Anthropology and psychiatry: the contemporary convergence

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EDITORS' INTRODUCTION

Anthropology and psychiatry as disciplines appear to have a considerable amount of common ground. Both are interested in human beings, the societies within which they live and their behaviours. A key starting difference between the two is anthropology's interest in relativism, whereas psychiatry has been interested in universalism. Also, both anthropology and psychiatry have a long history of common interest in phenomenology and the qualitative dimensions of human experience, as well as a broader comparative and epidemiological approach.

Jenkins illustrates the common ground by emphasizing that both disciplines contribute to the philosophical questions of meaning and experience raised by cultural diversity in mental illness and healing. Both disciplines also contribute to the practical problems of identifying and treating distress of patients from diverse ethnic and religious groups. Psychiatry focuses on individual biography and pathology, thereby giving it a unique relevance and transformation. Patient narratives thus become of great interest to clinicians and anthropologists. Development of specializations such as medical or clinical anthropology puts medicine in general and psychiatry in particular under a magnifying glass. Using Jungian psychology as an exemplar could lead to a clearer identification of convergence between the two disciplines. The nexus between anthropology of emotion and the study of psychopathology identified in her own work by Jenkins looks at normality and abnormality, feeling and emotion, variability of course and outcome, among others. She ends the chapter on an optimistic note, highlighting the fact that the convergence between these two disciplines remains a very fertile ground for generating ideas and issues with the potential to stimulate both disciplines.

Introduction

The convergence of anthropology and psychiatry is one of the most productive zones of intellectual activity in the history of ideas, bringing two disciplines to bear on a set of questions fundamental to the definition of human being. The notion of a comparative psychiatry dates back at least as far as Kraepelin. Psychiatrists since Freud have become fascinated with the experiential diversity of ethnographic data, and anthropologists such as Benedict and Devereux, struggling with the slippery boundary between normal and abnormal, have had repeated recourse to the data of psychiatry. Anthropologists such as Levi-Strauss and psychiatrists such as Frank have invoked an analogy between indigenous ritual healing and psychotherapy in their attempts to understand the efficacy of both genres of treatment. Both anthropologists and psychiatrists have struggled with the question of relativity in defining forms of psychopathology, in a debate ranging from the demonstration that there are universal core symptoms of some disorders to the identification of culture-bound syndromes that exist only under certain human conditions. Active collaborations have been undertaken periodically since at least the time of Sullivan and Sapir. Although the expertise of the two disciplines is divergent, both contribute to the philosophical questions of meaning and experience raised by cultural diversity in mental illness and healing. Likewise, both contribute to the practical problems of how best to treat the distress of patients from diverse ethnic and religious groups,

and how to conceive psychiatric disorder in successive revisions of the DSM nosology.

My strategy in this chapter does not focus on discriminating the contributions of the two fields, but on outlining a series of topics common to their contemporary mutual interest in the relation between culture and mental illness/healing. In doing so I organize the material in such a way as to call attention to conceptual contrasts that transcend or lie outside the disciplinary distinction between anthropology and psychiatry. How, for example, is it different to examine the cultural factors affecting the use of psychopharmaceuticals and those affecting the use of alcohol and social drugs? What is the consequence of adopting the different perspectives implied by the study of psychiatric treatment and psychiatric services? What is the difference in views of human variability that seek out the existence of culture-bound syndromes and those that recognize cultural variations in psychiatric disorders defined essentially in Western terms? How much in common is there among the perspectives of psychiatric anthropology, (trans) cultural psychiatry, and ethnopsychiatry? Is there a significant difference beyond that of magnitude of trauma in the mental health of immigrants and that of refugees?

Defining the convergence

A variety of statements both synthetic and programmatic have defined the convergence between anthropology and psychiatry since the early essay by Kraepelin on '*Comparative Psychiatry*' in 1904. Particularly useful is the collection of seminal works from 1880 to 1971 edited by Littlewood and Dein (2000), which traces a repertoire of interests ranging across defining the normal and abnormal, the Oedipus complex, family structure, magic and religion, death, suicide, intoxicants, anxiety, symbolism, and culture-bound syndromes. Raimundo *et al.* (2005) examines the historical precursors of cross-cultural psychiatry among nineteenth century alienists, whose work was predicated on the notion that insanity was rare among primitive peoples and increased along with civilization and its increasing levels of cognitive organization, demands for mental production, and occasions for mental excitation. This apparent observation was eventually interpreted in racist neurobiological terms such that the natives' brains were said to be more simple and crude than those of civilized peoples.

Bains (2005) examines the more recent history of transcultural psychiatry, pointing out that its identity as a distinctive discipline dates from after World War II. A powerful voice from this postwar period was Ernest Becker (1962, 2005), whose concern with meaning resonates more than 40 years later. The 1970s and 1980s saw a rapid development and reformulation, in the midst of which a 'new cross-cultural psychiatry' emerged from a synthesis of interpretive approaches from anthropology and an increasingly sophisticated academic psychiatry (Martins, 1969; Wittkower and Wintrob, 1969; Wittkower and Dubrenil, 1970; Galdston, 1971; Kiev, 1972; Kennedy, 1974; Cox, 1977; Padilla and Padilla, 1977; Miller, 1977; Estroff, 1978; Kleinman, 1977, 1980; Murphy, 1983, 1984).

Summarizing the decade of work since Kleinman's (1977) watershed definition of the revitalized interdisciplinary field, Littlewood (1990) contrasted the new cross-cultural psychiatry's anthropological emphasis on psychiatric epistemology and clinical practice to assess the universality of psychopathology with the old cross-cultural psychiatry's relative emphasis on examining the applicability of psychoanalytic concepts to non-Western societies. Writing in the same year Leff (1990) suggested that the shift in focus and the new agenda for investigation was a case of throwing the baby out with the bathwater. Within several years Lewis-Fernandez and Kleinman (1995) hailed cross-cultural psychiatry as a mature discipline addressing the complexities of sociosomatics and clinically relevant cultural processes, while decrying the limited impact of the field with respect to cultural validation of the DSM-IV, persistent misdiagnosis of minority patients, continued presence of racial bias in treatment, and inattention to ethnic issues in

medical ethics. This claim to maturity of the field has been reiterated by Lopez and Guarnaccia (2000, 2005) with reference to the study of cultural psychopathology as the study of culture and the definition, experience, distribution, and course of psychological disorders. An important synthesis of the discipline in textbook form has been contributed by Helman (2000).

The mutual relevance of anthropology and psychiatry remains an important concern for scholars and clinicians in the field (Mihanovic *et al.*, 2005; Stix, 1996; Skultans and Cox, 2000). On the one hand, Kleinman (1987, 1988) has highlighted the contribution of anthropology to cross-cultural psychiatry with respect to issues such as translation, the category fallacy in defining psychiatric disorder, and pathoplasticity/pathogenicity, emphasizing anthropology's attention to cultural validity in addition to reliability, and to the relevance of cultural analysis to psychiatry's own taxonomies and methods. On the other hand, Kirmayer (2001) has reprised Edward Sapir's argument that psychiatry's focus on individual biography and pathology gives it a unique relevance for anthropology's concern with cultural transmission, suggesting that recent work focused on illness narratives help to position individuals in a social world. Skultans (1991) examines the uneasy alliance between anthropology and psychiatry historically and with respect to the way differences in orientation between the two disciplines have led to conflicting ideas about the nature of cross-cultural research, particularly anthropological fieldwork.

Theory, method and clinical relevance

Occasional attempts have been made to establish a conceptual and theoretical grounding specific to the convergence of anthropology and psychiatry. One group of scholars has examined the value of Jungian psychology with its emphasis on imagination and phenomenology for both clinical and research work in cultural psychiatry (Abramovitch and Kirmayer, 2003). The key concept of explanatory models, focusing on the patient's understanding of illness episodes, was introduced by Kleinman (1980) and has inspired a substantial body of research, as well as debate about the concept's use in clinical work (Bhui *et al.*, 2002, 2004, Dein, 2002). Foulks (1991) has addressed the underlying concepts of normal, abnormal, and deviant against the conceptual background of social pathology, cultural relativism, evolution and the biological basis of mental disorders, heredity, and the distinction within DSM between Axis I and Axis II spectrum disorders. An evolutionary concept of mental disorder has been elaborated in terms of culture and context by Kirmayer and Young (1999). Paris (1994) argues that evolutionary social science is relevant for transcultural psychiatry insofar as it is consistent with a biopsychosocial model of etiology, and recognizes universals which underlie cultural variations in psychopathology. Jovanovski (1995) suggests that the pathoplasticity of mental disorders across cultural contexts indicates that abnormality is phenotypic rather than genotypic, but argues that neuroses are more associated with culture while psychoses with biology.

Jenkins (1991b) has introduced the notion of political ethos to bridge analysis of the state construction of affect and the phenomenology of those affects in the mental-health sequelae of political violence experienced by refugees. In other work Jenkins (1991a, 1994a,b, 1996) examines the nexus between the anthropology of emotion and the study of psychopathology with respect to distinctions between normal and pathological emotion, feeling and emotion, interpersonal and intrapsychic accounts of distress and disorder, variability of course and outcome, mind–body dualism, and the conceptualization of psychopathology as biologically natural event or sociopolitically produced response. The concept of personality has been addressed by Lewis-Fernandez and Kleinman (1994), who show with examples from Chinese and Puerto Rican societies how socially oriented indigenous interpersonal models of personality and psychopathology can augment the cross-cultural validity of clinical formulations. Byron Good (1994) places meaning

squarely at the conceptual center of the convergence between anthropology and psychiatry, with a hermeneutic critique of rationality that flows into a celebration of experience. In the context of a critical examination of how we interpret psychiatric symptoms, Martinez-Hernaez (2000) elaborates the complementarity of psychiatric observation and anthropological understanding.

Equally important as the theoretical and philosophical bridge between disciplines of anthropology and psychiatry is the pragmatic bridge from the conceptual work to its clinical relevance. Alarcon *et al.* (1999) describe five interrelated dimensions that specify the clinical relevance of culture as (1) an interpretive/explanatory tool in understanding psychopathology; (2) a pathogenic/pathoplastic agent; (3) a diagnostic/nosological factor; (4) a therapeutic/protective element; (5) a service/management instrument (see also Emsley *et al.*, 2000). Good and Good (1981) argue cogently for a cultural hermeneutic model for understanding patient experience in clinical practice. Moldavsky (2003) points out that contemporary transcultural psychiatry focuses more on the illness experience than the disease process, while distancing itself from the absolute relativism of antipsychiatry, focusing on clinical issues that aid clinicians in their primary task of alleviating suffering. DiNicola (1985 part I, part II) has offered a synthesis between family therapy and transcultural psychiatry, and Castillo (1997) elaborates a client-centered approach to culture and mental illness. Okpaku (1998) has offered a global compendium of case studies and clinical experience to provide practicing clinicians with a basic foundation of culturally informed psychiatry. Ponce (1998) advocates a value orientations model of culture for use in clinical practice, the rationale and internal logic of which is predicated on the concepts of paradigm and epistemology.

Guarnaccia (2003) has outlined methodological advances that will likely help define research in cross-cultural psychiatry in the early twenty-first century. Hollan (1997) advocates person-centered ethnography as a method ideally compatible with the goals of cross-cultural psychiatry. Experiments have been made with focus-group methods in order to enhance the contextual basis for making culturally sensitive interpretations (Ekblad and Baarnhielm 2002). Rogler (1999) offers a methodological critique of the procedural norms that lead to cultural insensitivity in mental-health research, highlighting the development of content validity based on experts' rational analysis of concepts, linguistic translations that conform rigidly to the literal terms of standardized instruments, and the uncritical transferring of concepts across cultures. The methodological contribution of cognitive neuroscience is discussed by Henningsen and Kirmayer (2000), comparing the two orders of higher level explanation constituted by intentional vs. dynamical systems theory and the subpersonal explanation of cognitive psychology and neurobiology.

From a comparative and anthropological standpoint, Jenkins and Karno (1992) have examined the theoretical status of expressed emotion, one of the most heavily used methodological constructs in studies of major mental disorder. Starting from the WHO cross-cultural studies of schizophrenia, Hopper (1991) critically examines the validity of various aspects of methodological critique registered by anthropologists against such large-scale psychiatric epidemiological studies, concluding that there is a natural alliance between clinicians alerted to cultural factors affecting course and outcome, and ethnographers attuned to cultural beliefs, work patterns, kin-based support, uses of public space, and indigenous understandings of affliction. Uehara *et al.* (2002) suggest that ethnographic understanding in the assessment of Asian-American mental health would benefit particularly from use of semantic network analysis and common-sense-reasoning analysis.

Shared research agendas

The research agenda for this hybrid field continues to be defined and redefined. At the current moment the field has been given a certain degree of coherence and consistency by a collective mobilization

to address the strengths and weaknesses of the attempt to integrate cultural factors into the professional psychiatric nosology institutionalized in the DSM-IV. Good (1992) has made a cogent argument mediating between cultural relativists who consider the DSM nosology as culture-bound and ethnocentric, and universalists who understand the nosology to reflect invariant characterstics of psychopathology, pointing out that the psychiatric nosology is a valuable ready-made comparative framework while at the same time being vulnerable to cross-cultural critique by demonstration of variability in psychiatric syndromes. A substantial body of experts collaborated in the effort to incorporate cultural issues into DSM-IV. Eventually included were an introductory cultural statement, cultural considerations for the use of diagnostic categories, a glossary of culture-bound syndromes and idioms of distress, and an outline for a cultural formulation of diagnoses in individual cases (Mezzich et al., 1999). In the aftermath these same experts collaborated in an analysis and critique of what was proposed in comparison to what was excluded (Mezzich et al. 1996; Kirmayer, 1997). As of this writing, attention is already being focused on the challenge of further enhancing the role of culture in DSM-V (Alarcon et al., 2002). Meanwhile, the ongoing development and testing of psychiatric categories in the 10th Revision of the International Classification of Diseases has drawn sustained attention of Sartorius (1988, 1991) and colleagues (Sartorius et al., 1993, 1995).

An important tool for furthering the integration of culture into DSM-IV has been its inclusion of an outline for cultural formulation (Lewis-Fernandez and Diaz, 2002). The cultural formulation is perhaps the most concrete expression of the contemporary convergence of anthropology and psychiatry. It is also at the same time a clinical tool in that it is a comprehensive summation of cultural factors in an individual case, and an ethnographic document in which cultural context and themes are elaborated from a person-centered standpoint. It is unclear the extent to which the cultural formulation is currently being used in clinical practice, but it has a strong presence in the research arena as a regular feature in the journal *Culture, Medicine, and Psychiatry*, which for more than a decade has published cultural formulations in the form of brief articles of value to both clinicians and ethnographers. Novins *et al.* (1997) take a step toward using the DSM-IV outline to develop comprehensive cultural formulations for children and adolescents, critically reviewing the use of the outline in the context of preparing cultural formulations of four American Indian 6–13-year olds. Sethi *et al.* (2003) suggest that the cultural formulation can be useful for bridging the gap between understandings of form and content in the understanding of psychiatric signs and symptoms.

The traditional North American conceptualization of ethnopsychiatry focuses on the study of indigenous forms of healing understood as analogous to what in Western terms is broadly defined as psychotherapy (Kiev 1964; Frank and Frank 1991). Renewing and updating this agenda, cultural variants of healing and therapeutic process emphasizing modulations in bodily experience, transformation of self, aesthetics, and religion have been contributed by Csordas (1994, 2002), Desjarlais (1992), Mullings (1984), Laderman (1991), and Roseman (1991). At the same time, the distinction between ethnopsychiatry as traditional, religious, or indigenous healing and Western biomedical psychiatry as a cosmopolitan and scientific clinical enterprise has broken down insofar as professional psychiatries from many countries have been subjected to analysis as ethnopsychiatries (Fabrega 1993; Hughes 1996). This was already evident in Kleinman's (1980) juxtaposition of Taiwanese psychiatry and shamanism in his seminal examination of depression and neurasthenia in Taiwan. It was made emphatic in the collection of papers edited by Gaines (1992) giving equal weight to the cultural construction of both folk and professional psychiatries. Sartorius and Jablensky (1990) have compared diagnostic traditions and the classification of psychiatric disorders in French, Russian, American, British, German, Scandinavian, Spanish and Third World psychiatric traditions.

A variety of approaches, more or less cultural, have been taken to the analysis of professional psychiatry. Al-Sabaie (1989) has examined the situation in Saudi Arabia, and Angermeyer *et al.* (2005) have compared the situation in the Slovak Republic, Russia, and Germany. In the United States, Luhrmann (2000) documents a watershed moment in contemporary psychiatry as cultural meanings and social forces move the entire field from a clinical culture in which psychoanalysis was prominent to one in which biological psychiatry and neuropsychiatry are dominant. Significant works in clinical ethnography in the United States include Angrosino's (1998) study of a home for the mentally retarded, Estroff's (1981, 1982) study of an outpatient psychiatric facility, and Desjarlais' (1997, 1999) work on a shelter for the homeless mentally ill; Biehl (2005) has contributed an examination of an asylum for the socially abandoned mentally ill in Brazil. A volume edited by Meadows and Singh (2001) examines mental health in Australia, though it pays little attention to cultural psychiatry and care for indigenous and migrant groups. Barrett (1996) does a close analysis of how psychiatrists in Australia construct schizophrenia through social interaction and discursive practices.

An early discussion of ethnopsychiatry in Africa by Margetts (1968) emphasizes the importance of investigating topics such as conceptions of normality and abnormality, magic and religion, social hierarchy, life-cycle rituals, symbolism, demonology, secret societies, death and burial customs, politics, suicide and cannibalism. More recently, the state of psychiatry in Africa has been discussed by Ilechukwu (1991), who observes that colonial era notions about the rarity of major mental disorder in Africa have been disproven, leading to changes in the health-care system, with particular mention of the Aro village system which integrates indigenous and western psychiatric care. Swartz (1996, 1998) examines the changing notion of culture in South African psychiatry, from a de-emphasis of difference in order to avoid the use of relativism as a justification for oppression to an interest in diversity with a post-apartheid society, and the potential contribution of this change to developing community-based care, understanding indigenous healing, and nation-building.

In counterpoint to this trend toward analytically indigenizing professional psychiatry are observations about international intercommunication and globalization as processes affecting institutional psychiatry (Belkin and Fricchione 2005). Kirmayer and Minas (2000) observe that globalization has influenced psychiatry through socioeconomic effects on the prevalence and course of mental disorders, changing notions of ethnocultural identity, and the production of psychiatric knowledge. Crises in the global world system in the context of development create a truly global challenge and an urgency in understanding links between culture and mental disorders (Kleinman and Cohen 1997). Fernando (2002, 2003) argues that global psychiatric imperialism and individual racial/cultural insensitivity must be surmounted in order to achieve legitimately universal concepts of mental health. In this domain, theoretical and clinical appear especially clearly as sides of the same coin. For example, thinking about the effects of racism in psychiatry is parallel to viewing psychiatry as an arena in which to analyze and understand racism (Bhugra and Bhui 2002). In a postmodern, postcolonial, and creolizing world, argues Miyaji (2002), attention must be given to clinicians' shifting identities and fluid cultures, as well as to positionality in both local and global power dynamics.

Cultural competence has proliferated as a catch-word in parallel with a shift in focus from "treatment" development and efficacy to "service" provision and delivery (Cunningham *et al.*, 2002). Distinctive clinical training has been developed in dozens of residency programs in the United States (Jeffress 1968), such as one for residents treating Hispanic patients and emphasizing the availability of cultural experts in supervision, skills in cultural formulation of psychiatric distress, and culturally distinct family dynamics (Garza-Treviño *et al.*, 1997). Yager *et al.* (1989) describe training programs in transcultural psychiatry for medical students, residents, and fellows at UCLA. Rousseau *et al.* (1995)

show that psychiatry residents' perceptions of transcultural practice vary in relation to their own cultural origin rather than with respect to their degree of exposure to patients from different cultures or their training in cultural psychiatry. International videoconferencing has been introduced to the training of medical students in transcultural psychiatry, in one case linking Sweden, Australia, and the United States (Ekblad *et al.*, 2004). Beyond the training of clinicians, insofar as social and cultural factors can impact treatment modalities and outcomes, managed and rationed healthcare must take this into account to ensure the availability of cost-effective treatment within an integrated system of services to patients of all cultural and economic backgrounds (Moffic and Kinzie, 1996).

An extensive review of empirical work on the perennial topic of cultural variability in psychopathology would require at least as much space as I have devoted to general theoretical, methodological, topical, and clinical considerations. I mention here only the most comprehensive and definitive edited collections as a pointer toward three critical issues: on culture-bound syndromes see the volume by Simons and Hughes (1985); on depression see the volume by Kleinman and Good (1985); and on schizophrenia see the volume by Jenkins and Barrett (2004). The relation of culture to trauma, violence, and memory has been taken up in a series of critical works by Antze and Lambek (1996), Bracken (2002), Breslau (2000), Robben and Suárez-Orozco (2000), Young (1995), Kinzie (2001a,b), and Rousseau (1995). Related to the literature on trauma, the experience of geographical dislocation has become of increasing concern as researchers and clinicians address the mental health of immigrants and refugees (Bhugra, 2000; Boehnlein and Kinzie, 1995; Ingleby, 2005, Hodes 2002; Hollifield *et al.*, 2002; Kinzie, 2001a,b; Azima and Grizenko, 1996; Kirmayer, 2002; Lustig *et al.*, 2004).

The cultural analysis of psychopharmacology both from the standpoint of subjective experience and global political economy is attracting increasing attention (Lakoff, 2005; Petryna, Lakoff and Kleinman, 2006; Jenkins, 2005; Healy, 2002; Metzl,

2003). Significantly more attention should be paid to the consequences of distinguishing studies oriented by the therapeutic discourse of "treatment" (Tseng and Streltzer, 2001; Seeley, 2000) and studies oriented by the economic discourse of "services" (Kirmayer *et al.* 2003) in mental-health care, particularly since the discourse on services has grown increasingly dominant in the arena of research and funding. Finally, although my concern has been with the convergence between anthropology and psychiatry, some acknowledgment must be made of a third discipline that operates in the sphere of mental illness and psychiatric disorder. Psychiatric epidemiology makes an important contribution regardless of the fact that epidemiology shares neither the methodological disposition nor the intellectual temperament that renders the dialogue between anthropology and psychiatry so natural.

These issues do not exhaust the evolving research agenda that continues to take shape in the convergence of anthropology and psychiatry. The underlying comparative approach of this field has led to the recognition of variations in the practice of cultural psychiatry itself across national boundaries (Alarcon and Ruiz, 1995). Freeman (1997) has described the French school of ethnopsychiatric treatment for immigrant families oriented by the psychoanalyst Tobie Nathan. Somewhat different approaches are associated with the British school headed by Roland Littlewood and colleagues, and the North American groups at Montreal including Laurence Kirmayer, Gilles Bibeau, Ellen Corin, and Allan Young. And at Boston including Arthur Kleinman, Byron Good, and Mary-Jo Good. Useful studies could be made comparing these schools' intellectual orientations. Likewise, serious comparison of the treatment strategies adopted in clinics specializing in the treatment of different ethnic groups would be of considerable value.

Concluding considerations

Despite the critical importance of culture to understanding psychopathology, in the United States

the National Institute of Mental Health has not emphasized the funding of ethnographic studies of mental health (Manson, 1997). This may be due in part to the difficulty of conducting such studies, and in part to the lack of orientation of anthropologists to NIMH as a research funding source. Additional insight can be gained from Manson's (2003) examination of the epistemological and disciplinary tensions involved in generating the 2001 Surgeon General's report on "Mental health: culture, race, and ethnicity," a document evoked as a touchstone for research priorities in this area.

We must note that there are gaps and silences in the convergence between anthropology and psychiatry. Although the field is implicitly comparative, the greatest part of the literature concentrates on particular cultural settings. Although issues of cross-cultural communication are implicit in virtually all the literature in this field, explicit consideration of ethical issues in fieldwork in psychiatric settings across cultures are rarely raised (Addlakha, 2005; Okasha, Arboleda-Florez, and Sartorius, 2000). Likewise, despite implicit concern with differences in meaning and experience across cultures, the explicit consideration of how these differences intersect with gender differences across cultures is rarely seen, and neither is the role of culture in child psychiatry often addressed (Munir and Beardslee, 2001; Timini, 2002).

In the final analysis, the convergence between anthropology and psychiatry remains en exceedingly fertile ground for generating ideas and issues with the potential to stimulate both parent disciplines. With respect to theory and clinical practice, global political economy and intimate subjective experience, the nature of pathology and the process of therapy, this hybrid field is a critical locus for addressing the question of what it means to be human, whole and healthy or suffering and afflicted.

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