Anthropology and Psychiatry
A Contemporary Convergence for Global Mental Health

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Editors' Introduction

Anthropology and psychiatry have long shared common intellectual and scientific 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, gender, class and religious backgrounds. 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

Contemporary emphasis on global mental health can benefit greatly by a well-informed understanding of the long-standing interface of anthropology and psychiatry. Indeed, such knowledge is a prerequisite for transnational inquiry into specific aspects of mental health as well as broader questions of human being. Nineteenth century eugenic notions of the inferiority of then-considered 'primitive' minds were scientifically critiqued and denounced by anthropologist Franz Boaz (1911), but in comparative psychiatry implicit or explicit presumptions regarding the similarity or difference in 'primitive' or 'modern' minds dates back at least as far as the early twentieth century with psychiatrist Emil Kraepelin (1904) and subsequent challenges by anthropologist–psychiatrist W. H. R. Rivers (1918). Psychiatrists since Freud have been fascinated with the experiential diversity of ethnographic data, and anthropologists such as Margaret Mead (1930, 1935), Ruth Benedict (1934) and Edward Sapir (1932, 1938), all students of Boaz, produced pioneering works which actively engaged the methods and data of psychiatry. All were concerned with the vexing problem of differentiating the normal and the abnormal, whether conceived dichotomously or on a continuum. Such collaborations led to highly productive exchanges, including that of Sapir and psychiatrist Harry Stack Sullivan (1940, 1964), whose scholarly interchange has been documented by Helen Swick Perry (1982). Psychiatric anthropologist Cora Du Bois (1944) and Georges Devereux (1980) wrote convincingly about the unreliable boundary between normal and abnormal, as did, in 1943, philosopher of medicine Georges Canguilhem (1991) and anthropologist Claude Levi-Strauss (1962). In addition to the issues surrounding the normal and the abnormal in defining forms of psychopathology, anthropologists and psychiatrists

have struggled together with the question of relativity in debates surrounding the a priori presumption of the universality of core symptoms of particular types of disorder in the absence of empirical demonstration. Although the expertise of the two disciplines is distinct, both contribute to the conceptual questions and experiential questions of meaning in mental illness and healing. Likewise, both contribute to the immediate and significant problems of how best to treat the distress of patients across domains of diversity prominently to include gender, ethnicity, religion and marginalization by virtue of intolerance, discrimination, warfare and political violence. Productive work on these questions has been accomplished by the foregoing scholars not only through interdisciplinary scholarship but also by their close transnational relations; in 1942, while giving a speech at the Columbia University Faculty Club during which he attacked the Nazis, Franz Boaz died from a stroke in the arms of Levi-Strauss.

In this chapter, I outline a series of topics of common interest for psychiatry and anthropology by highlighting areas of mutual interest concerning the relation between culture and mental illness, and healing. In doing so, I also organize the material in such a way as to call attention to conceptual contrasts that transcend or lie outside the disciplinary distinctions 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 services? How to conceptualize and classify psychiatric disorder in successive revisions of the *Diagnostic and Statistical Manual* (DSM) or International Classification of Diseases (ICD) nosology? How to compare indigenous ritual healing and psychotherapy, as undertaken by psychiatrist Jerome Frank (1973), the potential efficacy of distinct cultural genres of treatment? What is the difference in views of human variability that seek out the existence of culturally peculiar syndromes and those that recognize cultural variations in psychiatric disorders defined essentially by researchers and clinicians from the global north or the global south? How much in common is there among the perspectives of psychiatric anthropology, (trans)cultural psychiatry, ethnopsychiatry, and the burgeoning field of global mental health?

Delineating the Convergence

Diverse formulations both synthetic and programmatic have defined the convergence between anthropology and psychiatry since the early essay by Kraepelin on 'Comparative Psychiatry' in 1904. A useful collection of seminal works from 1880 to 1971 edited by Littlewood and Dein (2000) traces a repertoire of interests ranging across definitions of the normal and the abnormal, family structure, cultural symbolism, suicide, anxiety, intoxicants and controversially conceived 'culture-bound syndromes'. Current thought among contemporary psychiatric anthropologists places less stock in the existence of such 'exotic' and 'rare' occurrences and more attention to the way in which culturally and historically defined conditions of mental illness or distress *typically* have culturally distinct features worldwide. Cultural psychiatrists and psychiatric anthropologists share common interest in epidemiological variation of disorders across populations, potential aetiological variation in relation to cultural, biogenetic and structural-institutional features, and the cultural puzzle of significant variations in the course and outcome of disorders transnationally.

Raimundo *et al.* (2005) have traced the convergence of psychiatry and anthropology to the historical precursors of cross-cultural psychiatry from nineteenth century alienists who proposed evolutionary notions of insanity as supposedly rare among 'primitive' peoples and increased with 'civilization' that were imagined to require increasing levels of cognitive organization and demands for mental production. While the colonial legacy of racist thinking seemed 'apparent' during that historical epoch, it is worth noting that the notion of 'non-Western' (non-European) populations as being relatively less 'sophisticated' has not entirely disappeared in contemporary discourse. Developments in transcultural psychiatry following World War II served to delineate a specific identity of transcultural psychiatry as a field concerned with replacing racist evolutionary frameworks with cross-cultural empirical data. At the same time, existential and meaning-centred approaches began to appear. A powerful voice from this post-war period was Ernest Becker (1962, 1963), whose concern with meaning resonates more than five decades later. The 1970s and 1980s was a period of rapid development and reformulation, in the midst of which a 'new cross-cultural psychiatry' that emerged from a synthesis of interpretive approaches from anthropology and an increasingly

19

JANIS JENKINS

sophisticated academic psychiatry (Martins, 1969; Wittkower and Wintrob, 1969; Galdston, 1971; Kiev, 1972; Kennedy, 1974; Cox, 1977; Kleinman, 1977, 1980; Miller, 1977; Padilla and Padilla, 1977; Estroff, 1978; Murphy, 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 earlier attempts in cross-cultural psychiatry to apply psychoanalytic concepts to non-European societies. 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 (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).

Contemporary analysis of practices in psychiatry can be shown to be entangled in what was classically formulated in anthropology several decades ago, that is, the conceptual triad of magic, science and religion (Rivers, 1924). In Malinowski's (1954: 35) terms, problems arise over how to reduce a 'complex and unwieldy bit of reality into a simple and handy form'. Applying this to the global field of mental health, we have recently seen the circulation of public-health campaigns that are culturally formulated under banners such as 'A Flaw in Chemistry, not Character' in the US, or 'Defeat Depression, Spread Happiness' in India, 'Silence is not Health' in Argentina, or 'Chains Free' in Indonesia (Jenkins, 2015a). As set forth by Jenkins (2010), the conceptual mélange of magic/science/religion can also help to illuminate applied contemporary developments with respect to pharmaceutical practices, markets and global capitalism. Multivalent symbols of pharmaceuticals as 'magic bullets', 'awakenings', 'placebo', 'gold standard' or 'God's miracle' are suffused across cultural domains of magic, religion and science. Strategic areas for investigation in anthropology and psychiatry concern the increasingly widespread distribution of psychopharmacological drugs worldwide and raises the question of whether we are *all* becoming *pharmaceutical selves* (Jenkins, 2010). Specific domains of inquiry are:

> . . . how are culturally constituted selves transformed by regular ingestion of these drugs – for therapeutic, non-therapeutic, or recreational reasons; whether to alleviate suffering or enhance performance; whether awake or asleep? To what extent are *Homo sapiens* transforming themselves into pharmaceutical selves on a scale previously unknown? Does the meaning of being human increasingly come to mean not only *oriented* to drugs but also *produced* and *regulated* by them?
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> (Jenkins, 2010: 4)

Further, 'how unequal distribution and access to these drugs reproduce social inequalities in health and subjective states of suffering?' (Jenkins, 2010: 4).

In sum, the mutual relevance of anthropology and psychiatry thus remains an important concern for scholars and clinicians in the field (Stix, 1996; Skultans and Cox, 2000; Mihanovic *et al.*, 2005). Even so, 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. 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 helps to position individuals in a social world.

Expanding and Refining the Scope of this Convergence

A serious challenge concerns the gap between the established research in cultural psychiatry and psychiatric anthropology and the aims of the burgeoning field of global mental health (GMH) with calls to 'scale

JANIS JENKINS

up' mental health services worldwide (Patel *et al.*, 2007, 2009; Andreoli *et al.*, 2009; Eaton *et al.*, 2011; Campion *et al.*, 2012; Becker and Kleinman, 2013). Recently, Jenkins and Kozelka (2017) have argued that while proponents of GMH advocate mental health as a matter of urgent need and human rights, the evidence-based approaches that are advocated are typically restricted to psychopharmaceuticals with little or no actual psychosocial intervention (Patel *et al.*, 2007, 2009; Patel, 2014). Typically, only the former is offered, with psychosocial interventions understood as requiring adaptation as a matter of cultural validity. This is a serious misconception since psychopharmaceutical practices are substantially shaped by cultural processes (Whyte *et al.*, 2002; Metzl, 2003; Jain and Jadhov, 2009; Read, 2012; Ecks, 2013; Ecks and Kupfer, 2015). We argue that what currently counts as 'evidence-based' treatment typically does not adequately take into account both structural and ecological constraints (Kleinman, 1986; Jenkins, 1991b; Jadhav and Littlewood, 1994; Farmer, 2004a, b, 2015; Jain and Jadhav, 2009; Metzl and Hansen, 2014; Jenkins, 2015b). Broadening the scope of global mental health holds 'enormous potential to contribute to [these] challenges by exploring cultural feasibility and acceptability of interventions, understanding the impact of health services on the daily lives of providers and patients, and uncovering institutional processes that lead to inadequate and disproportionate commitment to mental health' (Kohrt *et al.*, 2015: 341).

Effective efforts to advance the newly emerging field of global mental health can only be accomplished through serious and sustained engagement with the aforementioned summary of the decades of substantial scholarship that has been accomplished at the intersection of anthropology and psychiatry. Toward this end, this chapter identifies specific problems with respect to illness experience, cultural interpretation and local provision of care in relation to psychopharmaceuticals. This is vital to avoid shortcomings of earlier pioneering efforts such as the WHO International Pilot Studies of Schizophrenia (IPSS), which found significant differences in course and outcome. Because these investigators did not collect ethnographic data for the sites, the findings of cultural variation have been difficult to interpret (although see theoretical model of empirical variation provided by Jenkins and Karno, 1992). The IPSS could have averted much of the difficulty of interpreting their important findings by incorporating an interdisciplinary team for the research at the outset. Key issues concern the cultural validity and meanings of particular conditions, and ethnographic understandings of local interpretations and healing practices. By working from a foundation of ethnographic knowledge, along with perspectives of health practitioners from other disciplines such as nursing, public health, clinical psychology, health policy, social work and intervention implementation sciences) in collaboration with local indigenous non-medically oriented practitioners, the psychiatry–anthropology interface is considerably enhanced. Anthropologists can work toward these collaborative efforts not only by providing ethnographic techniques to observe, interpret and assess the mental-health landscape both 'up close' (through experience-near, person-centred ethnographies) but also to provide an overall integration of perspectives (through holistic, multilevel analysis that incorporates institutional and structural arrangements). We further suggest the need for attention to the perspectives of first-person experience should be foregrounded in research agendas and clinical approaches, to include partnerships with increasingly popular approaches among 'voice hearing/voice hearer' groups (see Woods and colleagues (2013). Such movements embody the fundamental anthropological insistence on the primacy of subjective experience, the personal and cultural meanings of illness experience, and the legitimacy of defining problems and strategies in accord with the lived realities from those with first-person experience. Insistence that capacities to hear voices, and so forth, are entirely real for those experiencing such, meaningful (vs random or little more than rubbish to be discarded), and not necessarily to be pathologized (even if often experienced as distressing).

Specific Issues of Common Interest: Theoretical, Methodological and Clinical Considerations

Emphasizing the critical importance of the patient's understanding of illness episodes, Kleinman (1980) inspired a substantial body of research (Bhui *et al.*, 2002, 2004, 2015; Dein, 2002). Recent illustrations that take an integrated approach to theory, method and clinical relevance are set forth here with respect to four issues: (1) cultural meaning; (2) methodological advances; (3) psychiatric–anthropological research

21

constructs of enduring relevance; and (4) approaches that seek to move 'beyond' culture.

The Centrality and Magnitude of Cultural Meaning

Byron Good (1994) places meaning squarely at the conceptual centre of the convergence between anthropology and psychiatry, with a hermeneutic critique of rationality that flows into a celebration of experience. Good's (1994) incisive critique of the notion of 'belief' in anthropology and psychiatry is essential reading for any informed approach. 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 or pathoplastic agent; (3) a diagnostic/nosological factor; (4) a therapeutic or 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 (1985a, b) has offered a synthesis between family therapy and transcultural psychiatry, and Castillo (1997) elaborates a client-centred approach to culture and mental illness. Okpaku (1998) offered a global compendium of case studies and clinical experience to provide practising 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. Most recently, the outline for a cultural formulation for the *Diagnostic and Statistical Manual-5* which has been reviewed and updated in light of myriad cultural factors and the diagnostic process and how best to assess these (Lewis-Fernandez et al., 2014).

Productive Methodological Advances

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-centred 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 Bäärnhielm, 2002). Rogier (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 sub-personal explanation of cognitive psychology and neurobiology.

Yet another productive avenue comes from interdisciplinary research collaboration by anthropologist Thomas Csordas and child psychiatrist Michael Storck (Csordas et al., 2008, 2010). Their research team, working longitudinally on religious healing among First Nation Navajo people, demonstrated that methodological approaches which combined ethnographic methods with 'gold standard' research-reliable clinical instruments produced a rich context for 'double dialogue' that could reciprocally reveal dimensions of depression that, in isolation, neither approach could singly achieve. Ethnography vitally enhanced clinical understandings and revealed information not available to the psychiatrist; conversely, the psychiatrist was able to determine and to interpret a great deal of experience that the anthropologist could not (Csordas et al., 2010). Together, their research team pioneered an integrated approach that can usefully serve as a model for future studies (Storck et al., 2000). Additional interdisciplinary collaborations (with relatively large sample sizes) are of value because they were designed to combine specific research clinical diagnostic instruments (requiring months of methodological training for administration and scoring to achieve research reliability) along with intensive anthropological techniques of ethnographic interviews, observations, and participation in everyday settings

JANIS JENKINS

(Karno *et al.*, 1987; Jenkins and Schumacher, 1999; Nasser *et al.*, 2002; Lopez *et al.*, 2004; Hollifield *et al.*, 2005; Sajatovic *et al.*, 2005; Jenkins and Hollifield, 2008; Floersch *et al.*, 2009; Jenkins and Haas, 2015).

Vital and Enduring Research Constructs

For present purposes, we restrict ourselves to two vital and enduring research constructs that are indispensable. The first of these (noted earlier) is that of an 'explanatory model' (EM) as formulated by Arthur Kleinman (1980). The formulation of an EM is fundamental and thus crucial to obtain initially and to continue to engage over time (since EMs are hardly static or immutable) for all clinical and research endeavours. The second research construct remains as the most robust and thoroughly investigated of psychosocial research constructs for several decades now, that of 'expressed emotion' (EE), initially developed in London by Brown *et al.* (1972) and replicated by Vaughn and Leff (1976). The early British studies were later replicated by Vaughn and colleagues (1984) among English-speaking Euro-Americans in California and led by psychiatrist Marvin Karno and colleagues (1987) among Spanish-speaking families of Mexican descent. These research projects utilized the same methodologies (for research diagnostic reliability, to ascertain EE according to research-reliable methods for administration and scoring of the Camberwell Family Interview (CFI). The Mexican–American study was only begun following a 1-year period of pilot testing to ensure cultural and linguistic validity (see Jenkins, 1991a). Having done so, Karno and colleagues (1987) found the same statistically significant relationship with respect to relapse among families of Mexican descent in southern California, that is, persons living in high EE (critical, hostile) environments were far more likely to relapse than their counterparts. Also notable were significant differences in levels and qualitative types of EE, that is, families of Mexican descent were less likely to be critical, more likely to be sympathetic and to display warmth toward their afflicted relative. Further, kin were likely to conceptualize the problem (diagnosed as schizophrenia) as *nervios* (a culturally specific, normative problem that anyone can suffer but varies as a matter of degree (Jenkins, 1988a, b). These early collaborations for British, Euro-American, and Mexican–American studies thus provided data that revealed that EE was culturally distinct in a variety of ways. While the dimensions of 'expressed emotion'

varied, with Mexican-origin families significantly less critical or hostile and far more likely to express sympathy and warmth, the significant relationship of EE for statistical prediction of the course and outcome was nonetheless replicated (Jenkins, 1991a). This Mexican–American research, carried out through a psychiatric–anthropological partnership in close collaboration with colleagues from the original studies, draws us back to earlier anthropological research on conceptions of mental illness. Anthropologist Robert Edgerton, in his classic 1966 article in the flagship journal *American Anthropologist*, examined conceptions of psychosis in four East African societies. This seminal work is clearly a forerunner to what anthropologist–psychiatrist Kleinman (1980) later formulated as 'explanatory models'. These two constructs, EMs and EE, are central to shaping social and emotional response of kin that is of significance for who will improve and who will not. Additional overviews of the clinical relevance of attitudes toward mental illness, including 'explanatory models', have been provided (Bhugra, 1989; Bhugra and Bhui, 2002), demonstrating the continuing relevance of understanding patients' perspectives, particularly among minority or marginalized groups, and particular types of clinical distress that receive little attention among such groups (Fernández de la Cruz *et al.*, 2015).

Beyond Culture: Nation State, Structural Ecology, Political Economy and Globalization

While a deep understanding of culture in accord with contemporary anthropological formulations (see Jenkins, 2015a: 9) is requisite, it is also clear that more than culture need be considered. While economic and social determinants are undeniably involved, so too are variations across nation states, as pioneered through the work of DelVecchio Good and colleagues (1985). This research drew attention beyond culture and toward understandings of the ways in which emotion and sentiment are formulated nationally and transnationally. Further, it is possible to extend the work of Gregory Bateson (1936) through his formulation of the notion of 'ethos' in micro-social settings (such as English society), as a patterning of social sentiment, Jenkins (1991b) extended Bateson's notion by formulating the concept of a specifically 'political ethos' for its relation to the mental health

23

JANIS JENKINS

of a population, including those plagued by political violence and warfare. This concept provides a bridge between the analysis of the state construction of affect, on the one hand, and the phenomenology of those affects in the mental health sequelae of warfare, political violence and dislocation, on the other. In other works that link anthropology and psychiatry, there has been an examination of the nexus between the anthropology of emotion and the psychiatric 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 socio-politically produced response (Jenkins, 1991a, 1994a, b, 1996). Finally, we have influential collaborative studies of the forces of globalization in relation to mental status, treatment and social stigma (Bhugra and Mastrogianni, 2004; Jadhav et al., 2007; Korszun et al., 2012: Klineberg et al., 2013; Trani et al., 2015; Keown et al., 2016).

Shared Research Agendas

The research agenda for this continuing hybrid field continues to be dynamically 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 a priori presumed invariant characteristics 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). Meanwhile, the ongoing development and testing of psychiatric categories in the eleventh revision of the International Classification of Diseases (due 2018) has proceeded significantly in the wake of sustained attention by Sartorius and colleagues (1988, 1991, 1993, 1995). For the DSM-5, attention has continued to focus on the challenge of further enhancing the role of culture in DSM-5 (Alarcon et al., 2002; Lewis-Fernandez et al., 2014).

An important tool for furthering the integration of culture into DSM-IV and DSM-5 has been its inclusion of an outline for cultural formulation (Lewis-Fernandez and Diaz, 2002; Lewis-Fernandez et al., 2014). 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-centred 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 two decades has published cultural formulations in the form of 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 Native American 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 European terms is broadly defined as psychotherapy (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) and Mullings (1984). The case for the untenable separation of studies of psychiatry and studies of religion has been argued by Bhugra

JANIS JENKINS

(1997). At the same time, the distinction between ethnopsychiatry as traditional, religious or indigenous healing and 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.

Also important for investigation, from a variety of psychiatric-anthropological approaches, is the analysis of professional psychiatry, which can be culturally heterogeneous (Gaines, 1992). Sartorius (1990) has compared diagnostic traditions and the classification of psychiatric disorders in French, Russian, American, British, German, Scandinavian, Spanish and Third World psychiatric traditions. 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 movements across 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, Desjarlais' (1997, 1999) work on a shelter for the homeless mentally ill and Joao Biehl (2005) has contributed an examination of an asylum for the socially abandoned mentally ill in Brazil. Anthropologist–psychiatrist Robert Barrett (1996) conducted a close analysis of how psychiatrists in Australia construct schizophrenia through social interaction and discursive practices. 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. This shortcoming has been addressed, however, as recently formulated by Ventriglio and Bhugra (2015).

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 healthcare system, with particular mention of the Aro village system which integrates indigenous and psychiatric care developed in the global north. Swartz (1996, 1998) examined 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 of 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 socio-economic 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; Bhui *et al.*, 2015). 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 local and global dynamics of power.

Cultural competence has proliferated as a catchword 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 programmes in the United States (Jeffress, 1968), such as one for residents treating Hispanic patients and emphasizing the availability of cultural

25

JANIS JENKINS

experts in supervision, skills in cultural formulation of psychiatric distress, and culturally distinct family dynamics (Garza-Trevino *et al.*, 1997). Yager *et al.* (1989) describe training programmes in transcultural psychiatry for medical students, residents and fellows at UCLA. Rousseau *et al.* (1995) show that psychiatry residents' perceptions of transcultural practice varies 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 Suarez-Orozco (2000), Young (1995), Kinzie (2001a, b) and Rousseau (1995). Related to the literature of trauma, the experience of geographical dislocation has become of increasing concern as researchers and clinicians address the mental health of immigrants and refugees (Boehnlein and Kinzie, 1995; Azima and Grizenko, 1996; Bhugra, 2000; Kinzie, 2001a, b; Hodes 2002; Hollifield *et al.*, 2002; Kirmayer, 2002; Lustig *et al.*, 2004; Ingleby and Watters, 2005). The specific vulnerability of girls and women in relation to mental health problems, particularly depression, has been documented globally; the 2:1 epidemiological ratio of depression among females is to be accounted for in significant part by gender inequality, discrimination, misogyny and sexism (Jenkins and DelVecchio Good 2014).

The cultural analysis of psychopharmacology both from the standpoint of subjective experience and global political economy is attracting increasing attention (Metzl, 2003; Lakoff, 2005; Jenkins, 2010; Petryna *et al.*, 2006). Significantly more attention should be paid to the consequences of distinguishing studies oriented by the therapeutic discourse of 'treatment' (Seeley, 2000; Tseng and Streltzer, 2001) and studies oriented by the economic discourse of 'services' (Kirmayer *et al.*, 2003) in mental healthcare, 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).

Summary and Concluding Considerations: Psychiatry, Anthropology and Global Mental Health

To summarize, we now have several decades of research at the interface of psychiatric anthropology and cultural psychiatry which have provided empirical evidence that demonstrates the inextricability of culture and mental disorder. As Jenkins (2015a: 14) recently set forth, 'from onset to recovery, culture matters vitally in understanding the experience of mental illness'. Indeed, the range and depth of cultural factors and processes that shape mental illness are compelling, and include (Jenkins, 2015a: 14):

1. risk/vulnerability factors;
2. type of onset (sudden or gradual);
3. symptom content, form, constellation;
4. clinical diagnostic process;

26

JANIS JENKINS

5. subjective experience and meaning of problem/illness;
6. kin identification and conception of and social-emotional response ('expressed emotion') to problem/illness;
7. community social response (support, stigma);
8. healing modalities and healthcare utilization;
9. experience, meaning, and utilization of healthcare/healing modalities (including psychotropic drugs);
10. resources for resilience and recovery; and
11. most significantly, course and outcome.

At this juncture, it is worth emphasizing the particularly productive research paradigm that should neither be neglected nor forgotten in light of the volume of transcontinental research on 'expressed emotion' that has empirically demonstrated (1) significance for clinical outcomes, and (2) substantial cultural differences in the features of social and emotional response by kin toward relatives who experience distressing disorders (psychiatric and stress-related non-psychiatric alike; see Jenkins (2015a) for an updated overall summary of this literature). Given the importance of 'expressed emotion' for the onset, course and outcome of mental illnesses, there had been a notable theoretical gap in formulations to identify precisely what a research index as significant as EE is actually 'tapping'. Working from conjoined anthropological and psychiatric perspectives, ten specific features of this research construct have been identified (Jenkins and Karno, 1992). Nevertheless, future studies are needed to flesh out features that could be particularly vital for the course and outcome of disorders transnationally. This is an important charge since Hopper (1991) has critically examined the validity of the WHO cross-cultural studies of schizophrenia longitudinally over a 25 year period, seeking to address various aspects of methodological critiques registered by critics of the WHO and EE studies. Following systematic analysis and re-analysis of the original data sets, Hopper (2004: 71) concluded that the findings of 'consistent outcome differential favoring the developing centres is remarkably robust' pointing to WHO investigators who themselves had urged the examination of cultural and social factors (Sartorius et al., 1977). Clearly, we have considerably more work ahead of us to identify precise pathways and mechanisms, including the subjective experience of persons living with such conditions (individuals and their kin).

Currently, it is disconcerting that such research has taken a back seat to the identification of 'neuro-signatures' that are elusive at best and as a matter of urgency hold little to no relevance for the immediacy of needed care. The World Health Organization (2014), the United States National Institute of Mental Health, and several other institutional bodies have increasingly de-emphasized funding for cultural psychiatry and psychiatric anthropology in imbalanced favour of neuroscience. We cannot fail to observe the gaps, silences and erasures of decades of research that has been accomplished despite the productive convergence between anthropology and psychiatry thus far, and the need for more in the future with calls to 'scale up' in the field of global mental health. In the final analysis, the convergence between anthropology and psychiatry remains an 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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29

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31

JANIS JENKINS

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32

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33

JANIS JENKINS

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JANIS JENKINS