THE ROLE OF CULTURE IN A THEORY OF PSYCHIATRIC ILLNESS

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Abstract—A medical theory of phenomena thought of as psychiatric would rely on concepts and seek explanations that pertain to the concerns of biomedicine. A social theory of the psychiatric needs concepts and seeks explanations that pertain to concerns of the social and cultural sciences. Some of the requirements of such a social theory are reviewed with an emphasis on why and how the concept of culture is important. The Western medical bias of psychiatric illness needs to be faced as well as the problem of cultural relativism. The paper discusses the heuristic usefulness of a concept of human behavioral breakdowns. The many ways in which culture influences knowledge and practice of biomedical psychiatry are examined critically. The scope of a social theory of the psychiatric is also outlined.

Key words—psychiatry, theory, ethnomedicine, relativism

Psychiatry attempts to clarify etiologic and therapeutic aspects of a number of 'biological' disorders which differ from others in medicine only with respect to the organ affected and type of pathologic process or 'lesion' [1–3]. In this light, a theory of schizophrenia or bipolar manic disease (the classic 'diseases' of psychiatry) would address genetic factors, environmental precipitants, pathogenesis and natural history as well as response to pharmacology. These are factors whose conceptualization and empirical investigation are analogous to those of diseases in general medicine. Contemporary psychiatry is quintessentially biomedical. The formulation and investigation of a disease entity is grounded in the biological sciences and in allied sociomedical sciences (e.g. epidemiology, demography), all of which share a system of categories, explanatory frameworks, and underlying rationale with respect to what disease means and the purposes of treatment.

A social theory of psychiatric phenomena is different insofar as it must be cross-culturally relevant. What the 'psychiatric' refers to in biomedical terms (e.g. schizophrenia, mania) may have no identity or meaning in a local culture. Yet, one anticipates that behavioral disturbances (i.e. psychiatric phenomena) are likely to be prevalent cross culturally. This, in essence, is the problem of cultural relativism which entails the idea of emic and etic categories, all of which have received a great deal of attention in anthropology and psychiatry [4–9]. A social theory of the psychiatric thus encounters this problem directly.

To attempt a social theory an analyst must first define the psychiatric abstractly in order to embrace phenomena that are comparable across societies but which may be conceptualized differently. Then, a way must be found of measuring in social terms how instances of the psychiatric (as the analyst defines this) are labelled and handled in different societies. This topic is elaborated in the paper with emphasis given to both cultural and historical factors. I will also discuss that even in the contemporary setting, where scientific objectivism characterizes psychiatric knowledge and where rationalism dominates the thinking of mental health personnel and patient, culture plays a no less critical role. For not only have cultural factors conditioned basic meanings of psychiatric concepts, they also influence the interpretation and application of clinical psychiatric knowledge. Finally, the whole enterprise of biomedical psychiatry itself is rooted in distinctive cultural traditions and hence has a cultural character.

The aim of this essay is to outline the issues pertinent to a social theory of psychiatric phenomena concentrating on the conceptual problems posed by the idea of culture and cultural relativism. By 'culture' I mean a system of meanings that is learned, that provides people with a distinctive sense of reality and which helps shape behavior and affective responses [10]. The cultural, historical and medical factors that must be considered in formulating the relation between psychiatric phenomena and the functioning of societies will be discussed. More specifically, I (1) argue for a broad synthetic approach to theory construction in social science/psychiatry; (2) review epistemological dilemmas linked to cultural relativism; (3) introduce and discuss a concept of 'human behavioral breakdowns' as a way of clarifying epistemological dilemmas; (4) elaborate on why culture is so intertwined with the study of human behavioral breakdowns and psychiatric illness; and (5) offer some remarks about the kinds of issues in social science that a theory of psychiatric phenomena must confront. For now, I will use the term 'psychiatric illness' in an abstract sense referring
to conditions that disrupt the social life of persons and their immediate co-members and that might be equatable with biomedical categories (e.g. anxiety, schizophrenia, mania).

THE STUDY OF MEDICINE IN A COMPARATIVE FRAMEWORK

To deal theoretically with psychiatric illness in a comparative, cross cultural framework is part of the enterprise of an ethnomedical science and involves making use of its basic concepts [11]. Fundamental to this field is a distinction between the concept of disease as a biomedical condition and illness as a social behavioral response. In addition, ethnomedicine encompasses a range of concepts pertaining to properties and modes of functioning of systems of medicine; for example, explanatory frameworks pertaining to cause and treatment of illness, modes of production of medical knowledge, idioms of distress, practitioners and healers of different persuasion, institutions for training them and social practices governing diagnosis, treatment and prevention [12–15]. A fundamental axiom of ethnomedicine is that all societies are affected by disease.

Any theory of disease viewed in purely biological terms as affecting morbidity, mortality, reproductive level and its range of social consequences, ultimately rests on the theory of evolution [16, 17]. Given (1) biological errors and genetic characteristics intrinsic to populations that operate as vulnerabilities and (2) environments that challenge and strain the organism, conditions are met for the endemicity of disease and the production of illnesses [18]. In an ethnomedical theory of illness, the endemicity of disease could be taken as a given fact; that is, as providing the ultimate conditions that create the social phenomena of illness which the theory was designed to explain; and hence, as outside the domain of the theory. On the other hand, there are advantages to not excluding biological factors from a theory of illnesses, if for no other reason than to increase the scope and power of what the theory could explain.

However, to allow phenomena explained in terms of biology to intrude into the domain of cultural analysis raises the problem of universalism and cultural relativism [19]. Biology implies universal mechanisms and processes and points to sameness in the material production of illness and its manifestations. Yet, culture implies differing contents and contexts of meaning and, with respect to psychiatric illness, cross cultural variation in appearance and interpretation. How can sameness and differences be reconciled? This problem is central to a social theory of psychiatric illness.

It is necessary to address the challenge of ‘radical’ cultural relativism, as well. The theory of evolution and biomedical science, which would serve to explain the ubiquity of disease, are Western products. According to some (‘radical’) cultural relativists, such knowledge is necessarily ‘culture bound’. The knowledge produced by a Western ‘science’ of biology would thus appear to dissolve as an explanatory foundation. Such a cultural relativistic perspective would place Western scientific knowledge and theory either external to a culturally sensitive theory and/or render its inclusion in such a theory highly problematic [19]. All of this would seem to narrowly confine or to render misguided a comprehensive social theory of psychiatric illness as conceptualized here; namely, as importantly requiring the concept of culture.

A ‘radical’ form of cultural determinism which stops short of biology and does not allow using concepts which have meaning across cultures (epistemological relativism) is eschewed here as being pernicious to a scientific inquiry into illness, disease and related social behavior [19]. Consequently, no inconsistency is presumed to arise when one connects the study of illness as a sociocultural enterprise to the study of disease as a biological one.

The ubiquity of disease in human populations means that illnesses are recurring eventualities in social groups that constitute deviations and give rise to corrective actions [20]. This means that how people describe, show, recognize and respond to illness varies in relation to cultural meanings. However, what can be labeled a medical event almost always involves a gross disturbance in adaptation, usually with a bodily focus. Given that illness appears naturally anchored in the body, it is reasonable to assume that there exist universal indicators of illness. This would include such things as bleeding, visible anatomic lesions, varieties of pain, changes in bodily awareness and function, and impairments in sensory and neuromuscular functioning all of which (to be sure) are registered in social behavior and adaptation and can be directly observed as well as reported. In short, although the concept of illness is subject to cultural variation since it rests on sociopsychological and/or behavioral conventions about behavior, it refers to phenomena that also are somehow universal and ‘biological’. A biocultural unity operates at the level of manifestation of any illness episode as well as at the level of causation, since reciprocal influences exist between phenomena labeled as biological or cultural.

Because illnesses which we think of as physical and bodily are universal to human societies, manifest in relatively similar ways and are generally distressing, concepts about them are widely encountered [14, 18]. They are easily found among the cultural objects of any comprehensive ethnography as are theories of causation and medical treatment. What we ordinarily mean by psychiatric illnesses, however, are more difficult to locate in the medical vocabularies of different people. Such illnesses prominently involve alterations in social and psychological behavior and often are not identified locally. A concept that can approximate the psychiatric is needed.
HUMAN BEHAVIORAL BREAKDOWNS (HBB)

Our current understanding of psychiatric illness is rooted in developments of Western European influenced societies. Three related developments can be singled out. One is cultural or symbolic in nature and includes, on the one hand, conceptions about personhood, social identity and social deviance; and on the other hand, conceptions of well being, illness and medical care. It is in the intersection of these conceptions that one finds the category of psychiatric illness. The second set of developments are historical, political and sociological in nature. They include the demographic transition, growth of large urban centers, industrialization, the impoverishment and marginalization of population segments, centralization of governmental power, spread of liberal democratic ideas, the collectivization of social welfare activities under the auspices of the state and the growth of health and welfare related professions. The third set of developments are biomedical in nature. These include the growth of scientific understanding of brain function, psychiatric disease processes, and medical therapeutics. This knowledge has had an important effect on how the psychiatrically ill are viewed and handled in Western societies.

Of course all three developments, though analytically distinguishable, are in practice complementary and correlated. The cultural/symbolic, historical, sociological and biomedical developments enumerated here account for the way the category psychiatric illness is understood, used and applied today. In this sense, its meaning is quintessentially Western European.

In using a concept of psychiatric illness to explain behavior, illness and well-being, one must thus guard against casting definitions and formulations in a Western European mould. If biological markers pertaining to disease existed in psychiatry, they could provide one basis for cross cultural measurement, but this would entail side-stepping the cultural context of illness and behavior. To deal effectively with the problems in a society although I will be giving principal attention to material pertaining to this eventuation. A fundamental issue in cultural studies of psychiatry involves the question of what is medical as opposed to something moral, political or religious, and on what bases these distinctions are made. This problem will not be addressed directly in this essay, although several considerations that bear on it are taken up later. In a loose sense, all societies are held to possess medical care 'systems' [21]. It is in terms of the knowledge and practice structures of these 'systems' that people may diagnose and treat HBB as illness. The point here is that HBB and HBB which

in which such anomalies can be classified. One can use external and observer imposed (so-called 'etic') conventions or one can use those that are culturally specific and local to the society ('emic' conventions). Anomalies of social behavior are sometimes judged positively by co-members, with affected individuals valued and accorded power and status. Other anomalies are devalued and judged negatively. Whether the behaviors are judged as willful or not is a further important consideration in the way behavioral anomalies are culturally defined.

Sustained anomalies of behavior that are judged as not willful and evaluated negatively by co-members are here termed 'human behavioral breakdowns' (HBB). They incude all or some of the following: disturbances in mentation and awareness that render work and relationships unproductive, impairments in emotional well being, irregularities of social identity and conduct, and failure to meet standards of appearance, dress and cleanliness. An HBB encompasses behaviors that could be the object of professional psychiatric diagnoses as well as lay labels of behavioral derangements or dilapidation. However, it need not totally impair the individual's functioning. The idea that the behavioral change is locally devalued is the important feature. The term breakdown and/or disturbance means that the behaviors in question are defined as constituting an impairment and a disruption in behavior; and a compromise of or threat to organized social life. The behaviors, in other words, cause trouble, or confuse, or interrupt the flow of social life of the people connected to the individuals showing HBB.

HBB related behaviors are (1) shaped by culture in some way; and (2) labeled by co-members using categories drawn from a culturally constructed repertore of symbols. Each society possesses a system of categories and explanatory frameworks in terms of which the self and the world, including HBB, are understood. In labeling a behavioral anomaly as an HBB, a cultural co-member has classified the behavior: he or she, in identifying it as a local variant of HBB, has 'seen in it' criteria that constitute the conceptual category HBB.

The label applied to HBB is by definition 'negative' because HBB involve changes that are devalued. It does not follow that HBB are handled as 'medical' problems in a society although I will be giving principal attention to material pertaining to this eventuation. A fundamental issue in cultural studies of psychiatry involves the question of what is medical as opposed to something moral, political or religious, and on what bases these distinctions are made. This problem will not be addressed directly in this essay, although several considerations that bear on it are taken up later. In a loose sense, all societies are held to possess medical care 'systems' [21]. It is in terms of the knowledge and practice structures of these 'systems' that people may diagnose and treat HBB as illness. The point here is that HBB and HBB which
are culturally interpreted as illness are two ways of developing a concept of 'the psychiatric' that might be useful for an ethnomedical theory of psychiatric illness.

Emphasis on HBB as illness is important because labeling something an illness and hence worthy of medical care tends to bring into play special symbols, qualifications and practices that have as their goal the restoration, melioration, and assimilation of HBB [22]. Local conventions about what illness means are thus incorporated theoretically, allowing richer analyses. The successful treatment of HBB illnesses is not always possible. Some HBB that are labeled as illness may be recurring, persistent, debilitating and associated with increasing deterioration. This raises the important question of how medically labeled HBB come to be viewed and handled in the society if local treatment practices prove unavailing. Conventions about what constitutes a medical HBB and adequate treatment for it may or may not be shared across societies and cultures. HBB is likely to vary significantly across societies, within societies across time, and even within societies at one point in time but across social space. Nevertheless, the concept of HBB (and the more general one of human behavioral anomalies) may be put forward as an etic category for an ethnomedical theory of psychiatric illness. How one can capture such a locally anchored concept (HBB) in a general and abstract frame of reference (one that allows comparison across cultures) constitutes the central theoretical problem in ethnomedical psychiatry [23].

**HUMAN BEHAVIORAL BREAKDOWNS AND TRADITIONAL ANTHROPOLOGICAL ANALYSES**

Illnesses that we qualify as psychiatric are recently invented objects. They are inextricably linked to historical and cultural contingencies of Western European societies [24-27]. This point will be elaborated in greater detail below. One can understand 'psychiatric illness' to refer to types of human behavioral breakdowns (HBB) that can result from any number of genetic and/or environmental factors. HBB are realized in visceral, psychological and social behavioral changes and are recurring eventualities in human groups. However, HBB carry differing meanings. Prophets, shamans, malcontents, eccentrics—to name but a few—may be defined as manifesting forms of HBB [28]. Yet none may be negatively labeled within their own societies. There also exist across societies behavioral syndromes ('ethnic psychoses') that appear strongly conditioned by local cultural meanings and models of behavior [6,29]. They also fall within the category HBB.

Individuals showing HBB who are in deteriorated and dilapidated behavioral states are generally identified as ill [6,30,31]. Besides symptoms of behavioral disorganization, the lack of a capacity for some level of adaptive function and independent living, perhaps rendering them socially ineffectual, appears necessary for an occurrence of HBB to be judged as illness. Yet what constitutes a 'psychiatric illness' is very much a socially and culturally negotiated condition [32, 33]. At root here is the question of 'normal' vs 'abnormal' behavior.

In 1956 George Devereux [34] wrote an influential article entitled 'Normal and Abnormal: The Key Problem of Psychiatric Anthropology'. He discussed the criteria that enabled one to define behavioral phenomena in particular cultures as psychopathological. Devereaux pushed a key problem of cultural psychiatry into the intrapsychic sphere, there to be unraveled by careful assessments of how psychological conflicts were culturally contextualized, shaped and interpreted. His analysis was centered on the mode of adjustment of whole persons. He illustrated his perspective by concentrating on the shaman, whose behavior could appear erratic, schizophrenic and dissociated. Was the shaman normal or was he instead 'really schizophrenic' but merely labeled differently, being 'protected' by a role that sanctifies 'pathological' experience? Devereux’s logic was consistent with that of Silverman [35] who showed how an acute schizophrenic syndrome, when played out in a local culture, could come to transform the person’s mode of thinking and identity (by the unfolding of schizophrenia in the light of cultural meanings) so as to lead to the career of a shaman.

In Devereux’s [34] formulation, psychopathology consisted of the playing out of culturally specific conflicts that are common but ordinarily not problematic. Such conflicts were said to be located in the individual’s ethnic unconscious. The marginality of the role selected by the shaman was said to constitute one indicator of psychopathology, since it locates him/her in a position that is deviant and hence discrediting. Moreover, because it requires the shaman to play out culturally specific conflicts, it unduly burdens him/her and closes off opportunities for psychological growth, development and autonomy. Another indicator of the shaman’s psychopathology was said to reside in the stability and patterning of the psychological defenses that were relied on to resolve the conflicts of the ‘ethnic unconscious’. Such defenses were assumed to be weak or insufficient in protecting the shaman from behavioral difficulties. This (Devereux indicated) is especially true at later stages in the life of the shaman. Normal persons, who by definition harbor similar ethnic unconscious conflicts, have developed stronger and more flexible psychological defenses that are protective and thus ameliorate the behavioral difficulties that develop from these conflicts in the case of the shaman.

In the Devereux formulation constituent symptoms of psychopathology as classically identified in biomedicine do not receive primary attention. Delusions, hallucinations and other mental status changes
are not addressed directly. Devereux tended to employ generic diagnostic categories. Actual manifestations of illness are viewed in psychoanalytic terms and in relation to intracultural or idiosyncratic connotations of illness are viewed in psychoanalytic terms.

Differences in the way behavioral anomalies and/or possible HBB might be labeled and played out. Thus, he addresses the question of cultural differences but argues that psychiatric illness is universal and can be reliably measured and diagnosed cross culturally, using the universalistic language of psychoanalysis.

Devereux, then, dealt with the question of cultural relativism and argued for an underlying psychoanalytic universalism.

The idea that psychiatric illness had different manifestations and was interpreted differently cross culturally was attacked by Murphy [30]. Her position I term the weak or traditional relativist position insofar as it acknowledged surface or mere content differences cross culturally. Her study was actually meant to challenge the labeling approach in sociology which can be thought of as a radical form of relativism. Murphy concentrated on schizophrenia and emphasized that underlying surface differences, one found universalistic aspects, arguing that schizophrenic behavior not only looked the same but also tended to be judged similarly in different cultures. Murphy's paper actually supported a growing universalist perspective in contemporary psychiatry which, together with the ascendancy of neurobiology, has achieved dominance today. Qualifications of this position are taken up below. Despite the contemporary criticisms of the universalist position, recognition of and conceptualizations about many of our 'psychiatric illnesses' are found consistently across societies and their referents involve phenomena described above as HBB and similar to what Murphy and others have emphasized [4, 31, 36].

HBB are not transitory but possessed of some extension in time. The concept is not limited, however, to 'chronic', progressive or irreversible changes. It is widely assumed that the reason why long lasting forms of HBB are not frequently found in less complex societies is because of the differential survival of persons so affected. In subsistence economies, individuals functionally compromised with HBB cannot carry out expected responsibilities and are less likely to survive and/or to be maintained and kept alive [37-39]. However, seemingly 'chronic' forms of HBB defined as illness have been described [30, 31]. Another reason for the seemingly lower prevalence of HBB is said to be that the set of obligations/requirements inherent in less complex societies pose fewer and/or 'simpler' social psychological demands on persons; in this instance, it is claimed, HBB phenomena are less likely to be created and/or to surface as management problems. Together with differing baselines and values regarding what constitutes normal behavior as well as HBB, this would contribute to low levels of chronic HBB. In addition, of course, society's way of handling 'chronic' forms of HBB may contribute to their assimilation [40, 41].

Finally, less complex societies lack the central regulatory institutions and systems of surveillance and control that operate to closely regulate behavior and promote the categorization of deviance as well as its medicalization (see below).

Medical conceptualizations of HBB characteristic of pre-industrial societies are varied in nature. Some are ascribed to either natural causes, supernatural intervention, or human malevolent doings [14]. There is no tendency for medicalized HBB to be equated with distinctive causal explanations across societies nor is there a tendency for it to be explained differently from other medical illnesses [42]. There is perhaps a tendency for serious and/or chronic illnesses, regardless of their nature (psychiatric, medical), to be judged as more dangerous, ominous and threatening and to be explained in terms of supernatural and/or malevolent factors. An essential feature of the way illness, including some HBB, is handled in less complex societies is the social and public nature of diagnosis and curing. Illness constitutes a social and even political event in a group or village, and it brings into play moral and religious symbols [11, 12]. Unique social happenings within the group are incorporated into explanations of cause and the enactment of curing ceremonies and, together with details of the personal life of the sick person, come to be part of the social drama of illness. The highly individuated nature of illness, an emphasis on its functional aspects and elaborations of its situational implications argue against the existence of an ontological view of illness. In other words, the notion that illness has a unique existence with a predetermined, intrinsic course and outcome is not held, although illnesses do 'exist' in the sense of constituting categories which are identified and which command a measure of symbolic specificity.

**HUMAN BEHAVIORAL BREAKDOWNS AND THE GREAT TRADITIONS OF MEDICINE**

At least four 'Great Traditions' of medicine have existed. The ancient and medieval societies of India, China, Persia/Islam and Mediterranean Europe were each associated with literate, academic and scientific theories of illness [43-48]. In all these traditions, medical illnesses were handled as somato-psychically integrated objects and explained in terms of an elaborated ethnophysiology. The theory of illness was predominantly functional, in that illness tended to be handled with emphasis given to its individualistic character. The symptoms and symptom complexes of persons, seen in terms of temperament, habits, stage of life and the factors and processes delineated by the ethnophysiology, explained the illness and recommended the treatment. Although in some of these traditions an emphasis was given to types of illnesses and even specifically named conditions, an
ontological view of illness did not gain dominance. Thus, the idea that an illness had a unique identity that encompassed cause, mechanism, manifestation and natural history and that the illness, as it were, invaded or lodged itself in the person, was not characteristic of the Great Traditions of medicine. Of course scholars have pointed to ideas that implied an ontological perspective in Greek medicine [49, 50]. For example, in the Hellenistic corpus, a nosology of sorts existed, which implies entification of illness (the elements of this ontology are still with us today), and Galen is said to have used the idea of 'seeds of disease', which implies the same. However, an ontological view as such is held to be a feature that became recognizable only after the ideas of Paracelsus, Van Helmont and Harvey in the early modern period [51–54].

All of the Great Traditions of medicine have encompassed certain varieties of what I have termed HBB as illness conditions. The degree of specific emphasis given to HBB illnesses in the corpus of medicine differed. For example, the organs and/or mechanisms that explained HBB phenomena as illness varied, as did the extent to which these illnesses received elaborate analysis. However, all appear to have singled out rather general sociopsychological behavioral problems that reflected adaptive failures, conditions of psychosis and social breakdowns [55]. An emphasis on elaborated aspects of human psychology (rationality, emotion) and their explanation in these terms, as in modern Western psychiatry, was not central. Yet, it has been possible for scholars to equate some forms of illness entities with our modern disorders [55–58]. All of the theories tended to handle HBB illnesses as naturalistic objects, which is to say that no stigma was attached to the ill person. An exception seems to have been the Western Mediter ranean tradition during the Christian era [59]. Moreover, in all the theories, what can be termed supernatural and/or demonic factors were sometimes represented and/or actively vitiated, which implies that competing or alternative conceptualizations (outside the Great Tradition) have attached to HBB illnesses. However, such factors were not uniquely associated with HBB illnesses, but with all types of illnesses. Finally, it would appear that in many of the societies where the Great Traditions prevailed (i.e. outside the dominant academic/scientific 'system' of medicine), a social stigma of sorts was found, although there were differences of degree [42, 59]. There appears to be wide differences in the way such HBB illnesses were labeled and handled based on the economic standing and family connectedness of the person ill, with affluent persons more likely to be treated by academic physicians, confined when necessary to their homes and less subject to ridicule and punishment.

Cultural factors no doubt affect the labeling of normal versus abnormal behavior, a social process that always precedes the recognition of HBB as illness [32]. Yet, the descriptions of manifestations and explanatory models in the Great Traditions that pertain to HBB illnesses point to similar behavioral characteristics. In large part, these descriptions of behavior conform to what in Western medical history is termed insanity, psychosis and/or madness. It would seem that the conditions referred to can be viewed as comprising a more or less universal medical category. In summary, the following generalizations seem warranted: (1) HBB phenomena are universal to human societies; (2) many varieties of these tend to be viewed as comprising illness; (3) when they 'enter' the system of medicine in which a 'great' theoretical tradition holds sway, HBB illnesses are scientifically 'naturalized', and thereby socially neutralized; and (4) the prevalence of a set of more or less common general sociopsychological behavioral manifestations of HBB illnesses supports the idea of human universals and the psychic unity of man. These generalizations do not contradict the points of view encompassed by what one can term the weak and strong forms of cultural relativism, but they appear to be disallowed by the radical form which, as I have applied, seems to preclude a consideration of biological factors and scientific explanation more generally [6, 19, 55].

HUMAN BEHAVIORAL BREAKDOWNS AND EUROPEAN SOCIETIES

Since the Greek period, the topic of HBB illness (i.e. melancholia, mania, the irrational) has become an important cultural category in Western societies. Conceptualizations of HBB illnesses were used as a vehicle for the clarification and celebration of basic values and beliefs, such as those associated with reason, individuality and civic responsibility—landmarks of the classical heritage [59–63]. Such attributes of personhood are not only contrastive with states of HBB illnesses, but in being raised to markers of the healthy and virtuous, they also help set apart as devalued the conditions which negate them. HBB illnesses could also be equated with the mysterious, the inexplicable, the fateful and with the dangerous and violent. They were explained as resulting from the punishment of the gods for impious actions and sacrilegious behavior and also equated with religious pollution requiring purification. Finally, from the picture of HBB illnesses created by the tragedians, it can be argued that such illnesses were seen as somehow rooted in sociocultural circumstances; influenced if not brought on by the play of social forces stem ming from cultural traditions and conflicts.

These themes that are found in the classical period raise the question of psychiatric stigma; that is, they associate the shadowy, harmful, and bad with HBB illnesses and suggest some social condemnation and disapprobation. If not quintessential ingredients, these at least constitute preconditions or requirements for stigma. There is evidence that these intellectually rooted cultural interpretations of HBB illnesses
were broadly held and extended in time into Hellenistic and subsequent periods of European history. Moreover, there exists ample evidence that socially, persons showing HBB illnesses could be forcefully confined and/or restricted [28, 59, 61–63].

Recent histories of modern psychiatry have emphasized categories such as madness and insanity. I have suggested that these categories cover phenomena that in this paper are termed HBB and handled culturally and socially in medical terms. Historical writings have also emphasized the sociological correlates of psychiatric phenomena [26, 64, 65]. The latter studies have as their focus the reform movements associated with the development of the asylum in European and Anglo-American societies and the growth of the discipline of psychiatry. Influenced by and/or reacting to the writings of Foucault [65], they have emphasized segregation and incarceration which, in leading to a loss of civil liberties and dependence, promoted marginalization. This has accentuated the problem of social, which raises the question of criminal responsibility, is part of this story [67]. This connection goes far back into European history and, of course, is not unique to European societies. The medicalization and consequent expulsion of persons with insanity/madness, and the social/legal dilemmas raised by this, were found in classical societies and in other systems of medicine [28, 42, 68, 69]. Scholars have pointed to the stigma linked to insanity in China, but this stigma attaches mainly to the family and seems rooted in moral traditions and outside the system of medicine itself [70]. Psychiatric stigma appears less apparent in Islam [63, 71], it is clearly reflected in ancient Indian texts [69], yet seems muted in some societies where Ayurvedic Medicine is practiced [40, 72, 73].

In summary, several things have contributed to the special cultural meanings of HBB phenomena, including HBB illnesses, in European societies [42, 59, 66]. To the special meanings of the classical period were added during the medieval era, aspects of demonology and deviant sexuality. These cultural associations were endorsed by clerical physicians and for a period got a foothold in the system of medicine [59]. In the early modern period, the handling of HBB phenomena in jails and poorhouses, with persons showing it assembled with the destitute and marginal, is important for it heightened condemnation and associated mortification. The state came to control, isolate and deprive of basic liberties persons showing HBB. Incarceration in asylums and brutal treatments are part of the story also. Later during the modern period, the profession of psychiatry itself contributed special cultural meanings involving the brain, hereditary mental degeneration and social behavior itself (the mental insanities). However, as agents of the state empowered to control and regulate ‘the mad and insane’, psychiatrists also came to be seen as ‘mad doctors’ and (mental) ‘alienists’ [26]. Eventually, all problems that psychiatrists dealt with came to partake of this amalgam of cultural meanings.

Psychiatric stigma has traditionally been associated with certain varieties of HBB phenomena (e.g. madness and insanity) but in the modern and contemporary period this stigma has broadened and spread to encompass such problems as somatization, neuroses, and personality disorders because they are dealt with by psychiatrists. Whether all of these ‘conditions’ can be handled conceptually as HBB phenomena is problematic. They certainly are defined as ‘psychiatric’ and thought of as forms of (somatic, psychological and/or interpersonal) ‘behavioral breakdowns’ by many psychiatrists. This topic is taken up in greater detail elsewhere [6, 27, 74] and is touched upon below also.

PSYCHIATRIC DISEASE AS A CULTURAL AND HISTORICAL PRODUCT OF WESTERN BIOMEDICINE

The social and intellectual history of medicine, psychiatry and mental illness is a field of study that has expanded in the last two decades. The notion that the modern concept of disease is particularly rooted in Western medicine has, of course, long been appreciated [47–52]. In the West, disease entities are described as possessing individuated histories, mechanisms, and, eventually, genes/chemistries/physiologies. Diseases have taken on the character of objects amenable to special technologies for their explanation, diagnosis and treatment. Such a modern concept has been instrumental in mediating the growth and development of distinctive disciplines within medicine. Recent studies involving psychiatry and mental illness have been based on and elaborated upon these ‘modern’ developments.

An important line of theoretical work has focused on the history of psychiatry as a scientific medical discipline [75–80]. The conceptual categories used to describe varieties of insanity/madness have been elucidated, emphasizing largely intellectual and rational functions, as in melancholia and mania. An expansion in the meaning of concepts took place in the early modern period, conditions being named in which intellectual/rational functions were relatively preserved, as in moral insanity, partial insanity and monomania. More recently, the concepts have included psychoses (dementia praecox, schizophrenia) disturbances of mood (mania and depression) and the neuroses. The line of development leading to a system of descriptive psychopathology has also been outlined and along with this the underlying conceptual framework, all of which leads up to the contemporary picture of psychiatric disease as depicted in biomedical psychiatry [80].

Although rooted in Western history and hence intrinsically a part of developments in Western psychology [81], these developments must be seen as culture bound. The Western cultural concept of the person is integral to the biomedical picture of the
psychiatrically diseased person [82]. Yet, because this picture is generated by the science of biomedical psychiatry it tends to be handled by academic psychiatrists as not only panhuman or universal but also as culture free. The neuroanatomic, neurophysiologic and neurochemical substrates of psychiatric disorders, core entities making up the contemporary HBB illness category, appear securely placed in the universalistic idiom of Western science. Thus, human populations may differ in genetic and neurobiological structures, not to say cultural and social conventions, yet the mechanisms and processes that account for contemporary varieties of HBB illness are held to conform to a common human form. As implied earlier, this biological universalism obviously clashes with the problem of cultural relativism.

EXPLAINING THE MANIFESTATIONS OF PSYCHIATRIC ILLNESS: EMPHASIS ON FORM VERSUS CONTENT

Several disciplines, including psychiatry, psychology, and portions of anthropology and sociology (as in psychiatric epidemiology) share a scientific perspective about psychiatric illness. The kinds of psychiatric illnesses that are said to exist are held to be finite and distributed throughout the species, though prevalence levels may differ across societies. More importantly, the social, psychological and behavioral properties of these illnesses are in an important sense described as universal and hence beyond the reach of cultural influences. This is stipulated in terms of the principle of 'form vs content' in explanations of behavior.

The form vs content principle can be applied to components of illness (e.g. elements of cognition, affect) or to whole illness syndromes (e.g. the nature of schizophrenia, depression). In a typical formulation, a disorder is said to be universally characterized by elements such as mood disturbances, delusions and hallucinations, while what these consist of and/or how they are interpreted and reacted to (their 'content') may differ. For example, anxiety disorder is said to consist of universal behaviors reflecting fearfulness, traceable to the autonomic nervous system and due to midbrain neurochemical changes. However, the realization of this disorder may involve morbid preoccupations about and health care actions directed at sensations involving the thoracic cavity and/or heart ('cardiac neurosis') or the lower abdomen and penis (Koro), two cultural variations based on distinctive content interpretations. The same is held to be the case for illness syndromes such as schizophrenia and depression and even the so-called ethnic psychoses. In other words, these also are said to reflect in their organization basic forms or taxa of behavior [29].

It will be recalled that Devereux's [34] formulation acknowledged differences in content manifestations and local interpretations but argued for psychoanalytic commonalities. Because of its (psychoanalytic) universalism, his formulation is similar to the form versus content principle. However, in contrast to the emphasis given to local interpretations and meanings of symptoms by Devereux, in the form vs content approach of Western contemporary psychiatry little importance is given to the question of whether a putatively psychiatrically ill person is judged locally as normal or abnormal. It is the universal, panhuman form of the behavioral syndrome that constitutes the important fact, not whether and if so how situational factors and local meanings blend in to the disorder coloring its essential nature.

Implicit in the form vs content principle is the notion that there exists a universal mode of psychological experience and that as a consequence any clinically relevant syndrome of behavior must reflect a common underlying pattern, architecture or taxa of behavior. All of the forms of behavioral syndromes or illnesses of mankind, it is assumed, can be reduced to or conform to a finite set of taxa such as schizophrenia, bipolar disease, anxiety, startle reactions, and acute/agitated panic attacks [29]. Superficial differences in these behavioral syndromes cross-culturally are to be expected insofar as persons hold different beliefs about self and reality, different ways of conceptualizing and displaying mental experiences and different ways of behaving in relation to a behavioral environment that differs as a function of culture. However, differences in the content of experience or behavior are held to be trivial. It is the underlying form that is salient.

The principle involving form vs content extends to the following assumptions: (1) the discoveries of the nineteenth century involving the phenomenology of experience make clear that self awareness in rational man consists of distinctive categories, such as beliefs, judgments, perceptions, volitions/intentions, feelings, emotions, etc.; (2) such categories constitute basic panhuman modes of awareness and experience; (3) such categories account for, indeed constrain and structure, the experience of self and of reality and underlie or regulate ongoing behavior; (4) disruptions of these categories of experience via disease/organic factors are registered in disorders of a person's awareness, sense of self and behavior; (5) such disruptions are the essence of psychopathology; and (6) the categories, structures or forms of psychopathology are universal since they reflect disturbances in the universal normal pattern in which human experience is cast. In this schema, then, contemporary HBB illnesses are quintessentially mental, a far cry from the more socio-psychological grounded behavioral descriptions of HBB illnesses found in other traditions of medicine.

The form vs content approach assumes that behavior can be culturally decontextualized. The meanings of the content of behavior are ignored and the structure or form is all important. From this perspective the claim that a cultural variety of HBB or 'schizophrenia' actually involves a difference in the
form of schizophrenia is false because by definition schizophrenia structures do not vary as a function of culture. In contrast, Devereux's approach requires the analyst to look at behavior in cultural terms. The litmus test in Devereux's approach is also, however, the architecture of the behavior viewed in relation to the way the culture programs individuals. Culture is not only responsible for the 'surface' content of behavior but also for part of its structure; that is, the nature of the conflicts, stresses, and the patterning of psychological defenses brought to bear on the conflicts all influence content as well as form. When behavior is shown to reflect a faulty architecture it is diagnosed as abnormal or psychotic. However, although the analyst is here required to take culture and content seriously, it is still in terms of intuitive intraphysical structures as stipulated in an external theoretical schema (psychoanalytic theory). According to Devereux, then, there exist culturally distinctive psychopathological structures (looked at psychoanalytically) whereas in the form versus content paradigm there exists only one common form that reflects psychosis pan-culturally.

LIMITATION OF THE FORM VERSUS CONTENT PRINCIPLE

Descriptive psychopathology and its sibling, clinical phenomenology, are the psychiatric offspring of the nineteenth century intellectual movement in the semiology of disease [80]. This 'science' of clinical medicine involved the study of the signs of disease, which were handled not as symbolic aspects but rather as ('real') external manifestations of the disease. Public and physical data amenable to the senses—sound, color, consistency, temperature and odor—constituted the proper means of describing the signs of general disease. The neurological exam can be considered an analogous approach to the mapping of the signs of neurological disease, seminal to the growth of this discipline.

The language of descriptive psychopathology claims to deal with signs of psychiatric disease. Cultural 'content' is held to constitute the external or surface manifestation of psychiatric disorders. Since the alleged link is between cerebral disease processes and changes in the form/structure of psychological experience, biomedical psychiatry creates the illusion that an analyst can cross the brain/behavior or body/mind 'barrier'; and provided linguistic semantic problems are 'solved' through translation, he or she can do so pan-culturally. Thus, the signs of organic psychiatric diseases are realized in disorders in the form of mental (psycho) pathology stipulated by means of the form vs content principle. This position simplifies a complex, philosophical problem [82–84]. I have already indicated that intellectual insights about experience and behavior developed in Western culture are generalized and applied to all societies where different conventions of personhood prevail.

What needs emphasis now is that even within European societies the application of the form vs content principle poses problems.

The doctrine of universal form includes such things as hallucinations and delusions. These are often easy to spot. However, many times it can be extraordinarily difficult to determine if a person's beliefs constitute true distortions of his or her sense of reality. Delusions about religion and delusions about discrimination and persecution are particularly difficult since they spring from general orientations of a group. Sometimes, delusions have the elusive property of being present only when the assumptive world of the mental health clinician differs from that of the client or patient. Distinguishing between belief and delusion is notoriously problematic. Very often, it is not the presence of a cognition per se that prompts diagnosis of delusion (i.e. an alleged feature of form) but rather the overall adjustment pattern and context for evaluation that underscores a behavioral dilapidation or adjustment failure. In other words, the person is non-functional, hospitalized and hence his/her strangeness 'must' entail delusions. The difficulty of saying what is a hallucination has raised disturbing questions, including the public versus private nature of perception [85] and exactly where altered perceptions or hallucinations are located (arising in or outside the head) and the degree of associated insight [86, 87].

Consider that the meanings of delusion and hallucination are blurred in German and French psychiatry: in the former case they refer to false beliefs and altered perceptions, respectively, but in the latter case hallucinations are really delusions about perception. Here, then, the cultural factors tied to national traditions influence what passes as a 'form of psychopathology' [79, 81, 88, 89]. Ambiguities about the nature of form elements of psychopathology have led analysts to suggest that they are best handled not as categories but rather as regions on a continua [90]. This, of course, might blunt some of the power of the universalists' claims which reflect categorical thinking and emphasize invariance. Related phenomenologic aspects of psychosis, such as the first rank symptoms mentioned by Schneider [77, 91] or the disorders of willed intention mentioned by Frith [92], are also postulated as though they constituted universal elements of form. But they could more likely implicate content issues related to our notion of self, autonomy of self, and personal control. Finally, there is the problem of ethnic differences in psychopathology [93–95].

Even in contemporary societies, an analysis of some of the symptoms and signs of psychiatric illness clashes with the notion of invariance in the form of psychopathology. Manifestations of psychiatric illness implicate content issues or meanings that are cultural, blending in with alleged features of form. Dilemmas raised by an analysis of the principle of form vs content do not, of course, negate a nosology.
classification or diagnostic criteria. They merely reinforce the view that (1) general sociopsychological and behavioral factors (as opposed to purely psychological ones narrowly conceived) are the essential hallmarks of HBB illnesses or psychiatric phenomena, (2) the purely intellectualistic and emotional manifestations of psychiatric illness appear rooted in rather fluid semantic structures; and (3) the targets of any classification schema are objects that are best seen as prototypical and not categorical, that is, as objects that can at best only be approximated and can never be fully and discretely itemized [96].

I want to challenge, here, the form vs content principle which stipulates a biomedical universalism. Part of my argument is that, although the principle provides a way of coping with the problem of cultural relativism (essentially by negating it), it nonetheless falls short because it seems based on implicit cultural conventions. Other models of human nature (based on differing sorts of structures) may be equally relevant to the study of HBB, illness HBB, or psychiatric illness. Third world psychiatrists and social scientists, for example, may develop alternative schemes in order to better understand 'psychiatric illness'. Could, for example, an Indian or Chinese psychiatrist prove important as a way of understanding the manifestations and course of psychiatric illness? Could other cultural conceptions of order, the self, the external world and behavior prove instructive for a description and theory of HBB illnesses and/or psychopathology? What inheres in the construction of psychiatric illness that reflects neurobiology and not ethnopsychologic conventions? Questions such as these touch on central theoretical issues in cultural anthropology and cultural psychiatry and are basic to an ethnomedical theory of psychiatric phenomena as conceptualized here [97]. Stated succinctly, the appropriate categories for the study of HBB, HBB illnesses and psychiatric phenomena more generally are those that are grounded not in models derived from Western psychology but in symbolic, culturally relevant parameters of social behavior [23].

A rigid adherence to the form vs content doctrine of biomedical psychiatry can close off opportunities for understanding how culture shapes the experience and organization of the self and social behavior and by extension, HBB and HBB illness [6, 23, 41, 82]. Psychiatric phenomena need to be conceptualized as involving disruptions in how the self is organized and how it meaningfully connects to social and interpersonal networks. Psychiatric phenomena thus are equivalent to disturbances of the self and its adjustment, a topic that requires considering symbolic factors and sociality consequential behaviors. A social theory of psychiatric phenomena using new approaches from cultural anthropology, could broaden understandings about manifestations and address questions about their universality vs particularity [98, 99]. It could also clarify differences regarding the course of psychiatric illness which are currently imperfectly understood [100].

THE ROLE OF CULTURE IN CONTEMPORARY PSYCHIATRIC THEORY AND PRACTICE

The differences between psychiatry and general medicine need emphasis. All systems of diagnosis in general medicine are complex, difficult to apply and ultimately based on statistical conventions of normality. Different 'schools' or groups of scientific clinicians, often endorse different interpretations with respect to cut-off points, significance, and the logical necessity of specific biological indicators. However, inferences about disease are anchored in processes and functions pertaining to lower order systems. In not connecting directly with the self, as beliefs, emotions, and hallucinations do, they stop short of qualifying the social person. The diagnosis and treatment of psychiatric illness, however, require direct involvement with the self, which creates special social problems and broaches cultural questions [101].

Psychiatry's reliance on the concept of culture is most vividly realized in the complex web of social psychological phenomena implicated in personal problems. It is among these 'disorders', described nosologically using 'clinical' terms (such as obsessive-compulsive neurosis, anxiety, adjustment disorder, dissociation or somatization) or descriptively (as involving eating, drinking, sexuality, stress, marriage or personality), that cultural standards about normality, the meaning of behavior, and general norms of function become integral to the psychiatric enterprise. In some of these 'disorders' one finds the concept of psychiatric illness coalescing with that of culture. Decisions about diagnosis and treatment literally require the clinician to use his or her cultural understandings (and biases) about persons and behavior. Thus, culture as it informs contemporary psychiatric diagnosis and practice is not a 'visible' or 'exotic' difference in symbolic orientation, but rather a subtle, pervasive frame of reference that the psychiatrist may or may not share with his/her patient, and that involves the construction of persons, the assessment of behavior, the choice of a therapeutic rationale and a suitable 'end stage' of adaptive function that is targeted as and/or signals a cure. An important task in cultural psychiatry involves clarifying the relationship between psychiatric illness and psychiatric practice as culturally grounded.

The cultural basis of psychiatric practice encompasses not only the content of manifestations of disorders, conventions about the form of disorders, conventions about the way the self is supposed to behave and conventions about the meanings and implications of behavioral breakdowns. The culture of modernity and of capitalism also influence strongly psychiatric practice. The system of biomedical psychiatry is promulgated by support from a state
The role of culture in a theory of psychiatric illness

Institutional apparatus that uses its nosology to control and regulate behavior in other institutional sectors. The criminal justice system, the welfare system and the educational system all interact with the mental health (psychiatric practice) system. Symbolic conventions about how people are to behave in various civic areas permeate the practice of psychiatrists; and its tenets, in turn, are integral to deliberations in these other institutional sectors. In this light, one is inclined to ask the following sorts of questions. What drives the biomedical psychiatry establishment—biological and scientific questions, purely political economic factors intrinsic to nation states or socially and culturally produced and shaped illness pictures? To what extent is the disorder-based taxonomy of biomedical psychiatry mirroring socioculturally produced psychiatric illness? To what extent is it selectively medicalizing, and to what extent is it selectively omitting or minimizing other illness pictures? These and related questions target a critical area for inquiring into the role played by biomedical psychiatry in contemporary Anglo-American societies. Ideally, a social theory of the psychiatric should make it possible to obtain answers to these questions. In grounding analyses in HBB, defining these in locally consequential terms (that take into consideration social responses), and addressing key societal reactions to HBB such as medicalization, criminalization and stigmatization, one places the psychiatric squarely in society and culture. In this analytic setting the problematic nature of the psychiatric becomes a theoretical problem amendable to the social sciences.

SUMMARY

In this essay I have reviewed different ways in which culture enters into an understanding of psychiatric phenomena and psychiatric practice. The goal of the paper has been to draw attention to the kinds of requirements, topics and problems that are associated with a social theory of psychiatric illness. A biological theory would address the causes and consequences of disorders viewed biomedically whereas a social theory would address psychiatric phenomena in relation to the functioning of social and cultural systems. The problems of cultural relativism has to be confronted in any attempt to develop a social theory of the psychiatric. Biomedical concepts are too specialized and too ethnocentric for a social theory of the psychiatric. The concept of human behavioral breakdowns (HBB) was introduced for consideration as a way of minimizing the ethnocentrism of disease categories in psychiatry. This concept is viewed as general and cross culturally applicable. Local conventions of meaning will contextualize how behavioral breakdowns are identified, measured and handled but a metalanguage for codification should be possible. In the essay, I reviewed how different societies and cultures have conceptualized HBB. The special mean-

ings associated with HBB illnesses in Western societies were given emphasis. The alleged universalism of key tenets of biomedical psychiatry as stipulated in the form vs content principle was challenged by drawing attention to how the tenets are shaped by Western culture. The practice of psychiatry is seen as particularly dependent on cultural conventions about normality and appropriate behavior all of which are linked to political economic exigencies implicit in state governance. The paper identifies a need for elaborating an analytic schema pertaining to HBB that will be socially relevant and capable of application cross-culturally.

REFERENCES


The role of culture in a theory of psychiatric illness