A call for cultural sensitivity is not cultural relativism

Response to comments on 'Culture in mental illness'

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De auteur reageert op de drie commentaren en verdedigt zijn opvatting dat culturele sensitiviteit in psychiatrisch werk niet gelijkstaat aan cultureel relativisme. Hij houdt vervolgens een pleidooi voor een vruchtbare samenwerking tussen psychiatrie en medische antropologie.

[psychiatrie, medische antropologie, culturele sensitiviteit, Kraepelin]

I am grateful to *Medische Antropologie* for focusing attention on my paper which was motivated, as I did point out in the introductory section, by the discomfort of black South African students (post-graduate medical anthropology) recruited to conduct interview on an interdisciplinary project on mental illness. I welcome the comments by Els van Dongen, Mario H. Braakman and Peter Ventevogel. The issues they raise are important ones, and some of the arguments are plausible and very fruitful. However, I am not persuaded by some of the criticisms of the paper, in particular, Ventevogel's, which, I must say is impressively robust yet consciously Machiavellian, at times writing in irritation. Perhaps, it should be, because the issue raised in the paper is not spent; however much Ventevogel, with his genuine irritation, trumpets. The point was to engage what presented itself to the research team as a problematic. Given the context (seven years after the demise of a social order that relegated a population and its culture in the 'order of things'; this is not rhetoric but a *social fact*), which Van Dongen not only recognises, but considers significant in relation to the issue, why would there not be a questioning of 'white coat' psychiatry with its Black Boxes, taken for granted elements (established facts, unproblematic objects) that are employed, risk free, for a variety of purposes (including making more black boxes)? The project was a rare opportunity for the students to peer inside the boxes. Their concern, having had such an opportunity, was not about what psychiatry is, does and should do. It was, in my opinion, a laudable attempt to subject to critique the "presuppositions inscribed in the fact of thinking the world", to borrow from Bourdieu (1990: 382). My response attempts to elaborate further on the issue. So, I like to start by addressing Van Dongen's and Braakman's disappointments about the conclusion of the paper. Let me say at the outset that we have to go beyond the simplistic cultural argument, which, Van Dongen and Braakman, wrongly, I must say, tried to pin on me.

Surely, the points that were raised in the paper are hardly new and I do not pretend otherwise. Literature search on the issues will confirm this point and the conclusion can be safely drawn that Anthropologists have contributed to the enrichment of Psychiatry, as have other social science disciplines. The result is that Psychiatry, a version of it, perhaps, has become very rich in the process. Again, I repeat, one needs to look at DSM IV to see the validity of this statement. Contrary to Ventevogel's suggestion that I think culture started with DSM IV, I want to say that DSM IV represents an acknowledgement of the contributions of anthropology and an indication of psychiatry's increasing consciousness of its other side – the systematic investigation into culture dependent differences in psychopathology, a less known aspect of Kreaepelin's work as Jilek reminds us (see Jilek 1995). What is particularly gratifying is that the contribution from anthropology has come in great measure from those who can comfortably straddle the two disciplines. It is these people who have mostly conducted cross-cultural studies of mental health, the results of which have made up a body of knowledge that one can comfortably put under the rubric, 'culture and mental health'. There is hardly any textbook on mental health in recent years that does not have a chapter on this and I doubt if there is any trained psychiatrist these days that escaped writing an essay or two on culture and mental health and indeed did not sit a written exam paper on it. Of course, this is not new to psychiatry. Kraepelin's original notion as Jilek (1995) notes was to identify, verify and explain the links between mental disorder and broad psychosocial characteristics, which differentiate nations, people and cultures. The problem is this: how come that with this background some psychiatrists tend to be oblivious (if I may say so) to culture? Braakman asked the same question, almost in exasperation. This should be the disappointment not my conclusion which is simply to reiterate the point that cultural meaning and context of psychiatric phenomena need to be stressed. That there should be due recognition of the *emic*, that is, the indigenous causality notions and of the explanatory models based on indigenous beliefs about health and sickness Saying this is not to get stuck in cultural relativism which I am accused of and to which I will return to later. The field of transcultural psychiatry is known for this viewpoint. Indeed, research in this area shows preference for ethnography over epidemiological methods. And this brings me to the two disciplines.

Anthropology and Psychiatry: Foes?

Ventevogel could not disguise his irritation towards anthropology when he writes: "I am afraid that the 'anthropological understanding of mental illness' is not at all regarded as 'new' by psychiatrists but on the contrary, is easily set aside as old fashioned and irrelevant. Mainstream psychiatry profoundly distrusts anthropological knowledge because it is discredited by cultural relativistic claims pushed to the extremes". In a much more milder way and of course, different, but similar, in the sense of the relationship between anthropology and psychiatry, Braakman gently notes that medical anthropologists portray doctors as enemies. I do not think that medical anthropologists do. By definition, anthropology is not a discipline that defines the 'other' as enemy, the

'other' might not be 'us' but surely the 'other' is not an enemy but that strange, exotic, sometimes incomprehensible creature, feared, abhorred, and yet in some ways also envied. This is a constant thread in anthropology. I think Braakman got it wrong here. One is not preoccupied to showing that "Doctors are wrong" nor is one suggesting that they choose a "relativistic position", which will result in making their "therapeutic acting no longer rational". The problem arose from fieldwork and it will continue to be the case so long as it is not satisfactorily resolved. And when it arises, researchers have to deal with it in a manner that will aid their research. Dealing with it necessarily means, sometimes, questioning the basic parameters of the preferable treatments of mental illness in psychiatry, which occur within a framework that constitute a set of ideas and assumptions and related practices in which they are embedded. This is an issue to which many authors have returned. Ventevogel may dismiss it as old hat, but that is the nature of knowledge and knowledge production. As Gellner (1985: 7) remarked, "knowledge is cumulative and progressive. The cognitive capital of mankind *grows*. There are occasional cases of the reopening of issues which had been supposedly closed, of a reversal of past consensus; but nevertheless, by and large, *later means better*. This is so notwithstanding the fact that it is difficult to express formally the criteria in terms of which progress is achieved". Psychiatric diagnoses can only be better by factoring in (and I am reminded that they do because they are trained to) other significant aspects of life.

Ventevogel in fact acknowledges this. Why would he not? Did Kraepelin not write during his trip to Java that "If the characteristics of a people are manifested in its religion and its customs, in its intellectual and artistic achievements, in its political acts and its historical development, then they will also find expression in the frequency and clinical formation of its mental disorders, especially those that emerge from internal conditions." Just as the knowledge of morbid psychic phenomena has opened up for us deep insights into the working of our psychic life, we may also hope that the psychiatric characteristics of a people can further our understanding of its entire psychic character. In this sense comparative psychiatry may be destined to one day become an important auxiliary science to comparative ethnopsychology (*Völkerpsychologie*; Kraepelin 1904: 437 cited from Jilek 1995). In a discussion of this quotation Jilek suggests that Kraepelin believed that national-cultural characteristics are reflected in individual psychopathology. According to him, Kraepelin assumed that there are significant differences in presentation and prevalence of mental illness in populations of different ethnic-cultural backgrounds and different stages of modern development; that is, Kraepelin assumed that sociocultural factors exert *pathoplastic*, illness-shaping and *pathogenic,* illness-causing, effects, as are known today. Clearly, this lesser known aspect of Kraepelin would seem compatible with some versions of anthropology. Van Dongen has addressed this issue somewhere else noting the "cultural foundation" of both disciplines (Van Dongen 2000). This brings me to the issue of cultural uniqueness and one of the crucial statements by Ventevogel which clearly shows his irritation: "It seems to me that we can come to a conclusion now, and sweep away all studies using DSM criteria in a non-western context". It would be wrong to assume that this is what is suggested or even implied in my paper. I want to go back to Kraepelin and schizophrenic disorder, a concept, which he originated, to answer Ventevogel.

Cultural uniqueness?

The thrust of his research into the condition was towards elucidating its biological basis, which included questions such as whether particular parts of the brain were damaged more than others. As David and Cutting (1994) point out, the spate of higher-order neurological deficits uncovered in the last half of the nineteenth century – aphasia, agnosia, apraxia, alexia, etc. – led many psychiatrists to suppose that schizophrenia, like these other conditions, would turn out to have a specific link with some damaged brain site. An example given was Broca's aphasia with a lesion in the left second and third frontal gyri. According to them, Bleurer's incorporation of Freud's and Jung's psychodynamic explanations of psychiatric phenomena opened the door for a number of non-neuropsychological approaches – psychodynamic, social, existential, behavioural, and cognitive models. They suggested that these approaches merely adopted some psychological model of mind (or non-mind in the case of behavioural) and schizophrenia was slotted into them in the most plausible way possible.

Evidence from assorted areas suggests that schizophrenia can usefully be divided in terms of presence or absence of abnormalities presumed to arise *in utero* or during early childhood. For example, abnormal development of brain structure (Jakob & Beckman 1986; Folkai & Bogerts 1986; Bruton et al. 1990; Roberts 1991), obstetrics difficulties (Eagles et al. 1990), minor physical developmental defects (Guy et al. 1983), abnormal childhood personality traits (Foerster et al. 1991a, 1991b) all appear to exist in a proportion of schizophrenics prior to the onset of frank psychosis. The occurrence of these developmental abnormalities is universal and not confined to a specific culture, western or non-western. Yet it is in schizophrenic disorders that the influence of culture on symptomatology, course and outcome of mental illness has been shown in comparative studies of recent past. Most prominent among these were the global collaborative research projects by the Mental Health Division of the World Health Organisation (WHO) led by Sartorius. The studies confirmed that the syndrome originally described by Kraepelin and Bleuler is clearly recognisable in subjects of diverse ethnic and cultural backgrounds at all research sites in Europe, North and South America, Asia and Africa. Although in terms of symptom profile, there was cultural variation.

The *Determinant of Outcome of Severe Mental Disorders* (DOSMED) study of WHO found a higher frequency of depressive symptoms, primary delusions, thought insertion and thought broadcast in schizophrenic patients of developed countries. There was a higher frequency of directed auditory hallucinations and visual hallucinations in patients of developing countries (Jablensky et al. 1992). A sub-study of the DOSMED project conducted in Agra (India) and Ibadan (Nigeria) showed significant differences in the way schizophrenia was manifested in the two populations. The Indian patients showed more affective behaviour while in the Nigerian group the expression of the psychosis had a more paranoid, bizarre and anxious quality. The researchers thus concluded that the content of psychotic symptoms identifies critical issues in a culture. In the 1980s, research confirmed previous findings that the most common delusions in African and Afro-Caribbean patients with schizophrenic and

with non-schizophrenic psychosis are of persecutory nature, followed by religious themes, which, were in conformity with the indigenous culture traits. The prevalence of auditory hallucinations in African patients with emotional disorders suggested that in African cultures auditory hallucinations of all types are not necessarily indicative of schizophrenic psychosis.

I suppose it is generally agreed that sociocultural factors influence every aspect of psychiatric disorder. As Jilek (1995) notes, cultural variation is greater in reactive and neurotic conditions than in major psychoses, cultural influence, and variability decrease further as organic substrates are more directly implicated, but the influence of cultural factors can be demonstrated even in structural brain lesions. The paper was critical of 'white coat' psychiatry but does not dismiss the criteria of DSM. I subscribe to universalism in that there are universal elements in human behaviour, normal or abnormal, that transcend individual and ethnic-cultural differences. If not subscribing to the extreme universalistic view that mental disorders are the same everywhere is scientific naïveté, as I have been accused of, I cannot but plead guilty to the charge. In collaborative interdisciplinary research on mental the age-old universalism vs. relativism problematic cannot be wished away as Ventevogel would want to. Grounding students in the problematic is part of the process of 'socialising' them as social scientist. This will continue.

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