Identity and Critique: two hidden logics in transcultural psychiatry

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In this position paper, I concentrate upon two forms of cultural intervention that are present in transcultural psychiatry, but which are, I think, disavowed to some extent. The first of these is the overlap of psychiatric transculturalism with contemporary identity politics, whether in traditional, ethnic forms, or in the creation of activist identities that call for recognition of a putative mental illness as a way of life. The second is the ambition within transcultural psychiatry to engage in a wider project of cultural and social critique via diagnosis of the specific "pathogenic" features of Western culture. The result is a form of critique that shares all the ambitions of contemporary "critical theory", but which is protected from counter-critique by the rhetoric of medico-scientific objectivity.

Transcultural psychiatry has made headway over the last few decades in moving away from a simplistic model of culture as a pattern that consistently moulds the personalities of each and every member of a distinct group. Cultures are increasingly regarded as much more dynamic, mobile, and mixed – especially in our modern globalizing world. But adherence to rather essentialized, Herderian models of culture can still persist, even if un-noticed. Juan E. Mezzich, et al.'s article on "Cultural Formulation Guidelines" (Mezzich, Caracci, Horacio Fabrega, & Kirmayer, 2009) helped to clarify my intuitions about this lingering association between "culture" and the "spirit" of a people. The article outlines a way of preparing a cultural formulation to complement standard ways of evaluating a patient. But as Mezzich et al. begin to operationalize their definition of culture, and to turn it into actual questions to be posed to patients, it becomes clear that their interest is more in ethnic identity. They suppose that "[a] key concept […] is ethnicity. Ethnicity refers to one's groups of reference, especially ones that hold beliefs in particular national or regional origins" (Mezzich et al., 2009, p. 392). By making "ethnicity" the centre of gravity for cultural difference, other dimensions (such as class, gender, geography, education, cultural capital, and so forth) tend to become represented as accidental variations on the underlying ethnic substance of culture. Furthermore, the proposed cultural formulation uses cultural difference as a way of getting to the patient's sense of membership of certain social groups whose cultural differences are taken to demand recognition and respect. This scientific evaluation is therefore an intervention as much as an observation – if the patient is vague about their ethnicity, then questions about it from a psychiatrist will incentivize them to produce an acceptable answer. Lurking within the cultural formulation described by Mezzich et al. is a contemporary political-ethical demand to transmute the base metal of cultural difference into the gold of identity.

Even recognition of cultural hybridity in transcultural psychiatry may nonetheless conceal a reified view of culture. A typical model within transcultural psychiatry distinguishes between culture as "pathogenic" or as "pathoplastic" in its effects. When acting pathogenically, culture is regarded as the fundamental cause of a condition (culture bound syndromes, such as the East Asian penis-shrinking disorder of *koro* epitomize this category (see Crozier, 2012)). But culture may also be pathoplastic: the fundamental cause lies elsewhere (for instance, in neurology), but culture moulds or shapes the symptoms (for example, in the contents of hallucinations or delusions, which may involve Allah, God, or Elvis, as the causative culture varies). As well as the pathogenic-pathoplastic distinction, there remains, though, the concept of "cultural congruence", which also, in a sense, refers to the cultural causation of mental illness. The norms of a culture determine what constitutes mental illness, in the same way that the laws of a country determine what counts as criminally deviant behaviour: so we might speak of cultural norms "causing" mental illness as we might speak of new, more stringent legislation "causing" increased crime rates. In his article "Religious Experience and Psychiatry", Mohammed Abouelleil Rashed advises

clinicians to investigate whether the patient's apparently odd behaviour may in fact be "congruent" with his or her culture: for instance, a white North American hearing the voices of the dead is having a pathological experience, while the Native American Lakota having a similar experience is not (Rashed, 2010, p. 196). Rashed advises that broad-brush stereotypical categorizations are to no avail in such investigation, and any clinical assessment must involve "a painstaking assessment of the myriad influences a person has been subjected to" (Rashed, 2010, p. 197). The problem even with this nuanced, idiographic approach is that it may still nonetheless reify culture into a static, independent entity. For instance, if deviance from norms of mental health really is a matter of cultural incongruence, why not introduce the white North American voice-of-the-dead-hearer to some Lakota – for whom this will be normal – or to some other white North American voice-of-the-dead-hearers? Then he or she will be congruent with an existing culture, or given the option of building a culture with which he or she would be congruent. It is precisely this kind of activity that has enabled movements such as the Hearing Voices Network, which has been building a culture of normalized voice hearing, where none had existed before, except in very special and restrictive contexts (e.g. religious inspiration). If there is no mental illness without cultural incongruence, then the discovery, creation and legitimation of a culture of congruence may also be an ambition for patient (and medic).

The formation of organizations such as the Hearing Voices Network and Intervoice leads me to wonder to what extent mental health user groups and networks may in fact be doing "double duty" as both pragmatic alliances, and as new, transnational identity groups. In the former aspect, they would be destigmatizing, educating, and so on, and in the latter they would be providing a sense of ethnicity by, as it were, re-uniting a "diaspora without origins". I wonder if there is even something like a romantic nationalist phase at work in the creation of a canon of literature for some or all disorders, and in the insistence on the millennia-old antiquity of certain experiences (e.g. voice hearing). Perhaps "post-colonial" or "de-colonizing" would be also appropriate analogies for such movements, since by arguing, for instance, that voice-hearing is or should be a typically benign mode of difference or diversity, there is a kind of anti-inferiorist ethic at work. Questions arise, though, about the limits of claiming rights of respect for one's way of life as a person with a "mental illness" (the term is of course disputed by the claim itself): what are the differences, if any, between organized voice hearers, congregations of self-harmers, and communities that are "pro-anorexic"?

Reading Sami Timimi's "The McDonaldization of Childhood" (Timimi, 2010) informed my understanding of another latent logic in transcultural psychiatry: the ambition to psychiatrically diagnose, from a transcultural perspective, the supposed pathologies of the West. In a way that many will find plausible and congenial, Timimi's article condemns both contemporary cultural pressures upon Western children, and the way in which children's unhappy responses to these pressures have been medically pathologized. There is a kind of post-colonial counterflow at work in Timimi's analysis: were we so minded, he argues, we might understand that non-Western cultures have different traditions that are, on the whole, less individualistic, and which offer a preventative remedy to our Western cultural pathologies, especially those of childhood. To make his argument, Timimi has, of course, to engage with a much wider intellectual context than psychiatry alone. In his account of Western culture, he draws for instance upon the contentious (and psychoanalytically informed) diagnosis of Western "narcissism" so famously inaugurated in 1978 by Christopher Lasch in *The Culture of Narcissism* (Lasch, 1980). To pretend that Timimi's article is solely psychiatric is, I think, futile: it is clearly recirculating and elaborating a wider critique of post-war Western consumer society. Given such interests, transcultural psychiatry cannot claim to be apolitical: it is a psychiatric subdiscipline that freely offers quasi- or pseudo-psychiatric comment on wider social, political, ethical, and cultural matters, rather as

a traditional public intellectual might exercise his "cultural authority". If, as some have argued, the public intellectual's authority has been eroded by that of celebrities and business leaders (e.g. Furedi, 2005; Posner, 2003), then it may that the role persists in the form exemplified by Timimi's generalist commentary to a specialized professional audience. Work like Timimi's in transcultural psychiatry may also be seen as a less widely circulated analogue to the "science in culture" ventures of, for instance, B.F. Skinner's utopianism (Skinner, 1976), Frank Tipler's cosmological speculations (Tipler, 1996), and Richard Dawkins's endeavours in theology and religious studies (Dawkins, 2006). The capaciousness of transcultural psychiatry gives it room for a similar relaxation of normal disciplinary restrictions, and an ambitious *coup de main* assault upon subject areas that are hotly debated within the humanities and social sciences.

Websites

Hearing Voices Network: http://www.hearing-voices.org/
Intervoice: http://www.intervoiceonline.org/

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