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Ciencia Tecnología Sociedad

Research Article

Classifications in Psychiatric Education. A Postcolonial Approach *

Las clasificaciones en la formación psiquiátrica. Una aproximación postcolonial

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* This article is derived from the thesis entitled *Scientific Training and Standards: Eight sociotechnical lessons that psychiatry residents must learn about psychiatric standardized classifications* submitted to the Universidad Nacional de Colombia for the master's degree in Social Studies of Science.

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Received: January 29, 2022
Accepted: March 31, 2022

How to cite / Cómo referenciar

Daza-Cardona, J. A. (2022). Classifications in Psychiatric Education. A Postcolonial Approach. *Trilogía Ciencia Tecnología Sociedad*, v. 14, n. 27, e2298. https://doi.org/10.22430/21457778.2298

Abstract: This article contributes to the understanding of psychiatric classifications by adopting a postcolonial approach to science and technology. For this purpose, I examine the case of a psychiatry training program in a medium-sized city in Colombia. The method I used was ethnography, taking part in classes, case presentations, and academic meetings. It was found that learning about psychiatric classifications involves dynamics in which the global and the local are reconfigured according to the positions assumed by psychiatrists and psychiatry students. In this study, some participants stated that there is a cultural domination of North American psychiatry over its Colombian counterpart, and, therefore, they should adhere to the classification of the former. Others argued that psychiatric education should follow the European orientation and leave the North American classification aside. And a small group considered that they should use Latin American classifications. I conclude that the manuals of the American Psychiatric Association and the World Health Organization are established as what Rodríguez Medina calls subordinating objects, while Latin American classifications are positioned as local entities that serve specific purposes. However, the hierarchies involved in the geopolitics of knowledge can be contested in daily pedagogical practices.

Keywords: Classification systems, decolonization, science education, scientific culture.

Resumen: este artículo contribuye a la comprensión de las clasificaciones psiquiátricas partiendo de un enfoque postcolonial de la ciencia y la tecnología, para lo cual examino el caso de un programa de formación psiquiátrica en una ciudad intermedia de Colombia. Como método utilicé la etnografía, participando en clases, presentaciones de casos y reuniones académicas. Se encontró que el aprendizaje de estas clasificaciones involucra dinámicas en las que se reconfiguran lo global y lo local de acuerdo con las posiciones que asumen los psiquiatras y los estudiantes de psiquiatría. En este estudio, algunos participantes manifestaron que hay una dominación cultural de la psiquiatría norteamericana sobre su contraparte colombiana y que, por tanto, debían ceñirse a la clasificación de la primera; otros plantearon que la formación psiquiátrica debía seguir la orientación europea y dejar de lado la clasificación norteamericana; y un grupo minoritario consideró que debían remitirse a clasificaciones latinoamericanas. Concluyo que los manuales de la Asociación Americana de Psiquiatría y la Organización Mundial de la Salud se establecen como lo que Rodríguez Medina llama objetos subordinantes, mientras que las clasificaciones latinoamericanas se ubican como entidades locales que obedecen a objetivos concretos. Sin embargo, las jerarquías involucradas en la geopolítica del conocimiento pueden ser disputadas dentro de prácticas pedagógicas cotidianas.

Palabras clave: sistemas de clasificación, descolonización, enseñanza de las ciencias, cultura científica.

INTRODUCTION

Standardized psychiatric classifications are widespread tools that serve as references across countries to diagnose mental disorders. There are several of them, but I am going to start with a brief overview of the most widely discussed in the present text: the Diagnostic and Statistical Manual of Mental Disorders (DSM), the International Classification of Diseases (ICD), and the *Guía Latinoamericana de Diagnóstico Psiquiátrico* [Latin American Guide for Psychiatric Diagnosis] (GLDP).

The DSM is the classification of the American Psychiatric Association (APA) and, at the same time, the most disseminated and contested. Currently, it is in its fifth edition (DSM-5). The history of this device has been the arena of dispute of heterogeneous actors such as psychoanalysis, clinical psychology, social professions, psychopharmacology, insurance companies, pharmaceutical companies, antipsychiatry movements, LGBT activism, and even war veterans. As a response to many critiques to its foundations, the DSM switched from explaining mental disorders as the product of sexual and unconscious forces (DSM-I and II) to describing them as conglomerates of symptoms (DSM-III, IV, and 5). This move allowed the field to solidify its scientific image since this classification became a tool to standardize psychiatric disorders, no matter when or where (Strand, 2011).

The ICD is an international classification designed by the World Health Organization (WHO) to report statistically significant diseases in different countries with the aim of identifying levels of morbidity and mortality around the world. Its latest version is ICD-11 (WHO, 2019). It is not precisely a psychiatric classification but a health classification that includes mental disorders. Like many countries, Colombia has agreed to use ICD-10 (tenth edition) to record diagnoses in its entire national health system, including mental services (Resolución Numero 1895, 2001).

The GLDP is the classification of the *Asociación Psiquiátrica de América Latina* [Latin American Psychiatric Association] (APAL). It was published in 2004 and revised in 2012. This classification embraces a diagnostic model centered on the person and not on the diagnosis. Also, its main goal is to connect international classifications with Latin American realities, needs, and culture. Among other strategies to achieve this purpose, it devotes a whole chapter to cultural syndromes, which shows the local quality of mental disorders (APAL, 2012).

Psychiatric classifications are at the same time social and technical tools. To prove this claim, I suggest the reader the following exercise: Open the DSM-5 (American Psychiatric Association [APA], 2013), and you will find lists of several people from the task forces involved in its design, with their respective academic titles: M.D., M.Sc., Ph.D., etc. After that, you will mainly see codes, names of disorders, and diagnostic criteria. This information is accompanied by short notes about the features, prevalence, course, and risk factors of each disorder. Therefore, you could conclude that it is a scientific achievement supported by academic organizations, experts, and data.

In contrast with this technical perspective, Kutchins and Kirk (1997) argue that, although the DSM looks highly specialized, it outlines the way we think about our problems as a society since it demarcates normal from abnormal behaviors. For instance, it delimitates sadness from depression, sexual desire from sexual deviation, and happiness from mania. In addition, the DSM is applied beyond the clinical context: it is used in the judiciary to assess mental state in criminal behavior, it helps to establish if students need medication to achieve satisfactory academic performance, it guides studies by pharmaceutical companies that look for new molecules (and consumers), and it defines the questions that psychiatric researchers are going to ask in their protocols.

In this article, I explore the sociotechnical constitution of these classifications in the context of psychiatric education. Scholars like Fleck (1986) and Kuhn (1971) have pointed out that scientific training is a social process that shapes interest in problems, judgments, perception, methods, and technical style. Therefore, I understand psychiatric education as a practice in which psychiatry is constantly being done since students are embodying and recreating the reality of their field.

To address the way these classifications are taught and learned, I take Prentice's (2007) ethnography in operation rooms as a guide. For Prentice, each lesson, as technical as it may seem (for instance, using the non-dominant hand in surgery), involves social values (in this case, the importance of defamiliarizing students with their own bodies). Similarly, in my fieldwork, it was frequent that, when psychiatric classifications were tackled, discussions about national and continental psychiatric schools arose. In other words, as classifications were addressed, training meetings became spaces of debate about the psychiatric values and anti-values represented in the European and North American psychiatric schools.

As a result, in this article, I explore international tensions unfold in day-to-day psychiatric training interactions by adopting the framework of the South-North technoscientific exchange. According to De Greiff and Nieto (2005), this exchange is inseparable from the exercise of authority, control, and domination. In this regard, Restrepo Forero (2000) argues that, to a great extent, the subordination that some Latin American scientists have embraced depends on a self-image of inferiority, and Rodriguez-Medina et al. (2019) claim that the technoscientific peripheries are co-produced with the peripheral position from localities. Thus, the positions that Latin American and Colombian psychiatrists assume regarding foreign classifications are related to their degree of acceptance of the external authority.

Within this panorama, this text seeks to contribute to the understanding of psychiatric classifications adopting a postcolonial approach to science and technology. To achieve this, I analyze the case of a psychiatry training program in a middle-sized city in Colombia.

METHODS

This article is derived from the unpublished thesis entitled *Scientific Training and Standards: Eight sociotechnical lessons that psychiatry residents must learn about psychiatric standardized classifications* (Daza Cardona, 2015). The focus of that thesis was the construction of psychiatric expertise. In contrast, here I address psychiatric classifications adopting a postcolonial approach to science and technology. This implies understanding technoscience in a situated manner, where the local and the global are continuously reconfigured (Medina et al., 2014).

The original thesis project was based on a two-year ethnographic observation (2012–2013) and one year of analysis (2014). This period was particularly advantageous because it saw the transition from DSM-IV to DSM-5, an opportunity to understand how the introduction of a new standard reordered practices and epistemic commitments (Timmermans & Berg, 2003). Likewise, Sosiuk and Martín-Valdez (2021) hold that, by emphasizing the concrete settings in which knowledge is produced, we can explore how fields are created, ordered, and delimited. Hence, we can simultaneously understand the production of psychiatric classifications and psychiatry itself as localized and fluid processes.

In the first step in said thesis, the research protocol was presented to the academic committee of the psychiatry program and the psychiatric clinic where teaching took place; both accepted me as an observer. Also, the clinic's Institutional Ethics Committee approved the project and classified it as "riskless." Afterward, I explained the proposal to psychiatrists and psychiatry residents, and they agreed to participate by signing an informed consent form.

During the observation, I attended clinical practices, classes, case presentations, and academic meetings three times a week. In particular, I paid attention to situations where professors and students discussed psychiatric classifications. Additionally, in situ interviews were conducted. The information was collected in three media: videos, audio recordings, and hand-written notes.

The content analysis was carried out in a demo version of Atlas.ti 6.2. Using this software, I reviewed the material, identified the moments where classifications were discussed, and elaborated some interpretative notes. Afterward, the information was gathered using codes and visual networks, which helped me to select the most representative moments. Then, I described the scenes that showed the struggles that residents had in order to experience classifications as their collective. Finally, in a formal meeting, I presented the results to the participants, and we discussed their implications for psychiatric education.

Once the thesis was finished, I realized that one of the most pervasive themes in that research was the relationship between psychiatric training and technoscientific international affairs. Accordingly, in 2021 I revisited the text and reinterpreted the scenes adopting this new approach (i.e., postcolonialism).

Additionally, it is relevant to note that, in the program observed in the study, everybody spoke Spanish; hence, I translated the scenes into English. Although it may seem odd to address a postcolonial issue in a colonial language (even though Spanish has a colonial history as well), I have two reasons to do this: (1) practicality, because the original thesis was written in English and (2) to attract a larger audience. Sometimes, Latin American scientific publications only reach Spanish speakers due to language barriers. Therefore, even if it entails a colonial paradox, writing in English is a way of transcending borders, particularly for promoting exchange with other Southern regions and reflecting about the geopolitics of knowledge (Rodriguez Medina, 2019).

RESULTS

In the psychiatry program investigated here, the lessons changed according to the setting; I identified two settings: the first is the clinic, a location in which the professors regularly recommended students (in medical jargon, *residents*) not to use the DSM because it led to mistakes. The second is the academic meetings, in which the use of the standardized classifications was required, but their limitations were always underlined. The following scenes happened in the two settings; however, there were moments when the lessons taught in one setting came into conflict with those taught in the other.

Do not use phones for psychiatric interviews: the DSM and the "*gringo*" mechanical way

In the first scene, Julio[1] (a resident) presented a case to the clinical staff. While he was describing the dynamics of the patient's family, Erik (psychiatrist) asked him if the information had been obtained from a personal interview or by phone call. Julio answered that "by phone." After that, Erick got very upset and said:

> If you are going to present the DSM, it is nonsense. There is no point. You need to get over this excessively concrete thinking, so mechanistic. Is a person depressed? Even the doorman can tell. We need to transcend the DSM and ICD criteria. This is not about a set of symptoms, it's about patients' experience. We need to go back to Jaspers' phenomenology. Don't mess with the DSM, don't limit yourself to lists of symptoms. This psychiatric nosology is leading us nowhere. You keep reciting things, but you don't understand the patient (Psychiatrist during case presentation).

Finally, Erick stopped the presentation and concluded that the case should be repeated. The technical lesson here is not to use phones for psychiatric interviews; however, it is also about psychiatry values and anti-values. For this psychiatrist, the ICD, and especially the DSM, embodies the psychiatric anti-values. Expressions like "nonsense," "there's no point," "concrete thinking," "mechanistic," "don't limit yourself to lists of symptoms," and "you keep reciting

[1] All participants' names have been changed to protect their identity.

things" imply that those who use these classifications are fools, prepare inadequate cases, and are not able to make abstractions. Moreover, for Erik, these classifications are leading residents to rigidity and lack of reflection.

Mentioning the doorman is a way of saying that these classifications are so simple that even a person without psychiatric training (for example, someone who works opening and closing doors) can use them. Additionally, to "transcend the DSM and ICD criteria" suggests that these are only useful at the lowest level of expertise, and students need to reach higher levels. In contrast, residents were encouraged to embrace values such as understanding "patients' experience" and "Jaspers' phenomenology."

The following week, the presentation was repeated. When it was finished, Julio said that last time he had made a mistake because he was "superficial," "didn't understand the patient as a whole," and "did not pay attention to what was really happening." Erick answered: "You see the difference when you interview by phone. Don't fall into the *gringo* mechanical ways; that's what *gringos* do." This reaction implied a turn, an issue of psychiatric interviews became a matter of international science. The lesson now is not to follow North American psychiatry, which is described as "mechanical." Additionally, using expressions such as "*gringo*" and "*gringos*" as derogatory ways to talk about the United States, is another way to discredit the implementation of phone interviews and the DSM. Erick added two anecdotes to support his point. The following is the first one:

> Yesterday, I was astonished because a friend of mine brought his son to my private practice. They live in New York, and, over there, the son was diagnosed with schizophrenia. Then, I asked him, "Who was your psychiatrist?" The father said, "No, it was all by phone." I said, "How come?". "I am interviewed by phone, they send me the prescription on the internet, I print the prescription, and I go to the pharmacy." This is the new model of primary intervention to treat schizophrenics in the United States. When I interviewed the son, he had a tantrum, nothing to do with schizophrenia, but they had diagnosed him by phone (Psychiatrist during case presentation).

This story presents the kind of intervention that, for Erik, comes with a psychiatric model based on phone interviews, which is presented as the typical "*gringo*" way. In this situation, the psychiatric act was performed by phone, and the people who did it are pictured with the vague term "they." There are no psychiatrists; it is almost as if the telephone had its own agency, but a bad one because it produces misdiagnoses and wrong treatments.

Second anecdote:

> There is a Peruvian physician named Argos, who is very famous in the United States. He is a child psychiatrist, but he has never seen a kid. He is the leader in child treatment over the internet. He does therapy, diagnosis, and interviews from his house all day and charges 300 dollars for half an hour. I am not against technology, but, for many human issues, you need to have the patient in front of you. Who can tell me if what I am treating is the patient or a simulation? (Psychiatrist during case presentation).

In this anecdote, the internet has taken the place of the phone. The point is that many human issues need physical presence. Furthermore, it is interesting because it involves a Peruvian psychiatrist. The problem is not precisely the nationality, but specific methods for doing things that even someone from a Latin American country is at risk of adopting if she or he works in the United States. These "*gringo*" ways are represented by the 300 dollars for half an hour that Argos earns from the comfort of his house. In other words, Erik is suggesting that this psychiatrist values earning money fast and easy over understanding his patients and their well-being.

Should I carry the DSM around? European vs. North American psychiatric school

This section is devoted to Albert, a resident who used to carry the DSM summary with him all the time. Then, one day, he stopped this practice. In his words:

> I didn't do it in an entirely conscious way, but one day I thought, "How about that? I am not carrying that little book." It wasn't something like "I am going to leave it because…" I stopped carrying it with me because I didn't use it; it had ceased to be indispensable for me. Mainly, I stopped using it in the practices with Doctors Erick and Gustav. They have lectured me several times. They have said to me, "no DSM." They have told me that it is only about symptoms, and they are right because the DSM is only symptoms (Psychiatry resident during interview).

To carry some object around in your daily practice is not a minor detail, you only take this trouble with important objects. Albert's relationship with the DSM changed due to the constant instructions of psychiatrists at the clinic against its use. Nevertheless, there are some moments when using this manual is desirable or even mandatory.

> You use it depending on the professors or in some cases. In the academic meetings, you use the DSM as a guide because some professors are very strict with it. Then, you must carry it, open it, and review the criteria; but, with other professors or in other occasions, you don't do that. In general, you use the DSM throughout training because it is a guide. There are moments when it is needed more depending on the case, professor, or necessity (Psychiatry resident during interview).

During psychiatric training, the use of the DSM depends on the professors' preferences. Albert classified them into two groups: the DSM group from the academic meetings and the existential group that is mostly in the clinic. The former pushes students to use the DSM, while the latter forbids it. Albert also mentioned other situations in which he uses it, for example, when he addresses topics that are new to him.

Lastly, this resident explained that, even if he does not like this classification and he is closer to the existential group, he is forced (to some extent) to use it:

> The DSM is relevant for trying to speak the same language because it is used in most Western countries, in almost the entire world. Its purpose is that everyone understands each other, the unification of the psychiatric language. Some professors say that, in the United States, they are

> too mechanical when using it: they fit the patients in a diagnosis, the patients take medication, and the issue is over. What they say is that, in North America, the DSM is used a lot without the analysis of the patient. But, in Europe, the existential component is more relevant; therefore, they do not use the DSM as much. For example, they have told us that French psychiatry is more holistic (Psychiatry resident during interview).

Even if Albert did not carry the DSM with him anymore because it represents the mechanistic values coming from the United States, he needs to speak the DSM language to communicate with other psychiatrists around the world. Hence, being part of the Western psychiatric community involves knowing the DSM. Again, the solution to deal with this is the European school. In this case, French psychiatry is mentioned, and, previously, German psychiatrist Karl Jaspers was referred to.

The DSM is so fallacious that even some progressive groups in the United States are leaving it aside

Once more at the clinic, Erik is against the DSM. In this case, he argued that it is contrary to scientific knowledge and patients' well-being because it is the product of many interests. In his words:

> Until the DSM-III, Postpartum Depression was the most frequent kind of depression in the United States… The DSM is influenced by insurance companies, the pharmaceutical industry, political interest groups such as gays and lesbians, and the Jews. What happened? The insurance companies presented statistics saying that Postpartum Depression was the most frequent type of depression, and its treatment was costing thousands of millions. After that, a controversy arose in the design of the DSM, and the influence of the insurance companies was so great that they eliminated Postpartum Depression as a diagnosis. Then, women who get depressed after giving birth do not have the right to be treated under the diagnosis of Postpartum Depression. They denied them postpartum services. They removed it completely from the DSM. It's the DSM's game that one can see. How can we treat women? We cannot treat them. That calmed down the insurance companies (Psychiatrist during class).

Including this story in a class discussion is a strategy to prove that there was something real called Postpartum Depression. Then, the insurance companies, with their power and economic interests, managed to make it disappear, even at the cost of hurting women. Erik continued:

> The DSM is a fallacy of many interests. That's why the DSM-5 hasn't been finished, because it is a huge controversy… It is everyone's and no man's land. Recently, progressive groups in the United States have questioned this entire diagnostic manual. What's more, they are not teaching it. Instead, they are rediscovering the phenomenological existential approach in psychiatry (Psychiatrist during class).

The interests involved in the DSM's design led this psychiatrist to conclude that it is fallacious. Furthermore, he pointed out that the difficulties in agreements in the construction of the DSM-5 are proof that these interests are against psychiatric development. Finally, claiming that progressive groups in the United States decided not to teach the DSM because they do not

trust it, indicates that he is not the only one aware of the interests; even some psychiatrists from the country where it is mostly designed have noticed them.

The Latin American Guide for Psychiatric Diagnosis vs. the DSM

In an academic meeting, a resident that we are going to call Aaron started with the following:

> We are going to see a multi-axial approach different from the one of the DSM. The idea is to use these meetings to see other ways of doing things. Therefore, I will present the Latin American Guide for Psychiatric Diagnosis (Psychiatry resident during academic meeting).

Aaron recognizes that his audience is used to the DSM and maybe does not know about the GLDP. Then, he appealed to some sort of scientific curiosity saying that this is the moment to try alternative ways of doing things. Then, he continued:

> It is based on the International Classification of Diseases. And I find it interesting to see this other perspective because, in fact, instead of other guidelines for diagnosis, this is the one that we're supposed to be using according to the law. They are not so different, but I think this one allows more flexibility for the diagnosis. The guide says that the diagnosis—more than identifying diseases or distinguishing some diseases from others—support the way in which I can help the patient (Psychiatry resident during academic meeting).

Once the interest of the audience was captured, Aaron made the argument more serious. It is not anymore about scientific curiosity, but regulations. With "other guidelines" he is talking about the DSM; he is saying that they must stop using it and pay attention to the GLDP. According to this resident, the latter is based on the ICD, the classification that is used in the Colombian health system. Similarly, he claimed that the GLDP is not so different from the DSM; however, the former is better because it is more flexible and not exclusively designed for diagnosis, but for helping people.

Aaron continued defining the GLDP:

> It contains a multi-axial standardized formulation based on the ICD-10 that follows lines similar to those of the DSM-IV, but it is constructed based on the different multi-axial guidelines for diagnosis that have been used in Latin America. There is a Brazilian one, we have the Cuban Glossary, one from Costa Rica, and another one from Argentina (Psychiatry resident during academic meeting).

The GLDP connects international standards and regional classifications. In other words, it acknowledges global trends and is sensitive to regional dynamics. Lastly, it is remarkable how Aaron needs to use the DSM as a constant reference for comparison. He recognizes it as the standard, and, if he wants to implement different practices, he needs to prove that they are better than the established ones.

The DSM-5 and the North American cultural dominance over Latin America and Colombia

Luis (another resident) prepared a presentation about the changes that occurred in the transition from the DSM-IV to the DSM-5 concerning the Depression category. He started:

> In the DSM-IV-TR (text revision), Depressive Disorders and Bipolar Affective Disorders came in a group called Mood Disorders; instead, in the DSM-5, Depressive Disorders became an exclusive chapter called Depressive Disorders. These disorders include: a new diagnosis called Disruptive Mood Dysregulation Disorder; Major Depressive Disorder, which continues without variations except for some considerations about mourning; Persistent Depressive Disorder, a new label for the consolidation of two DSM-IV diagnoses; Premenstrual Dysphoric Disorder, which was not specified in the DSM-IV and now is a specific depressive disorder; Substance/Medication-Induced Disorders; Disorders Due to Another Medical Condition, which were not modified; Other Specified Disorders; and Unspecified Disorders (Psychiatry resident during academic meeting).

The publication of the DSM-5 brought along changes in the way psychiatry classifies disorders. Entities are separated, modified, and relocated. In this meeting, each one of the depressive disorders was discussed, and psychiatrists and residents talked about the meaning of the changes, the implications in the treatments, the contradictions of some symptoms, the good and bad aspects of the new classification, and the diagnoses that gained and lost importance.

In this meeting, the group laughed a lot. When they were asked why, this was Emerald's (a psychiatrist) answer:

> There is an apparent laugh because it's still controversial. It's a situation that concerns us all, and there are so many opinions: some are in favor, and some are against it. Also, a lot has been said about the pressure from the pharmaceutical industry behind the classification. I cannot deny this pressure, but I do not entirely agree with that because I think people are very serious, especially psychiatrists; they know what this implies for people's lives. Thus, I believe in the experts. Latin American experts who participated in the DSM-5 came to the last national congress and told us about private discussions. They said that it was not easy, but it was serious work. Some people's positions, other positions, the things that were discussed, the hours they spent modifying a term and reaching an agreement; all of this says that there was real work (Psychiatrist during academic meeting).

These are not the same arguments that Erick put forward when he presented the DSM as a fallacious classification. Emerald did not deny the pressure of the pharmaceutical companies, but she believes that it does not affect experts' intentions, mainly because they have offered testimony by talking about their private meetings (for example, the time they spent solving minor details to arrive at agreements). Likewise, this is related to the place of origin of the psychiatrists who gave testimony because Latin American experts have more credibility in the Colombian psychiatric congress than those from other places.

Emerald continued:

> We are in a stage of transition in which it is hard to appropriate the classification, to understand it well. It will probably be imposed as it happened with the third edition, the fourth, and the revised fourth because we cannot deny that it is planned as something global to rule everybody with a single classification. Also, Latin America is, to a great extent, dominated by the North American culture (Psychiatrist during academic meeting).

The DSM is about the classification of disorders but also a matter of intellectual colonialism. For this psychiatrist, the DSM-5 will impose itself because North America is a point of reference that rules Latin American culture, and psychiatric classifications are no exception. Nevertheless, regarding this North American predominance, Emerald's position is not entirely representative of all the psychiatrists in the program. For example, Morpheus said in the meeting, "The fact that we have a North American orientation does not mean that it is the same in the rest of South America."

It is interesting that, unlike Emerald, Morpheus does not believe that the whole South American culture is oriented towards North America. Instead, he invites the residents to understand that it only guides Colombian psychiatry because other South American countries implement different practices.

Between the DSM-IV-TR, the DSM-5, and the ICD-10. The rest are local classifications

At the end of the meeting mentioned above, Emerald and Angelique (another psychiatrist) said the following:

> Emerald: As specialists, we must pay more attention to this, but the classification in hospitals, clinics, and wherever you work is going to contradict the DSM-5 because the ICD is not being updated at the same speed. Thus, if you make a diagnosis and go to the clinical record of any clinic, you will have to use the ICD-10 again. So, this is a complex stage.
> Angelique: We are among three classifications: the DSM-IV-TR, the DSM-5, and the ICD-10. The ICD will not be changed because the Ministry of Health has told us that we cannot modify the entire software (Psychiatrists during academic meeting).

The contradiction between clinical records and the DSM-5 pointed out by Emerald exists because the Colombian health system uses the ICD-10 to record medical diagnoses, but the latter is not adapted to the changes of the new psychiatric classification (i.e., the DSM-5). Still, health institutions in Colombia have implemented technologies to record ICD-10 diagnoses; for example, it is common for clinics and hospitals to adopt software that restricts the possibilities to the ICD-10 categories only. In this sense, Angelique claims that the Ministry of Health will not change the ICD-10 because it implies modifications in the whole information infrastructure. As a result, they are forced to deal with three active standardized classifications: the unstable DSM-5, the stable DSM-IV-TR, and the regulated ICD-10.

Participants were asked if the GLPD could be considered a fourth standard that residents must learn. About this point, Pierre (another psychiatrist) expressed, "There are some local classifications—the Cuban, the French, the Argentinian—but all of them have a tendency towards the DSM and the ICD." Angelique added, "More local classifications are used for specific purposes."

The group does not accept other standards besides these three options. In this sense, Aaron's presentation about the GLDP did not accomplish the goal of changing their practices. The psychiatrists consider it a local classification with specific goals that does not have the global status of the ICD or the DSM. In other words, these two are the universal standards. Other attempts to classify mental disorders are considered local or specific.

DISCUSSION

The relationship between psychiatric standards for disorder classification and international psychiatric schools was an overarching issue in the present work. In particular, the psychiatrists and the residents in the program studied here were concerned about the DSM and the North American psychiatric school. Still, there was no agreement among them, and each one of their positions gave an account of how they relate to foreign authority.

On one end of the spectrum, the DSM is accepted as a tool for communication among western psychiatrists; nevertheless, the West is presented as "almost the entire world." Paraphrasing Nieto and Martín (2005) in an argument used to understand Eurocentrism, the risk of Americentrism is not to be excluded, but to be assimilated from a single perspective. In this case, the DSM is a tool for the communication of psychiatrists worldwide, and its origin is not important. In other words, it is not a North American standard but a Western (global) one.

Nevertheless, the universality of this tool slowly decreased. One psychiatrist posited that North America exerts dominance only over Latin America, but it is a general ("cultural") dominance of which psychiatry is only a part. The result of this is that the North American psychiatric standard is used in Latin America. In the meantime, another psychiatrist claimed that the dominance of this psychiatric school is only limited to Colombia and does not extend to all Latin America. Consequently, the DSM is particularly used in Colombia.

On the other end of the spectrum, another participant asserted that the DSM is implemented only in North America (with the exception of some "progressive groups"), but it is not the orientation that psychiatrists must follow. Instead, they should embrace the European (French) school. Moreover, they should reject the North American psychiatric school and the DSM because they are more concerned with earning money effortlessly than with understanding patients and their well-being.

As Collins and Pinch (1998) have pointed out, the interpretation of nature depends on people's position on facts. In this sense, both ends of the spectrum acknowledge that interest groups are involved in the construction of the DSM, but they attribute different effects to it.

On the one hand, those who sympathize more with the DSM tend to trust the testimony of the experts' "real work" in the design process; therefore, said classification is protected against the economic interests of pharmaceutical companies. On the other hand, its detractors affirm that such interests have made it fallacious and a tool that hinders adequate treatment for patients, privileging the profits of said companies.

When the GLDP was addressed, the participants referred to classifications from other countries, such as Brazil, Cuba, Argentina, Costa Rica, and France. Yet, despite the attempts of a resident who tried to convince the members of the program that the GLDP was better and even mandatory, psychiatrists identified it as a local classification with specific goals. In contrast, the ICD and the DSM are seen as general classifications whose purpose is to be global references.

This way of sorting classifications causes tension with the GLDP's official discourse, which proposes the following regarding the importance of national and regional annotation to the global classification:

> There is an open space for adding national and regional annotations to the psychiatric classification of the WHO (World Health Organization [WHO], 1992a). The 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association, the 2nd revised edition of the *Chinese Classification of Mental Disorders*, and the 3rd edition of the *Cuban Glossary of Psychiatry* are examples of such annotations, adaptations, or national or regional versions of the International Classification of Diseases (APAL, 2012, p. 11)[2].

In this statement, the WHO's classification is the global reference, and others like the DSM, the Chinese classification, and the Cuban Glossary are national and regional annotations to the ICD. In other words, even though it is not said directly, those who designed the GLDP are trying to put the North American classification at the same level as theirs.

Some of the GLDP's authors (Otero et al., 2011) identify two moments in the history of Latin American classifications. First, Latin American psychiatrists were not looking for a unified standard, but many isolated classifications were produced. Second, Latin American psychiatry achieved scientific "maturity," allowing the unified construction of the GLDP. However, if we look at it from the opposite perspective, we may think that the GLDP is a strategy by Latin American psychiatrists to present their school as an international reference able to produce its own knowledge.

Based on these ideas, we can claim that, in the program analyzed here, the DSM and the ICD are what Rodríguez Medina (2013, 2014) calls subordinating objects (*objetos subordinantes* in Spanish). According to him, subordinating objects are products that travel between social worlds equipped with uneven symbolic and material resources. These objects shape academic fields, not because of their content but because of the semiotic-material networks in which they are immersed. This phenomenon has three consequences: (1) the

[2] Translated by the author.

foreign is considered central and mandatory while the local is seen as peripheral, optional, and complementary; (2) the foreign is established as the new while it is assumed that the local lacks originality; and (3) the "true" categories chosen to understand the local are the foreign ones. In this respect, the DSM and the ICD are positioned as the standards. The ICD is a standard because it rules the Colombian health system, is connected to the established informational structures, and is published by the WHO—the world authority in health issues—. In turn, the DSM is another standard not only because it is the current psychiatric language but also because of the self-assumed authority of North America over Colombia.

To contest subordinating objects, Rodríguez Medina (2013) offers two solutions: (1) to densify the peripheral networks, for example, in South-South exchanges; and (2) to highlight the local epistemic identity. The GLDP seems to follow both recommendations. On the one hand, it is presented as the product of the exchange among Latin American countries. On the other hand, it includes a whole dissertation about what Latin America is and the importance of thinking about Latin American mental health issues with Latin American resources. Nevertheless, it has been overlooked. Therefore, future studies should examine the networks in which the GLDP is assembled and sustained.

The following closing paragraphs explore some methodological insights about psychiatric education, spatiality, and the use of classifications in practice. Scientific training is a way of remaking science because it is a moment when the reality of the fields is negotiated and embodied. Paraphrasing Latour (1992), it is "science in action" as facts themselves are being made. In this sense, my observations allowed me to address the actual process in which psychiatric classifications were constructed in the interaction between residents and professors.

Similarly, space itself was remade. In this sense, Raffles (2002) recommends understanding places in terms of place-making rather than ready-made places. Also, Pérez-Bustos et al. (2018) argue that places are the outcome of complex topologies that are not identical to geography. Likewise, our starting point was a psychiatry training program in a specific city, but we rapidly saw that, inside clinics and classrooms, countries and psychiatric schools of thought were in a constant making. Consequently, the limit between local and global was unclear, just as the classifications we addressed were neither and both.

Pickersgill (2012) claims that, in practice, psychiatrists use the DSM influenced by their personal and professional attitudes and the national and local cultures. For example, to avoid losing professional independence due to standardization, some psychiatrists from New York performed several "workarounds" (Whooley, 2010). For instance, they implement their taxonomies and then translate them into DSM terms, use few categories instead of the hundreds of options offered in this manual, focus less on the diagnosis and more on the treatment, intentionally skip recording the diagnosis, avoid diagnosis that may lead to social stigmatization, assign more severe diagnoses to make sure that the insurance companies pay for the treatments, and use vague diagnoses such as "not otherwise specified." Therefore, even the most widely recognized and standardized psychiatric classifications rely on actual practices and are not mechanical recipes adopted blindly.

CONCLUSIONS

If we assume knowledge as something that is only created in the metropolis, psychiatric classifications become fixed entities vertically assimilated by Latin American psychiatric schools. However, if we study them as fluid objects, we realize that they rely on daily practices. Then, if we adopt a situated approach to scientific training, we can acknowledge that psychiatric education is, at the same time, an issue of professional reproduction and a means to shape psychiatry.

Finally, the hierarchies involved in the geopolitics of knowledge can be contested within concrete pedagogical practices. One option opened with the present research is to teach the Latin American Guide for Psychiatric Diagnosis. Others could be to include more Latin American and Colombian scholars in the content of the courses, to understand diagnoses as local entities, and to include postcolonial reflections in psychiatry programs.

ACKNOWLEDGMENTS

I am grateful to Malcolm Ashmore, Luisa Daza, and Carlos Muñoz for their feedback and English writing suggestions. Likewise, I would like to express my sincere thanks to the psychiatrists, the university, and the clinic, who patiently allowed me to observe their practice without restrictions.

CONFLICTS OF INTEREST

The author declares no conflicts of financial, professional, or personal interests that may inappropriately influence the results that were obtained or the interpretations that are proposed here.

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