PART I

Theoretical background

1

Cultural psychiatry in historical perspective

Laurence J. Kirmayer

EDITORS' INTRODUCTION

The evolution of cultural psychiatry over the last few decades has been an interesting phenomenon to observe. Psychiatry is perhaps one of the younger disciplines of medicine. The coming of age of psychiatry as a profession was clearly linked with the development of training and laying claim to a knowledge base which gradually has become more evidence based. The period between the two world wars led to greater questioning of social factors in the aetiology and management of psychiatric disorders. In the UK at least, social psychiatry as a discipline became clearly established and produced impressive studies on life events and their impact on phenomenology, attachment and other social factors. In the last two decades, it would appear that social psychiatry has transmogrified into cultural psychiatry.

Kirmayer, in this chapter, maps out the history of cultural psychiatry as a discipline. In addition, he raises the concerns related to this discipline, especially related to universality of psychopathology and healing practices, development of diverse service needs to black and ethnic minority groups and analysis of psychiatric theory and practice as products of a particular cultural history. Culture has been defined as a civilizing process which, in European history, Kirmayer asserts, had to do with the transformations from migratory groups to agrarian societies to city states and, eventually, nation states. The definition of culture in this context was related to standards of refinement and sophistication. The second definition of culture has to do with collective identity, which is based on historical lineage, language, religion, genetics or ethnicity. Kirmayer suggests that these two definitions have become conflated. The historical development of comparative psychiatry in colonial times and until the 1960s, when research across cultures used dimensions of distress, ignored local cultural practices and interpretation of these experiences. The role of racism in diagnosis and management of individuals with psychiatric illnesses has not entirely gone away. Large-scale migrations from East to West and North to South across the globe have raised questions about ethnocultural diversity. An organized and relative newcomer within the larger discipline of psychiatry, cultural psychiatry is becoming mainstream and beginning to influence health-service delivery and research.

Introduction

Cultural psychiatry stands at the crossroads of disciplines concerned with the impact of culture on behaviour and experience. It emerges from a history of encounters between people of different backgrounds, struggling to understand and respond to human suffering in contexts that confound the alien qualities of psychopathology with the strangeness of the cultural 'other'. The construct of culture offers one way to conceptualize such difference, allowing us to bring together race, ethnicity and ways of life under one broad rubric to examine the impact of social knowledge, institutions and practices on health, illness and healing. Cultural psychiatry differs from the social sciences of medicine, however, in being driven primarily not by theoretical problems but by clinical imperatives. The choice of research questions and methods, no less than the interpretation of findings and the framing of professional practice, is shaped by this clinical agenda, which emphasizes the quest for therapeutic efficacy.

Textbook of Cultural Psychiatry, Dinesh Bhugra and Kamaldeep Bhui (eds.). Published by Cambridge University Press

Over the course of its history, cultural psychiatry has been driven by three major sets of concerns: questions about the universality or relativity of psychopathology and healing practices; the dilemmas of providing services to ethnically diverse populations; and, most recently, the analysis of psychiatric theory and practice as products of a particular cultural history. These concerns correspond to three successive waves of development of the field from colonialist and comparative psychiatry, to the mental health of ethnocultural communities and indigenous peoples in settler societies, and the post-colonial anthropology of psychiatry.

The emergence and development of each of these themes in cultural psychiatry can be tied to major historical events, especially to global patterns of migration and their associated social, political and economic consequences (Castles & Miller, 1998; Papastergiadis, 2000). From the mid 1700s onwards, colonialist expansion of European powers led to observations relevant to psychiatry and to occasional efforts to provide healthcare in distant lands. Large-scale migrations of Europeans to North America, Australia and other regions in the nineteenth and twentieth centuries prompted attention to the impact of ethnicity on mental health and illness. Successive wars made psychological reactions to stress and trauma a salient concern for psychiatry. The Great Depression and the emergence of the welfare state highlighted the impact of social class and poverty as causes of illness. The promulgation of scientific racism forced researchers and clinicians to clarify their thinking about ethnocultural difference. The flight of refugees and displaced peoples following World War II and later conflicts, led to renewed work both on trauma-related disorders and the adaptation of migrants (Murphy, 1955). The UN Universal Declaration of Human Rights in 1948 and emerging anti-colonialist struggles around the world challenged the hegemony of Western versions of history and opened up the consideration of alternative systems of knowledge on both ethical and epistemological grounds.

Most recently, new waves of migration from East to West and South to North have challenged models of culture and ethnicity developed for earlier groups of immigrants from relatively similar European countries (Castles & Miller, 1998). At the same time, increasing recognition of the historical injustices suffered by indigenous peoples has made their cultures a focus of attention both in terms of the damaging effects of forced assimilation and the potential for resilience in indigenous identity, community and healing practices (Cohen, 1999; Kirmayer, Simpson & Cargo, 2003). The growth of the Hispanic, Asian and other non-European populations in the USA, and the corresponding increase in the numbers of mental-health professionals from diverse ethnocultural backgrounds, have pressed for change both from without and within the profession, as reflected in the attention to culture in official psychiatric nosology (Alarcon, 2001; Mezzich *et al.*, 1996). Similar demographic changes are affecting most societies, and will make cultural issues a matter of central concern for psychiatry in the years to come.

The uses of culture

There are three broad but distinct uses of the term culture that are often conflated (Eagleton, 2000; Kuper, 1999) and each has its reflection in the history of cultural psychiatry. Originally, culture meant cultivation: the civilizing process which, in European history, had to do first with the move from migratory groups to agrarian societies (cultivating crops) and then to city-states and larger political entities including nations and empires. Throughout this history, there was a progressive elaboration of codes of conduct and civility and the cultivation of specialized knowledge and power, initially the possession of elite social classes, but gradually accessible to others through formal education (Elias, 1982; Gellner, 1988). Culture in this sense represents a standard of refinement or sophistication, measured against the cosmopolitan life of urban centres, the achievements of those with higher education, and the 'high culture' (with a capital 'C') of arts and letters. Culture as civilization

has influenced thinking about psychopathology from Vico's Renaissance views of culture as a civilizing force (Bergin & Fisch, 1984), through Rousseau's idealization of the noble savage, to Freud's tragic–heroic view of the ego wrestling with conflicts of desire and social constraint in *Civilization and Its Discontents* (Freud, 1962). Although Western European civilization has viewed itself myopically as the singular standard against which others can be judged, there are many other traditions with comparable levels of history and complexity, and some see the contemporary world as a contest of great civilizations with incommensurable values and epistemologies (Huntington, 1996).

A second meaning of culture has to do with collective identity, the setting apart of one group of people from another on the basis of historical lineage, language, religion, gender or ethnicity which may include membership in a community, regional group, nation or other historical people (Banks, 1996). While the notion of culture as cultivation may be presented as a universal system of values that can be attained by anyone allowed the opportunity to become 'civilized' (even if, in practice, essentialized notions of cultural identity subvert this possibility), ethnocultural identity is local and particular, the property of groups who regulate its distribution along lines of historical descent, kinship, citizenship, or other social markers of identity. Ethnicity is differently constructed in each society, and may merge with local notions of 'race', national identity or other invented traditions (Hobsbawm & Ranger, 1983). While ethnicity has been a source of positive identity, self-esteem and group cohesion, it has also fueled discrimination, inter-group conflicts and genocidal violence.

The third notion of culture corresponds to its current use in anthropology as a way of life: the values, customs, beliefs and practices that form a complex system (Kuper, 1999). As such, culture encompasses all of the humanly constructed and transmitted aspects of the material and social world. Culture may reside at many levels of social organization in institutions, knowledge and local practices and includes, but cannot be reduced to, the cultural models internalized by individuals. In the contemporary world, cultural formations may be constituted both by local communities or 'subcultures' and transnational flows of knowledge and practice shared by groups of experts and professionals (Hannerz, 1992, 1996). Psychiatry itself is one such transnational cultural institution with national variants and subcultures.

Comparative psychiatry and the legacy of colonialism

The roots of cultural psychiatry can be traced to the very beginnings of modern psychiatry. Indeed, long before psychiatry was clearly distinguished from other areas of medicine, examples of odd or deviant behaviour among distant peoples stimulated philosophical reflections on the uniqueness of mankind and the impact of the 'civilizing process' on human nature (Jahoda, 1993). These early commentaries drew on travellers' observations of distant peoples who were culturally different, whether coming from a recognizably different civilization or viewed as undeveloped 'barbarians'. This literature reveals an aesthetic fascination with the strangeness of the other that was often both morally and erotically charged (Segalen, 2002). European explorers and colonizers generally viewed their own traditions as the zenith of civilization, while others were seen as backward, primitive and uncivilized (Jahoda, 1999; Gilman, 1985; Lucas & Barrett, 1995; Todorov, 1993).

The taken-for-granted superiority of European civilization demanded that its institutions be established in the colonies, and asylum psychiatry was one of these exports. While attempting to care for suffering individuals, colonial psychiatry also served to justify and maintain the social order of colonial regimes (Bhugra & Littlewood, 2001; Keller, 2001, 2005; McCulloch, 1995; Sadowsky, 1999; Vaughan, 1991). Colonial asylums became important sites for comparative studies of psychopathology. However, their status as colonizers and limited access to the everyday life of people outside hospitals and asylums made it difficult for these practitioners to

recognize the social and cultural context of patients' afflictions.

In general, colonizers and alienists did not see large numbers of mentally ill and this prompted speculation about the protective effects of 'primitive' ways of life. The idea that insanity was rare among primitive or uncivilized peoples, as claimed by Jean-Jacques Rousseau, was popular among early writers in psychiatry including Esquirol, Moreau de Tours, Griesinger & Krafft-Ebing (Raimundo Oda, Banzato & Dalgalarrondo, 2005). Sometimes this notion of the 'healthy savage' was framed in terms of the protective effects of living a simple life with few demands in contrast to the increasing expectations for productivity and consumption in the complex, urbanized, industrialized environment of Europe. An increase in nervousness was associated with the over-stimulation of modern civilization, especially for those required to do 'brain work', and hence the upper classes were particularly prone to maladies like neurasthenia or nervous weakness – a diagnosis introduced by the American neurologist George Beard and taken up widely throughout Europe and East Asia (Beard, 1869; Rabinbach, 1990). Over time, the living conditions of the poor in large cities, along with the impact of alcohol and a general erosion of moral and religious values, were invoked to explain the apparent increase in mental disorders in urban settings.

Early studies in comparative psychiatry focused on the exotic in order to examine the universality of major psychiatric disorders. The psychiatric literature of the late 1800s and early 1900s was peppered with reports of 'culture-bound syndromes', e.g. *pibloktoq*, *latah*, *amok*, thought to be uniquely linked to cultural beliefs and practices (Simons & Hughes, 1985). These reports seemed to indicate the malleability of expression of psychopathology, captured in the distinction between *pathoplasticity* and *pathogenesis* (Yap, 1952, 1974). Major psychiatric textbooks usually devoted a chapter to exotic and culture-bound conditions. Unfortunately, early observers paid relatively little attention to the social context of the syndromes they were observing and describing.

For example, *pibloktoq* or 'arctic hysteria', which was described in early accounts by explorers among the polar Inuit, became a stock example of a culture-bound syndrome. Anthropologists and psychiatrists have sought to link pibloktoq to specific features of Inuit child-rearing, social structure, religious practice, environment and nutrition (Brill, 1913; Foulks, 1974; Gussow, 1960; Landy, 1985; Wallace & Ackerman, 1960). Historian Lyle Dick (1995) reviewed all available accounts of pibloktoq and found that the few detailed case descriptions came from Admiral Robert E. Peary's visits to Greenland. There, on a few occasions, Inuit women were observed to become agitated and run out on the ice, stripping off their clothes, prompting others to restrain them until their agitation eventually subsided some hours later. This 'hysterical' behaviour seems entirely inexplicable until Dick provides the missing context: Admiral Peary had sent these women's menfolk out on exploratory missions at a time before solid ice, exposing them to great risk. The women presumably engaged in shamanistic prayer and magic to ensure the men's safety. Peary also thought it important for the well-being of his crew that they have sexual companions and encouraged his men to take Inuit partners with little regard for existing relationships. The women's 'erratic' behaviour, watched with amusement by Peary's men, now seems less evidence of a discrete culture-bound syndrome than a grimly familiar story of vulnerability and exploitation.

In another historical analysis, Marano (1983) showed how the culture-bound syndrome *windigo*, described among the Ojibway as the fear that one is possessed by a spirit that is turning one into a cannibal, probably never occurred as a behavioural syndrome, but was a part of a legend or mythological belief that could be used as an accusation to attack others. This accusation was effective not only in traditional society but served to mobilize the Royal Canadian Mounted Police as well, invoking a new form of social control available as a result of colonization. Once again, a phenomenon better understood in terms of power, conflict and social change was reified as a psychopathological entity

located within individuals (Waldram, 2004). Similar historical accounts of behaviours like *amok* or *latah* suggest that adequate description requires attention to the social context of power and the dynamics of protest and resistance (Kua, 1991; Winzeler, 1990, 1995). This tendency to ignore social context also was characteristic of the comparative psychiatry (*Vergleichende Psychiatrie*) advanced by Emil Kraepelin (1856–1926), who visited Southeast Asia and Indonesia to study *amok* and examine the universality of major psychoses (Jilek, 1995). Kraepelin's conclusion was that clinical phenomenology justified a qualified universalism. However, the differences he did find, he explained in terms of a developmental hierarchy:

> based on a comparison between the phenomena of disease which I found there and those with which I was familiar at home, the overall similarity far outweighed the deviant features … In particular, the relative absence of delusions among the Javanese might be related to the lower stage of intellectual development attained and the rarity of auditory hallucinations might reflect the fact that speech counts for far less than it does with us and that thoughts tend to be governed more by sensory images. (Kraepelin, 1904).

Kraepelin viewed cultural differences as reflections of biological differences in races or peoples and effectively elided the social context of psychiatric illness (Roelcke, 1997). His advocacy of theories of biological degeneration as a cause of mental disorder contributed to the rise of eugenic policies in Germany that culminated in the Nazi genocides.

While not adhering to Kraepelin's biological essentialism, H. B. M. Murphy (1915–1987) at McGill University and Julian Leff at the Institute of Psychiatry in the UK identified themselves as heirs to the tradition of comparative psychiatry and used both clinical observations and epidemiological methods to make systematic cross-cultural comparisons. Although they eschewed the sort of colonialist thinking and social Darwinism that plagued earlier writing, both invoked developmental hierarchies in their explanations of certain cultural differences. Murphy (1982) contrasted 'traditional' and 'modern' societies and Leff (1981) argued for a progressive differentiation of the emotion lexicon in Indo-European languages with contemporary British English as the most differentiated (for a critique, see Beeman, 1985).

Much of the innovative work of Alexander Leighton and Jane Murphy (Leighton, 1981; Murphy & Leighton, 1965) in Africa, Alaska and rural Nova Scotia also falls under the rubric of comparative psychiatry, although they employed dimensional measures of distress and, owing to their anthropological training, were interested in the impact of social and cultural context on mental health and illness. Despite this ethnographic orientation, Jane Murphy's (1976) influential paper arguing for the universal recognition of psychotic symptoms across diverse cultures did not consider the impact of colonial history on attitudes toward psychosis in the African and Alaskan communities she studied (Sadowsky, 1999).

The 'neo-Kraepelinian' revolution of DSM-III in 1980 introduced operationally defined discrete diagnostic categories in place of dimensional or narrative descriptions of psychiatric disorders (Wilson, 1993). With this new nosology and the accompanying technology of highly structured diagnostic interviews, comparative psychiatry followed the rest of the discipline, abandoning in-depth ethnographically informed studies in favour of research organized around discrete diagnostic categories. This line of research has culminated in a series of important cross-national studies of the prevalence, course and outcome of major psychiatric disorders including the International Pilot Study of Schizophrenia (World Health Organization, 1973), the Determinants of Outcome Study (Sartorius *et al.*, 1986), the Cross-National Study of Depression (World Health Organization, 1983), and the International Consortium of Psychiatric Epidemiology (e.g. Andrade *et al.*, 2003). Successive generations of studies have used more refined measures, particularly standardized diagnostic interviews, most recently the Composite International Diagnostic Interview (Robins *et al.*, 1989). However, these instruments continue to have limitations when used across cultures and

methodological artifacts have not been eliminated (Hicks, 2002; van Ommeren *et al.*, 2000). As well, most epidemiological studies have made little provision to identify culture-specific symptoms not included in the core definitions of disorders. In this way, the diagnostic categories of psychiatry bury the traces of their origins in European and American cultural history and become self-confirming 'culture-free' commodities ready for export.

Another important line of work in comparative psychiatry has centred on the effectiveness of traditional or indigenous healing practices (Kiev, 1969; Marsella & White, 1982; Rivers, 1924). Drawing from a rich ethnographic literature on healing rituals, Jerome Frank (1961), Raymond Prince (1980) and others argued that psychotherapy shares essential features with traditional healing and that both could be understood in terms of symbolic action at social, psychological and physiological levels. This work has become increasingly important as efforts are made to integrate or coordinate the activity of mental-health practitioners and traditional or indigenous healers in many societies.

Cultural essentialism and racism in psychiatry

A central feature of most colonial enterprises was the use of racist concepts and ideologies to justify the subordination and exploitation of colonized peoples (Fredrickson, 2002). Though they have no clear foundation in biology, notions of race serve to mark off particular groups as intrinsically different and less than other human beings (Lock, 1993). Psychiatry itself has been used to buttress racist perspectives (Littlewood, 1993). The notion that southern or non-Western peoples had underdeveloped frontal lobes and hence were prone to disinhibited behaviours was promoted by several generations of neuropsychiatrists, both to explain cross-national differences and to account for inequalities within colonized nations that actually reflected the legacy of racism, slavery and economic marginalization. For example, influenced by Lucien Lévy-Bruhl's (1923) notion of primitive mentality, Antoine Porot (1918), the head of the École d'Alger, argued that the native Algerian's mind was structurally different from that of the civilized European (Begue, 1996). This biological essentialism was matched by a complete disregard of social, cultural and political context that served colonial interests. This sort of essentialism persisted into the 1950s in the work of J. C. Carothers on the African mind. For Carothers, the African was developmentally child-like owing to underdeveloped frontal lobes that result in an effective leucotomy (Carothers, 1953; McCulloch, 1993, 1995). A whole generation of African psychiatrists was educated with texts containing this tendentious account.

Of course, there were also essentializing accounts of cultural difference presented in psychological terms. In *Prospero and Caliban*, French intellectual Octave Mannoni ((orig. 1948) 1990) described the people of Madagascar as primitive, and uncivilized, with a fundamentally different mentality based on a 'dependency complex' that protected them from the neurotic conflicts that were the burden of Europeans. Although Mannoni later developed a more nuanced account of the psychology of colonization, with Lacan displacing Adler in his psychodynamic theorizing, his earlier portrait remained a provocation to others seeking to understand and escape from the colonization of the psyche that accompanied political domination (Lane, 2002).

The migration of North African workers to France after 1945 stimulated French psychiatrists' interest in cultural difference and gave rise to the field of ethnopsychiatry (Fassin & Rechtman, 2005). Thus, the study of ethnic diversity in colonizing societies was closely linked with the history of colonial comparative psychiatry. At the same time, there was the growing recognition that the colonial context itself was one of exploitation and stress that could account for some of the suffering and symptomatology seen in clinical contexts.

Frantz Fanon (1925–1961) was an important voice in this critique of the colonial origins of psychopathology (Macey, 1996; Razanajao *et al.*, 1996). Fanon denounced the theories of the École d'Alger, which

he saw as based on a colonial perspective with racist devaluing of the values, traditions and autonomy of others. In *Peau noire, masques blancs* (1982, original 1952), Fanon powerfully portrayed the self-alienating effects of racism and colonialism. Fanon's account of the psychopathology of colonialism echoed the earlier account by the sociologist W. E. B. Du Bois (1868–1963) in *The Souls of Black Folk* on the 'double consciousness' of African Americans (Du Bois, 1989). Fanon worked in the space between the political and the psychological – insisting on the primacy of politics and power, but showing how it was inscribed in the psychological and how change could come from within and without (Vergès, 1996). Ultimately, however, Fanon was less interested in the dynamics of culture and colonialism than in the struggle for political revolution and fell prey to the same tendency to essentialize cultural difference that plagued writers less aware than he was to the violence of racial stereotypes.

The process of unpacking the impact of racism and colonialism on the psychology of the colonizer and colonized is far from complete, the more so because the forms that oppression takes continue to mutate. This has been one focus of postcolonial theory, which offers a rich array of ideas about identity and alterity in the contemporary world that has as yet had little impact on cultural psychiatry (Bhaba, 1994; Chakrabarty, 2000; Gunew, 2003; Said, 1994).

Ethnocultural diversity: settler societies and indigenous peoples

The large migrations of Europeans to North America, Australia and other countries from the 1700s onwards created settler societies with high levels of ethnocultural diversity. This experience of people from many different national and regional backgrounds living side by side made ethnicity salient (Banks, 1996). Epidemiological studies were conducted from the 1930s onwards on differential rates of psychiatric hospitalization of ethnocultural groups (Westermeyer, 1989). Subsequent waves of migration following World War II and other conflicts made the mental-health needs of immigrants and refugees increasingly important in most psychiatric settings and led to a substantial literature on ethnic differences in illness behaviour.

The response to ethnic diversity has followed different trajectories in different countries owing to the history of colonization and migration but also following local ideologies of citizenship and dominant theories with psychiatry itself (Kirmayer & Minas, 2000; see for example, Baarnhielm *et al.*, 2005; Beneduce & Martelli, 2005; Fassin & Rechtman, 2005; Fernando, 2005). Thus, the US and France share republican values of egalitarianism that imply that all citizens should be treated the same, with no regard to their cultural background (Todorov, 1993). Along with this came the assumption that, over time, ethnic groups would assimilate and acquire the cultural identity and practices of the dominant society. In fact, ethnicity has persisted in most settler societies despite pressure to assimilate. In the US, this ideal has been complicated by the history of slavery and racial discrimination against many groups. The current language of culture refers to 'diversity', defined in terms of ethnoracial blocs (Hollinger, 1995), but this diversity is recognized mainly insofar as it is associated with health disparities (Smedley *et al.*, 2003). In Canada and Australia, the ideology of multiculturalism has encouraged explicit attention to ethnic difference as a positive social value that warrants direct support by the state (Kivisto, 2002). At other moments, and in other societies, ethnicity has been profoundly divisive and, along with biologically essentialized notions of race, served as an incitement to violence and genocide (Fredrickson, 2002; wa Wamwere, 2003).

In Britain, cultural psychiatry has focused more on issues of race than on culture or ethnicity because of the conviction that racism is a crucial determinant of mental health and of the adequacy of psychiatric services (Fernando, 1988; Littlewood & Lipsedge, 1982). African-Caribbean immigrants have been observed to have high rates of schizophrenia. This phenomenon, which affects some other migrant groups in other countries as well,

does not appear to be due to diagnostic biases but may result from the stress of marginalization, discrimination and social exclusion (Hutchinson & Haasen, 2004; Kelly, 2005).

Recognition of the importance of culture, ethnicity and race has been prompted by demographic and political changes in settler countries, sometimes crystallized by specific confrontations or violent events that have commanded public attention. In the UK the death of Stephen Lawrence increased public awareness of issues of racism and social exclusion and prompted a government inquiry that led to changes in policy, with attention being directed to counter racism in institutions including health services (Fernando, 2003). In Canada, the Oka Crisis of 1990 (York & Pindera, 1991) led to the reports of the Royal Commission on Aboriginal Peoples and the establishment of the Aboriginal Healing Foundation to provide support for projects to address the legacy of the residential school system (Kirmayer, Simpson & Cargo, 2003). However, much of the response to cultural diversity has been at the grassroots level with minimal governmental support (Fernando, 2005). At the same time, subtler forms of racism and social exclusion continue to go unmarked and unchallenged (Gilroy, 2005; Holt, 2000).

Anthropology of psychiatry

The revolution in philosophy of science provoked by the work of Thomas Kuhn made biomedicine and psychiatry appear not so much universal truths as culturally constructed bodies of knowledge. Postcolonial writing challenged the taken-for-grantedness of Euroamerican values. The antipsychiatry 'movement' of the 1960s (Boyers, 1974) and the labelling theory of mental illness (Rosenhan, 1973; Scheff, 1974) drew attention to the social and political dimensions of psychiatric diagnosis. Historical accounts showed the ways in which psychiatric notions of madness emerged from and helped to maintain core cultural values (Ellenberger, 1970; Foucault, 1965; Porter, 1988; Micale & Porter, 1994). Within mainstream psychiatry itself, the US–UK Diagnostic Project (Cooper *et al.*, 1972) revealed important differences in the practice of British and American psychiatrists, with overdiagnosis of schizophrenia and under-diagnosis of bipolar disorder in the US. Subsequent efforts to improve the reliability of diagnostic practice in the US contributed to the emergence of DSM-III (Wilson, 1993). These and other social changes encouraged a more self-reflective stance and led anthropologists to consider biomedicine and psychiatry as cultural institutions (Good, 1994; Lock & Gordon, 1988; Kleinman, 1988). The anthropology of psychiatry developed a substantial body of literature showing how psychiatric practices draw from and contribute to cultural concepts of the person and experiences of the self (Gaines, 1992; Kleinman, 1995; Young, 1995). The third phase in the history of cultural psychiatry is strongly influenced by this turn toward cultural analysis and critique of the institutions and practices of psychiatry itself.

The seminal figure in this body of work has been Arthur Kleinman (1977, 1980, 1986, 1988, 1995), who, through his incisive writing, vision and leadership, has stimulated a whole generation of scholars. The 'new cross-cultural psychiatry' introduced by Kleinman (1977) argued for a renewed emphasis on ethnographic research. Rather than assuming the universality of psychiatric categories and psychological modes of expressing distress, Kleinman insisted on paying close attention to the social and cultural context of suffering and healing. This approach could be applied equally well across cultures and within the institutional and community settings of Western psychiatry.

Kleinman introduced the notion of the category fallacy, the erroneous assumption that conceptual categories that work well in one cultural context will have the same meaning and utility in another. In cultural psychiatry this is most obvious in questions about the meaning of psychiatric diagnostic categories. A further epistemological complexity arises from what the philosopher Ian Hacking (1999) has called 'the looping effect of human kinds' – that is, the tendency for the ways we

categorize the world to become reified and institutionalized as cognitive and social facts.

The importance of these ideas for cultural psychiatry can be seen in the history of the emergence of diagnostic categories like post-traumatic stress disorder (Young, 1995) and dissociative disorders like multiple personality or fugue (Hacking, 1995, 1998). Psychiatric knowledge and practice reflect and reshape folk psychologies (Gaines, 1992; Littlewood, 2002; Nuckolls, 1992). For example, the reception and evolution of psychoanalysis and other forms of psychotherapy in different countries provides a window onto cultural concepts of the person (Cushman, 1995; Ellenberger, 1970; Rose, 1996; Shamdasani, 2003; Zaretsky, 2004). The broad shift away from psychoanalysis and toward biological accounts in the US in the 1980s reflects tensions within the discipline of psychiatry as well as larger political and economic forces (Luhrmann, 2000). Psychopharmacology has played a crucial role in the development of psychiatry, driving diagnostic nosology and clinical practice (Healy, 2002). A growing body of research shows the role of the pharmaceutical industry in controlling the production of clinical 'evidence' and influencing popular conceptions of mental illness, which now extends to marketing new disorders (Lakoff, 2005; Metzl, 2003; Petryna, Lakoff & Kleinman, 2006).

Clinical work is always part of a larger social system. Understanding the impact of this social system on patients' lives and psychiatric practice demands critical and social science perspectives. Of course, the attempt to apply social science perspectives to analysing psychiatric practice raises the problem of self-reflexivity, since social science theory itself is a product of the society it seeks to critique. Indeed, the notion of culture is also a cultural construction that changes with new configurations of society and geopolitical concerns.

The contribution of psychological anthropology

Cultural psychiatry has co-existed with, and derived some of its theoretical models from, the various schools and approaches of psychological anthropology that link individual personality with broader social processes, particularly culturally shaped child-rearing practices (Bock, 1999; Spindler, 1978). Franz Boas (1858–1942), often called the father of American anthropology, argued that culture could affect personality and behaviour by amplifying or suppressing certain traits thus creating conflicts for different individuals. In the 1930s, 'culture and personality' researchers (notably Ruth Benedict and Margaret Mead) attempted to relate social structure, child-rearing and other cultural life-ways to modal national characters and specific patterns of psychopathology within groups (Spindler, 1978; Stocking, 1986). They used mainly ethnographic observations and borrowed psychodynamic theory or learning theory to explain the links between individual and culture.

For Benedict, Mead and later contributors to the field of culture and personality, psychopathology could be understood in part as an exaggeration of cultural traits or as a mismatch between individual personality and overarching cultural norms and values. This tradition enjoyed a period of prominence during and after the Second World War when studies of 'nations at a distance', based on interviews with small numbers of emigrés and analysis of media, were used as a form of military intelligence (e.g. Benedict, 1934).

Benedict (1934) saw culture as personality writ large. Anthropologist Edward Sapir rejected this view, arguing that culture had no reality beyond the actions and representations of individuals, each of whom responds differently to social exigencies. Sapir was a close colleague of psychiatrist Harry Stack Sullivan and looked to psychiatry to provide a way of understanding culture through the vicissitudes of individual biographies (Sapir, 1938; Kirmayer, 2001). This approach led to more theoretically sophisticated accounts of the interplay of culture, social structure and character notably in the work of A. I. Hallowell (1955), but the field of culture and personality waned in the late 1950s owing to the failure to develop more rigorous methodology and a tendency to caricature whole societies with broad strokes (Levine, 2001).