness within themselves and others" (p.333).²⁵⁾ The challenge here is to work out how to codify the diverse stories of users, who are by no means a monolithic group, including not only the nature and severity of their disabilities but also the deep-seated divisions created by social stratification and economic disparity, as a form of citizen science.²⁵⁾

3. Testing Methods from the Perspective of Users/Tojishas

One of the things being attempted in the user research project as a way of overcoming this kind of division is to develop concepts and methodologies that are effective for converting subjectivity into objectivity, and to incorporate them into the routine of scientific research. For example, the "efficacy" used in conventional clinical

trials has been limited to the short-term effects of treatment that can be measured primarily within hospitals. However, what users are seeking is the long-term effectiveness of treatment experienced in daily life back in the community, and furthermore, answers regarding subjective satisfaction whether or not the treatment, even if it is effective, brings about an improvement in quality of life. By using such multiple axes, a method of introducing user subjectivity as the default of scientific practice is being explored. Furthermore, when examining user focus groups, it was found that there are many problems with the conventional questionnaire method and measurement method. For example, it has been pointed out that there are cases where the questionnaire items themselves use intense language that creates an overly negative image of mental illness or causes trauma. In addition, many of the test methods have questions that reflect social values, such as the idea that "people with many friends" are "healthy". Some research suggests that seeking out a wide range of social relationships may actually increase the risk of stress and relapse for people with schizophrenia and other disorders. It is important that scientific research, which is supposed to be value-neutral, should not spread such prejudice. Examining scientific practice

from the perspective of the users/tojishas is changing science into something more considerate and therapeutic.¹⁴⁾

III. Interaction Between Subjective Narrativization and Objective Generalization

1. Self-tracking

One of the further possibilities that we should pay attention to is that, beyond the context of the traditional user/tojisha movement, there is now a trend among ordinary people to "digitize the self" - and to reflect on the relationship between objectivity and subjectivity. The popularization of neuroscience discourse since the 1990s and the spread of medical knowledge on the internet have changed the image of the "patient" significantly. While large social networking companies are building 'databases of despair' based on accumulated text data to tackle suicide prevention,¹⁵⁾ there is also a movement among ordinary people who experience depression and anxiety to reflect on the meaning of their illness subjectively, using objective data on their physical and mental health on a daily basis obtained through the use of medical measuring devices.

2. The Quantified Self

One example of this trend is the "Quantified Self (QS) movement" that

began with IT experts in Silicon Valley²¹). Here, people who use self-tracking devices to monitor themselves throughout the day gather together, and regular meetings are held to reflect on how digitization is affecting their lives.

In the early days of the QS movement, there was an expectation that digitization would raise people's awareness of their health and lead to behavioral change as they "lived by numbers". On the other hand, there was also criticism that self-tracking would cause people to become obsessed with the minutiae of their own bodies, and would in fact exacerbate their pathologies. There were also concerns that, even though illness is only a small part of a person's life, the process of quantifying it might create an unhealthy obsession with health, and that this objectified and medicalized identity might undermine the person's subjectivity and even their healthy aspects.

An ethnographic study of actual self-tracking revealed a more complex phenomenon. Quantification through self-tracking certainly provided a new perspective on one's own health and mood, which change over time. In the QS movement, there were reports of people who, when they were sinking into deep depression, gained a sense of self-control by localizing their diffuse problems to the observation of a single

issue (e.g., heart rate).³¹⁾³²⁾ In a Finnish study in which participants were asked to keep a diary as well as having their stress levels measured, one participant was surprised to find that, despite the fact that there had been a stressful event (e.g. a heated argument with her spouse), there had been no change in objective values (e.g. heart rate variability) and she reconsidered the meaning of the event as a method of stress relief. In addition, it seems that by knowing the changes in subjective and objective stress levels, there are also changes in behavior, such as going to bed earlier or increasing the number of activities that reduce stress levels (for example, chatting with colleagues away from the computer).

3. Situated Objectivity

On the other hand, there were also reports of people becoming aware of the limitations of data-based medicine, as subjective stress was not being objectively extracted. For a woman who experienced an existential crisis after her divorce, the objective data was too crude a device for understanding her feelings, and she began to engage in other health practices in order to reflect on herself. In this way, the digitization of the self does not create the "mechanization of humans" that was initially feared, but leads to the relativization of "data". Data is

positioned within a larger life, and by being interpreted in relation to multiple factors, it creates a contradiction between subjectivity and objectivity, which in turn leads to deeper self-reflection. In other words, rather than simply promoting mechanical objectivity, data medicine has led to the emergence of "situated objectivity", which highlights interpretations that include each individual's values and environment.²⁶⁾

What is also interesting about data medicine is the discovery that a fine-grained clinical gaze on the mind and body does not necessarily lead to the personal and biological reductionism that was initially feared. Self-trackers often give out their data on the internet and exchange opinions about changes in each other's data. In the process, for example, people suffering from a decline in working memory are gaining a more complex understanding of human beings by focusing on the feedback loop between the brain and the environment, such as what happens when they are in a certain environment with certain people. As the editor leading the *tojisha-kenkyu* Masaaki Shiraishi points out, medical science as a specialized field of knowledge inevitably tends to become fragmented, but the aim of "restoring *tojisha*'s commonality" through digitization has the potential to provide

a perspective that transcends the vertical divisions of medicine.

The back-and-forth movement between storytelling and codification from the perspective of the user/*tojisha* is also changing the meaning of "data". At present, analyses of self-tracking data are being attempted by experts in various fields such as mechanical engineering, urban engineering, information science, and economics, and dialogues about more livable environments and social design are beginning. In the conventional medical model, diseases are divided into categories such as schizophrenia, depression, developmental disorders, and dementia, and the focus tends to be only on the defects and losses within the individual. However, for experts from other fields, the question of how to navigate the alternative world of people with strange distortions of memory, no matter what the illness, seems to be a treasure trove of ideas for technological innovation and an intellectual stimulus as an engineering problem. In the future, it may be possible to imagine and create a new society by going beyond the division of disease categories in psychiatry, clarifying the structure of the difficulties in living that are caused by disorders of the brain and nervous system through people's narratives, and constructing a "difficulties in living

database" through objective generalization.

Conclusion

In psychiatry, which is a technology of subjectivity, it is no exaggeration to say that the tojisha-ness of the individual has driven its history. The founders of psychotherapy, such as Freud and Jung, established new treatment methods by confronting their own mental illnesses and making use of the tojisha-ness. Bleuler, E., who established the concept of schizophrenia, is known for his detailed symptomatology, which was based on listening carefully to the stories of his patients, but it is said that this was motivated by his anger at the indifferent and cold attitude of the doctors towards his sister, who suffered from a mental disorder. Kanner, L. felt a strong affinity with his father's relatives, who had strong autistic tendencies, and he himself also had these characteristics, and it is said that this trait led to the discovery of "autism" from a unique perspective. Of course, the reason these doctors were able to gain authority was because of their commitment to objective generalization as scientists, and their personal stories may have been overshadowed because of this. However, it may have been the power of the stories that supported and drove their passion for scientific inquiry.

However, the fusion of subjective narrativization and objective generalization is not easy, as they rely on cultures that are at opposite ends of the spectrum. In particular, the traditional user/tojisha movement was overwhelmingly a place for subjective narrativization. There, the aim was to "reclaim the right to narrate oneself" by recounting in one's own words, rooted in one's own experience, the story of one's own body and mind, which had been hijacked by medical terminology. It can be said that the value of this space as a place that creates a language game that differs from scientific medicine was born because it emphasizes respect for "psychological reality" that does not necessarily involve the recognition of weakness or the examination of reality. Considering the reaction to introducing objective generalization, which emphasizes de-emotionalization and de-individualization, into such a space will be important in order to prevent unnecessary hurt and division.

In particular, as is being proposed at present, it may be necessary to give careful consideration to what the doctor-patient relationship will be like if not only tojisha, but also doctors themselves, become tojishas. From the tojisha side, there are concerns about why doctors would do this, and whether doctors, who already have enormous power as embodiments of objective generalization,

will become "super tojishas" who no one can argue with by speaking out as tojishas as well. However, the background to such a movement may be the structural vulnerability that doctors themselves feel, as Kleinman did, and their concerns about the impact this has on the therapeutic relationship.⁵⁾ It is hoped that the movement towards becoming a tojisha that lies ahead of this trend will bring about deep self-reflection and open dialogue that transcends division.

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