EDITORIAL

Major Conceptual and Research Issues for Cultural (Anthropological) Psychiatry

Culture, Medicine and Psychiatry has already published a number of papers that raise conceptual and empirical issues for cultural psychiatry, and more will be published in this volume. Such contributions also are appearing with increasing frequency in the psychiatric and anthropological literature. But by and large these papers have not systematically articulated analytic and comparative categories that create a methodological foundation for cultural psychiatry. That is to say, little attention has been given to establishing and refining questions that can be asked across different cultures, historical periods, and systems of psychiatry so as to integrate available empirical findings into a conceptual framework that can be rigorously applied to generate research hypotheses and determine what are psychiatry's universal and culture-specific aspects.

Perhaps this relative disinterest in developing theory in cultural psychiatry was a healthy response to the disturbing overgrowth of unsupported psychoanalytic interpretations and the deployment of overly narrow phenomenological categories of descriptive (chiefly German) psychiatry. But even if benefits may have accrued from this atheoretical stance in the past, this is not the case at the present. Now we are in a period in which large amounts of data have been and still are being amassed that are virtually incomparable, while great uncertainty exists as to what should be cultural psychiatry's scope, purpose, and major explanatory interests.

It seems to be, then, an appropriate time to summarize at least some of the major issues for cultural psychiatry. This exercise may serve to draw the critical attention of readers both to particular problems and to the status of the field generally – which might be thought of as constituted by the problems taken as a whole. I do not intend to catalogue all the relevant cultural issues for psychiatry, but instead I will list what I regard as the more important ones that deserve description in particular cultures and comparisons across cultures. I hope that this short list will aid readers in relating papers that on the surface appear very different and thereby in making sense of what is distinctive in an anthropological orientation to psychiatry. I not only regard these issues as the autonomous subject matter of cultural psychiatry but it is also my belief that to the extent we develop a discriminating understanding of them in local cultural settings and cross culturally, cultural (anthropological) psychiatry will emerge as an autonomous field with both applied and theoretical significance.

Elsewhere these issues have been illustrated by drawing on our current data base for psychiatry in Chinese culture (cf. Kleinman and Lin 1980). But in what

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follows I simply list them as general ethnographic and comparative categories and leave it to readers to fill in the details and assess their applicability for the cultures they themselves study.

1. *Cultural Influences on Cognitive, Affective, Communicative, Behavioral, and Psychophysiological Process*

This might be taken to be the basic science basis of cultural psychiatry. In order to study cultural influences on pathology and deviance, we need to understand the cultural patterning of normal psychological, physiological, and interpersonal processes. For example, how do core symbolic meanings and behavioral norms influence universal psychophysiological reactions so as to constitute a biosocial bridge between different phenomenological levels of reality (i.e., biological, psychological, social)? In order to study these psychocultural interrelationships, psychiatric and psychological studies must develop interdisciplinary methodologies that are anthropologically oriented toward meanings and norms and anthropological research must include psychobiological measurements.

While psychological anthropologists and cross-cultural psychologists have already contributed in a number of important ways to our understanding of this subject, a key interest of cultural psychiatry is only now being investigated: namely, the operations of cognitive coping processes to manage dysphoric affects by articulating them in certain culturally approved idioms for communicating distress and manipulating social relations. By studying how anxiety, depression and other dysphoric affects are experienced and expressed as somatic (not psychological) states in non-Western cultures, for example, we are able to investigate core cultural influences on cognitive, affective, communicative, and behavioral processes that underlie important clinical problems – in this instance the somatization of mental illness so prevalent in non-Western societies. By assessing culturally legitimated final common behavioral pathways along which particular societies channel particular kinds of normal and deviant behavior, we can derive a clearer sense of the psychocultural processes constituting the culture-bound syndromes. And by analyzing autonomic nervous system, neuroendocrine, immunological and other biological correlates of these processes, we can begin to determine the biopsychosocial pathways that contribute to particular stress response and disease patterns in particular cultures and subcultural groups.

2. *Cultural Influences on Family and Other Key Social Relationships*

This subject is of such obvious relevance to cultural psychiatry that it requires little elaboration. The family context of socialization, stress management, labeling of deviance, help seeking, and other clinically relevant issues needs to

become a central component of ethnopsychiatric description and cross-cultural comparisons. Recent research that discloses the capacity of social network supports to mitigate stress-induced effects adds additional significance to this subject. The current chicken-or-egg debate over whether family pathology creates mental illness in family members or results from it should not dissuade researchers from examining the different ways family reality is culturally constructed and its association with adaptive or maladaptive individual and group coping responses. Instead of merely gathering more general ethnographic data students of this subject should be encouraged to focus on the *relationships* between family function and individual behavior, interpersonal transactions and personal identity, social bonding and psychophysiological reactions that constitute particular psychocultural systems.

Obviously somatization and other culturally constituted idioms of distress are learned and deployed not just to express troubles, but also to manipulate interpersonal relations so as to produce desired change in particular social situations. That is to say, these coping responses possess social efficacy. The meanings and consequences of chronic pain behavior are examples with which most clinicians should be familiar. But whereas anthropologists have devoted considerable attention to describing and analyzing this phenomenon, cultural psychiatrists in the main have not. Hence the distinctive social contexts of illness behavior should become as central a descriptive and comparative category for cross-cultural psychiatric research as are the social contexts of personality development and psychodynamics for psychoanalytically oriented cultural psychiatrists.

3. *Cultural Influences on the Perception of and Reaction to Universal Stressors*

Although it is now widely recognized that culture can influence whether a ubiquitous environmental stimulus is perceived as stressful or not, how stressful it is ranked among other stressors, and what kinds of coping processes are brought into play to deal with particular stressors, cultural psychiatry must systematically collect data about each of these questions. For example, we do not yet know how common life event changes are differentially construed cross culturally and what significance these differences hold for the well documented impact of life event change on illness onset. Techniques for measuring the culture-specific meanings associated with universal stressors are not available. Nor is it clear how cultural psychiatrists will address what Schweder (in press) has suggested are the major determinants of behavioral response to stress: namely, " . . . 'idiosyncratic' or 'interactive' effects, the particular 'meaning' that a particular situation has for a particular person . . . ".

4. *Cultural Influences on Creation of and Coping with Culture-Specific Stressors*

Certain cultures may subject their members to distinctive stressors while 'immunizing' them against others. For example, Chinese culture appears to immunize its members against alcoholism, while subjecting eldest son and youngest daughter to particular stressors that yield higher rates of mental illness for these positions in the birth order and creating unique sources of tension for daughter-in-law/mother-in-law relationships, among others. In some ecological settings, individuals are subjected to heavy parasitic infestations that not only cause disease, but affect nutritional status, growth, intellectual functioning, and coping resources generally; whereas in inner city Black communities in America delinquency, drug abuse, and other forms of social deviance might be thought of as either 'cultural' stressors or maladaptive coping responses. Do we regard these problems as due to the tendency of certain cultures to predispose particular members to excessive amounts of ubiquitous stress, or do they create culturally unique forms of stress?

The fact that in certain societies trance and other dissociative states are readily available to individuals for responding to stress, whereas in others these psychocultural coping mechanisms are not, suggests that anthropological psychiatrists need to study both culturally unique types of stress as well as the cultural construction of coping resources. Much impressionistic ethnographic and clinical description supports this argument, but hardly any research studies have systematically examined these issues.

5. *Cultural Influences on Psychiatric 'Disease' and 'Illness'*

This topic includes cultural influences on susceptibility, epidemological rates, symptomatology, and course of universally occuring psychiatric diseases. Differential susceptibility to psychiatric disease may result from genetically-based racial differences and their interplay with variables in the cultural environment. Although the major psychoses appear to have roughly similar prevalence rates in very different groups (e.g., 2–10 cases of schizophrenia per 1000 population for a wide range of societies), the neuroses and psychogenic psychoses vary considerably. Yet we do not have reliable rates for these problems (e.g., hysterical psychosis, depression, hysteria, anxiety neurosis) cross culturally.

Although cross-cultural comparisons associate increased rates of mental illness with lower socioeconomic status, migration and urbanization, we require finer grained analyses to determine more subtle cross-cultural determinants of psychopathology, such as whether marriage in non-Western societies acts as it does in the West to protect men from depression while placing women at greater risk

or whether the absence of a confiding relationship is a risk factor for depression in non-Western groups as it is for Western ones.

One way to interpret the systematic and remarkably uniform structure of somatization of depression among certain ethnic groups as well as the culture-bound syndromes is as impressive instances of the cultural specificity of illness experiences and behavior. Seen in this light, universally occurring psychiatric *diseases*, whose psychobiological foundations seem to be the same in all human populations, are transformed through the effects of cultural beliefs and norms into culture-specific *illnesses*. For example, the experience of somatization among Chinese patients with depression and in Chinese culture-bound syndromes such as *shen k'uei* (kidney deficiency or weakness) is organized around culture-specific networks of psychosomatic symptom terms and the interpersonal dynamics these symbolic meanings express and manipulate, along with learned patterns of deploying 'externalizing' coping mechanisms in the management of dysphoric affects, final common behavioral pathways, and particular types of help seeking (Kleinman and Lin in press). The upshot is a unique cultural system of somatization. What we now need are detailed clinical epidemiological and ethnographic accounts of such systems, including precise description of semantic illness networks, phenomenology of illness behavior, determination of universal and particular features of sick role, and the psychocultural mechanisms that mediate these clinical transformations. Such accounts would provide the foundation for cross-cultural psychiatric comparisons that in turn would generate the descriptive clinical data for a truly comparative psychiatry.

6. *Cultural Influences on Help Seeking*

Although this subject is intimately related to illness behavior, I mention it separately because of the great practical significance of understanding cultural barriers to the delivery of psychiatric services. But studies of ethnic patterns of utilizing popular and professional care, which are appearing with increasing frequency in the literature, deal with primary health care much more often than mental health care. Surely this is an exceptionally important focus for current cultural psychiatric research. As opposed to the usual health services research concerns, an anthropologically oriented approach would examine the context of meanings and relationships within which certain choices are made not only to decide among alternative treatment options, but also whether to remain in care, when to switch practitioners and practices, how to interpret treatment outcome, and how to rationalize therapeutic failure and treatment errors. Whereas folk healers and professional practitioners have been the chief interest of most investigations in this field, the family and social network context of care deserves special attention. Based upon such research, cultural psychiatry will be able to

exert a practical effect on the planning and implementation of culturally appropriate psychiatric services.

7. *Cultural Influences on the Labeling and Societal Reaction to Social Deviance*

'Normality' and 'deviance' are cultural categories as much as are 'abnormality' and 'illness'. Culture will affect what primary deviance (behavior originally demonstrated by the individual prior to labels being applied to it) the individual chooses to self-label or others decide to label as deviance. These labels in turn help create forms of secondary deviance that include cultural expectations about how deviants segregated and stigmatized with a particular label should behave. These expectations then function, social labeling theorists assert, like a self-fulfilling prophecy. Behavior popularly labeled as social deviance need not represent psychopathology as defined by psychiatric disease categories, and the latter may not receive a label of social deviance. Surprisingly, cultural psychiatrists, psychiatric anthropologists, and cross-cultural psychologists neither have systematically compared the labeling of deviance in different societies nor, with the sole exceptions of Townsend's (1978) comparison of mental illness labels among patients and psychiatrists in Germany and the United States and Waxler's (1979) studies of the influence of labeling on the illness careers of schizophrenics in Sri Lanka and Boston, tested in cross-cultural field settings the hypotheses of social labeling theory. Since few concrete hypotheses have been advanced in cultural psychiatry that either could be confirmed by existing empirical evidence or disconfirmed in field research, one would imagine that labeling theory should become a quarry for mining testable propositions that might advance cross-cultural conceptualization of the determinants and outcome of mental illness. But clearly there are strong resistances in psychiatry, and perhaps psychological anthropology as well, to labeling theory. Even the potentially important and seemingly mundane issue of how labeling conflicts are negotiated between occupants of different social roles and statuses has rarely been examined from a cross-cultural perspective. The reason for this doubtless relates to the threatening implications of taking the culture analysis program seriously enough to reflexively study our own psychiatric categories as cultural constructions and thereby part of the sociopolitical dynamics of labeling – a point I shall return to below. Finally, it is necessary to admit that many aspects of the sociology and anthropology of deviance probably fall outside the scope of cultural psychiatry and point up the desirability of defining, even in a very rough way, the limits of cultural psychiatric enquiry. But these limits are likely to become a source of debate in the field for some time to come; and both narrow and broad interpretations of them can already be discerned.

8. *Cultural Influences on Indigenous and Professional Therapeutic Systems for Treating Mental Illness and the Psychosocial Concomitants of Physical Illness*

Local cultural systems of health care manage mental illness as well as the psychosocial concomitants of physical illness. These systems consist of three overlapping arenas of care: popular or family arena; folk (nonprofessionalized secular and sacred practitioners) arena; and professional arena. In societies for which we possess adequate ethnomedical data, most cases of mental illness and those in which there is a serious psychosocial burden of chronic physical disease are managed by the family and social network, sacred folk healers, and primary care professional practitioners, and not by psychiatrists and other mental health professionals.

While it is often stated that these treatment systems are effective, few studies have been mounted to investigate the outcome of indigenous and primary care for mental health problems. This would seem to be an important responsibility for cultural psychiatry, since many developing societies' health care systems need to seriously consider the option of integrating indigenous healers and primary care physicians in the delivery of mental health services, but do not possess the required information about actual cost/effectiveness, potential toxicities, etc. necessary for making policy decisions. The romanticism and reverse ethnocentrism demonstrated by many anthropologists and psychiatrists who have written on this topic, coupled with the astonishing absence of reliable data, have done mischief. It is time that these questions, including the feasibility and outcome of attempts at integrating indigenous and professional practitioners, become the subject of empirical field studies. Perhaps no issue discloses more starkly cultural psychiatry's and medical anthropology's inadequate data base.

9. *Cultural Influences on Clinical Practice*

A great number of ethnographies and clinical accounts describe clinical activities in different societies, and though much of what we know derives from studies of traditional healing, recently accounts of modern professional care have begun to appear as well. A substantial impediment to the development of more discriminating cross-cultural comparisons of clinical work is the absence of generally agreed upon criteria for determining similarities and differences. The following five more or less discrete categories can be used to compare practitioner-patient relationships, and therefore enable us to make cross-cultural comparisons of at least a few of the essential components of clinical practice. Elsewhere I have drawn on these categories to compare the different kinds of clinical relationships found in Chinese health care systems (see Kleinman 1979, 1980). If we are to

build a comparative science of clinical practice we need to know the concrete description of clinical relationships in terms of these or other categories and how different clinical relationships compare along universal and culture-specific axes of such a grid. For any type of practitioner-patient transaction, then, we can determine its:

(1) Institutional Setting (i.e., specific location in a given health care system's sectors – popular, folk, professional – and subsectors).
(2) Characteristics of the Interpersonal Interaction.
    (a) Number of Participants.
    (b) Time Coordinates (i.e., whether it is episodic or continuous, the average length of treatment, the amount of time spent in each transaction, the time spent in communicating and in explaining about the illness and its treatment, etc.).
    (c) Quality of the Relationship (i.e., whether it is formal or informal with respect to rules of etiquette, authoritarian or egalitarian, type of social role – primary, secondary, tertiary, emotional distance, restricted or elaborated communicative code, nature of transference and counter-transference, and whether it is integrated into or divorced from everyday life experiences and ongoing daily activities).
    (d) Attitudes of the Participants (i.e., how practitioners and patients view each other, particularly if they hold mutually ambivalent views of the other).
(3) Idiom of Communication.
    (a) Mode (i.e., psychological, mechanistic, somatic, psychosomatic, sociological, spiritual, moral, naturalistic, etc.).
    (b) Explanatory Models (i.e., whether shared, openly expressed, tacit, or conflicting; whether explanatory models are drawn from single, unified belief systems or fragmented, pluralistic ones; and whether clinical judgment utilizes the single causal trains of scientific logic or folk logics such as the resonant harmonies of Chinese medicine, the hot/cold balance approach so widely prevalent in folk medical systems, sympathetic magic, etc.).
(4) Clinical Reality (i.e., the type of social reality constructed in clinical relationships by systems of cultural meanings, norms, and power differentials).
    (a) Sacred or Secular (indigenous or Western).
    (b) 'Disease' Oriented or 'Illness' Oriented.
    (c) Symbolic and/or Instrumental Interventions.
    (d) Therapeutic Expectations (i.e., concerning interpersonal behavior, treatment style, therapeutic objectives, presence or absence of 'negotiation', whether these expectations are shared or discrepant).

(e) Perceived Locus of Responsibility for Care (i.e., the individual patient, family, community, or practitioner).

(5) Therapeutic Stages and Mechanisms.

(a) Stages of Care (e.g., healing rituals frequently involve a tripartite structure – the sickness and its cause are ritually identified, ritual techniques remove or neutralize the cause, and a new state of return to health or having been successfully healed is formally sanctioned; psychotherapy can be analyzed in terms of initial, middle, and terminal phases; hypnosis can be studied in terms of induction, trance state, post hypnotic period; etc).

(b) Mechanisms and Levels of Change (i.e., catharsis, insight, psychophysiological response, etc.; and whether psychological, physiological, social and cultural levels are involved separately or together).

(c) Adherence, Termination, Evaluation of Outcome (i.e., shared or discrepent assessments of satisfaction, efficacy, cost-effectiveness, toxicities, etc.).

A practical value of such comparisons may be able to develop a more discriminating assessment of potential problems in transcultural therapeutic encounters where practitioners and patient come from different cultural backgrounds. Another value would be to develop specific hypotheses of what are the culturally adaptive and maladaptive aspects of particular therapeutic relationships, test these in actual clinical practice, and as a result determine how to modify these relationships so as to maximize their cost effectiveness. This could lead to more systematic attempts to define and provide culturally appropriate care. When attempts are made to integrate traditional and modern treatment systems in local health care systems, a comparative framework such as this might be used to compare and contrast these relationships so as to rationalize integration and assess its outcome. Cultural psychiatry should be at the forefront of research and clinical applications in all aspects of cross-cultural studies of healing. Indeed cultural psychiatrists need to educate their colleagues who conduct psychotherapy research that in cross-cultural perspective, psychotherapy is a special instance of the more general phenomenon of healing about which a great deal more needs to be learned before we understand psychotherapy itself.

Other kinds of cultural influences on clinical practice are important and deserve to be studied. For example, differential biological response of different ethnic populations to pharmacological agents in terms of different pharmacodynamic and pharmacokinetic reactions should be routinely determined for major therapeutic drugs, and similar information should be available for other somatic treatments.

10. *Cultural Influences on Psychiatric Categories*

A strong program of cultural analysis in psychiatry cannot, and I would argue should not, avoid calling into question the cultural construction of our own professional psychiatric categories. In a year in which the American Psychiatric Association is officially sanctioning a new diagnostic system (DSM III), it seems especially appropriate to view cultural psychiatry's role as one that treats professional psychiatric categories as 'emic' and that seeks to establish "etic" psychiatric categories that are cross-culturally valid by drawing on anthropological, epidemiological, cross-cultural psychological, and clinical findings to determine the universal and culture-specific features of current psychiatric concepts. Surely, cultural psychiatrists should determine serious cultural influences on DSM-III and develop a powerful critique that documents problems and offers alternative solutions.

This aspect of cultural psychiatry all too frequently gets discounted, but I wish to suggest that it is the single most important issue for an anthropologically sophisticated orientation to psychiatry. For culture probably has its most profound and difficult to assess influence on psychiatry through the elaboration of conceptualizations of mental illness and psychiatric care that parade as value-neutral science but in fact represent a cultural construction of social reality that is only in part empirical, but also an admixture of professional ideology and shared cultural bias. I can think of no greater service that cultural psychiatry could perform for psychiatric science than to reflexively establish the key cultural influences on psychiatric knowledge and methods of generating that knowledge. Moreover, at a time when scholars generally are opening their eyes to the fact that well more than three-fourths of the world's population are non-Western, should it not be the charge of cultural (anthropological) psychiatry to assure that psychiatric categories and norms are not constructed almost entirely out of experiences with Western populations as regrettably has been true in the past, but that they be based on experiences with non-Western groups as well, if not more. I believe that to the extent cultural psychiatry takes its own work seriously it will accept this charge, demand that anthropology join biology and psychology as the scientific foundation of psychiatry, and argue forcefully that cross-cultural comparisons be viewed as an essential methodology for the development of psychiatric science. In the midst of a dangerous retrenchment by academic psychiatry to an overly narrow biomedical model that has been found to be inadequate as a guide for primary care medicine, and that consequently has little hope of being adequate for clinical psychiatry, it is of enormous significance that cultural psychiatry highlight the web of cultural meanings that surrounds illness and care and that plays a dynamic, constitutive part in the construction of clinical knowledge. This determinative cultural context of clinical reality, which

is as essential to clinical practice as it is to dealing with the ethical dimensions of clinical research, necessitates an interdisciplinary *meaning-centered* approach that anthropological psychiatry should exemplify (see Kleinman 1979).

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