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NASJARO CAPTURED IN MEDICAL AND NORMALISING GAZES

The need for an anthropological gaze in mental health centres and juvenile detention centres

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Ronald May asked me in 2002, referring to interculturalisation: "How can we alter the course of a tanker, like a mental health institution with thousands of employees?" At that time, I didn't have an answer. Even nowadays, after having directed the interculturalisation project of a branch of 'de Gelderse Roos' for six years, I still don't have universally applicable answers. But I did find answers to questions of how, in individual cases, treatments could be more effective, more affordable and more equal. Without an anthropological gaze, youth care and mental health care costs will rise and the quality principle will be violated.

In interculturalisation – making mental health practices more 'culture-sensitive'- the ultimate goal is initiating learning processes in professionals to offer clients with and without migratory history equal quality of care. This starting point implicates the effective coping of professionals with differences in perceptions and in defining power. Pierre Bourdieu describes defining and symbolic power as 'to make people see and believe which is given by the imposition of mental structures' (1984, 482). It is the capacity of a person, a professional, whether or not in a collective structure, to determine other people in their self-image in gentle, but still violent, 'hidden ways' (Bourdieu 2000, 1/2). According to Bourdieu (with which position I identify) the task of anthropologists and sociologists is to prevent abuse of defining power by revealing 'doxal' (by power hidden) relationships (Van Bekkum 2001, 2002).

How can health care workers (starting from their power definition and having a DSM-IV and protocols at hand) render justice to the experience and presentation of a client's illness and suffering? Who defines which experiences are called peculiar and which behaviour is deviant, threatening or dangerous? The ethnocentric 'western' perspective of, and reaction to, deviant and 'psychiatric' behaviour can be analysed with the concept of the *medical gaze* (Foucault, 1986). Rene Devisch and Filip DeBoeck (1989:35) describe the working of the medical gaze: "The primacy of visual perception encompasses an understanding of disease as a localised, visible, measurable and manageable organic fact. The physician ought to take a neutral and detached stance towards the patient to warrant objectivity". Foucault (1975) argues elsewhere that psychiatric treatment and imprison-ment seek to attain normalisation and internalisation of dominant codes of conduct and to foster the emergence of conscience. Analogous to the medical gaze I will refer to this as a 'normalising gaze'.

To provide today's mental health care with more equity and more effective care, an anthropological gaze is indispensable. This view endeavours to integrate differences in (cultural) perceptions of the experience of health and illness, in diagnosis and treatment, including narrating family and migration stories and conceptions of body, mind and soul. Working from an anthropological gaze reveals hidden, ethnocentric influences of symbolic violence of professionals towards their clients. I will illustrate the anthropological gaze by using a report of Nasjaro's life story and an analysis of his vicissitudes.

Nasjaro is an Afro-Surinam, Maroon boy from the interior of Surinam, who migrated with his mother to the Netherlands when he was three years old. The rest of his family, embedded in Maroon kinship networks, arrived later on. Maroons are descendants of runaway slaves from plantations of the Dutch. Maroon families lack the traumatized legacy of Afro-Surinam families who were freed by the abolishing of slavery at the end of the 19th century. In the Netherlands, they are also embedded in wider Maroon community structures that affect identity developments of boys and girls. The way in which a young Maroon learns how to relate to community and world, is for most professionals in youth and mental health care hard to imagine without additional knowledge and expertise (Pakosie 2002).

Nasjaro is the middle child in a family of eleven. His father lives somewhere else, but still fulfils an important role in the lives of his children. At the age of welve, Nasjaro committed a series of minor offences, including shoplifting and burglary, as the youngest member in a group that consisted of white boys only. At the age of thirteen, a juvenile court convicted him to treatment in a juvenile delinquent facility. After one year, he was diagnosed as mildly mentally retarded with having 'aggression impulse dyscontrol'. Without properly supportive arguments, Nasjaro was incarcerated in juvenile delinquent facilities until he was 21 years old. During those years, his family started six lawsuits to have him returned to their family. Listening to the accounts of Nasjaro and his family, I understood that his stay in the juvenile delinquent facilities was extended constantly, as health care workers felt he still hadn't moderated his behaviour enough and wasn't able to control his sudden rages.

After I had interviewed Nasjaro several times for my PhD, I remembered a British report from the nineties, titled Big Black & Dangerous (Prince 1993). The author discusses the investigation of the deaths of three black men by over-medication in a psychiatric ward of the Broadmoor Hospital. The report concludes that the employees applied a stereo-typical image of 'threatening' and 'dangerous', which brought about the events that culminated in the deaths of these men. In the Netherlands, "black men" behaving "strangely and threatening" are diagnosed with paranoid psychosis more often than other men and imprisoned in psychiatry with a lawful authorisation (Selten et al 1997). Is Nasjaro captured in, and a victim of, medical and normalising gazes?

When he was thirteen years old, Nasjaro was already big for his age. When he was twenty-one, he had become a broad-shouldered, athletic man. He had been released

from a juvenile prison four months before I met him. He had been detained in ten different juvenile delinquent facilities over a period of eight years. Transfer was usually justified by the comment that "he didn't fit in the group any more". According to Nasjaro, some institutions were bad and some institutions, where he stayed longer, were more agreeable, because the staff was more kind and reliable and he got more 'free space'. The moment that marked Nasjaro's decision to change his behaviour, and brought his repeatedly extended stays to an end, was after the personnel of the group had forgotten to arrange for the weekend leave to attend his mother's birthday. He told me about that in our last conversation:

"I grew so angry because it wasn't the first the first time that this had happened. I asked team leader Ton, who told me about it, if he could still change it because it meant very much to me. Ton told me he didn't have time and had to go to another ward. As he went out the door, I started throwing chairs and I was brought to the isolation by four social workers (..). I have never attacked a social worker. I did fight with other guys in our group (..) After that weekend I decided from deep within to do exactly what they wanted me to do. During every meal, during any incident in the group or insult to me, I reminded myself of my mother's birthday that I had been unable to attend and I kept myself aloof. For months I followed the rules, even if I was bullied with all sorts of nasty words like 'jungle ape' or 'nigger'. Six months after my mother's birthday, Ton told me I could go home for good."

When I brought Nasjaro to the bus stop after our last interview, I asked him casually if he did any sports. He remained silent for a long while and then said:

"How funny that you ask right now. Because of all these years in juvenile facilities, I have probably missed out on a soccer career. When I was eleven, scouts of Ajax came to watch and invited me to have an audition in Amsterdam. However, a few months later I had to go to X (a juvenile delinquent facility, DvB)."

We looked each other in the eyes and his (and mine) were filled with tears. I walked him to the bus stop, shook his hand and watched him as he stepped on the bus leaving for an employment assistance program (for mildly retarded people) to start learning a trade.

The events in Nasjaro's early adolescence have had dramatic consequences, maybe for the rest of his life. To those who are familiar with youth care or psychiatry for migrant families, what happened to Nasjaro is not an exceptional story. Yet, it is unknown where and how often things go wrong. I, from my professional expertise, could not see Nasjaro as mentally retarded. Perhaps only after cases of death occur, as happened in the UK, it will render space for research in the Netherlands; and even then, such practices turn out to be very difficult to change (Anonymous, 2004). Might this be a case in which cultural-historical patterns of accumulated status and symbolic power and violence correspond proportionately with a resistance to change? Is the scenario that leads to the repeated extension of stays, predictable in other cases by the ethnocentric reflexes in medical and normalising gazes?

An anthropological gaze may have clarified Nasjaro predicament. To what extent was Nasjaro subject to equity in diagnosis and treatment? How objective and free of prejudice were both? In my research, I analyse the sometimes inevitable consequences of medical and normalising gazes for young men in penitentiary and mental health care institutions. I trace what scenarios cause an ineffective and prolonged stay in juvenile detention centres. For a guy, such as Nasjaro without incarceration, an accumulation of vulnerabilities triggers conflicting loyalties and mental instabilities, a loss of self and uncontrollable emotions. These vulnerabilities are (Van Bekkum, 2001a): a) his coming of age, b) the consequences of structural exclusion based on class, gender and ethnicity; c) the unprocessed consequences of family history of migration and / or flight, d) the influence of medical and normalising gazes and the loss of embedding. The years of incarceration with the never ending moments of symbolic violence probably enhanced the moments of inner conflicts even more. An increasing amount of research has shown that a loss of embedding in a safe environment of family and origin, causes youth to exhibit 'deviant' (psychiatric, addictive, criminal) behaviour (Meurs, 2005; Berry et al, 2006; Tjin A Djie & Zwaan, 2007; Van Geel, 2009).

Medical and normalising gazes are deeply intertwined within European perceptions of deviant behaviour, physical features and extroverted expression of emotions. Those perceptions regularly lead to misdiagnosis, ineffective treatment and unjustified elimination from the public domain as a consequence of forced clinical admission, a hospital order and detention (Van Bekkum & Van der Heide, 2010). The criteria by Dutch professionals determine if boys like Nasjaro pose a threat to themselves or public order, are themselves culture bound and not free of prejudices. Moreover, the blind spots in the systems cause additional costs. The defining power of the established order is displayed by the decision making processes that caused the extension of Nasjaro's stays in juvenile delinquent facilities. The results confirm and reproduce that status quo. If young men, once they have been jailed, demonstrate "threatening" (non-adapted) behaviour towards staff of mental health care or detention centres, this will inevitably result in more intense and prolonged isolation from stabilising family and community environments, in the case of black migrant youth in particular (RSJ 2009). This in turn, is a main cause in the repeated crime in 60-80% of the cases.

Intertwined cultural and power differences play an important role in the making of misdiagnoses and of contra-productive treatments in mental health care centres and of (judicial) youth. The definition power of professionals is obvious and undisputed, because they conform to DSM-IV and evidence based medicine. However, both are culture bound and ethnocentric. Defining power is not immutable. Migrant groups gradually increase their influence by positioning their own perceptions of illness and health along with their own mental health care institutions and practices, through research and publications (Pakosie, 2003; Edrisi, 2009; Can, 2010).

A society without defining power is unthinkable, but an

anthropological gaze reveals the undesirable consequences. Anthropologists reveal by directing their gaze at western professional practices and ethnocentric reflexes. For that reason, they are indispensable in diagnosis and treatment in mental health care, youth care and correctional institutions. They make cultural and power differences visible. Nasjaro's stay in juvenile delinquent facilities would have been briefer, less costly and maybe even unnecessary, if anthropological expertise had been drawn into the evaluation and interpretation of his behaviour. More justice would have been done to the principle of equity.

It is a wonder that young men like Nasjaro and their families are still able to find their way, after having been caught in medical and normalising gazes. Recently, I have learned that Nasjaro is going to live together with his girlfriend, not far from the rest of his family. Apparently, forces exist that can correct injustice done and we, anthropologists and other people involved, can only behold with awe and astonishment.

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