Transcultural psychiatry: a position paper

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Why do we talk about transcultural psychiatry but not transcultural cardiology? It is not that we think that rates of heart disease are constant across cultures and communities. But we do not think that the nature of the disease itself might vary across cultures. And thus there is no danger to the validity of heart disease categories from such variation.

By contrast, there does seem to be evidence of differences in the way that patients present with mental illness, not just that there are variations in rates of mental illness across cultures. And hence it is widely felt that there is a need for something like a 'cultural formulation' for mental illness but not for cardiology.

But the very idea of cultural variation is consistent with distinct models of mental illness and mental health. I will describe two contrasting views of cultural variation and hence the role and nature of a cultural formulation before examining some of the issues that mental health (by contrast with illness) raises for cultural variation. My aim is merely to set out some of the possible positions. Deciding which best fits the data is a further task.

The two factor model of cultural variation

Mental illnesses might be, or be underpinned by, pathologies of aspects of an essential human nature such as biological nature or essential features of our rationality or mindedness. Such underlying pathologies would be culturally invariant. But overlying them, cultural variation might lead to local differences in the way that such fundamental pathologies were *expressed*.

It might then be that particular mental illnesses diagnoses were the names of the distinct surface forms or of the underlying invariant pathologies. Either way, on this overall picture, a cultural formulation would be a way of reverse engineering, from locally divergent symptoms, the common underlying causes. This seems to be the view of Mezzich et al. in their discussion of 'Cultural formulation guidelines' when they say:

> The cultural formulation of illness aims to summarize how the patient's illness is enacted and expressed through these representations of his or her social world. [ibid: 390]

and

> Performing a cultural formulation of illness requires of the clinician to translate the patient's information about self, social situation, health, and illness into a general biopsychosocial framework that the clinician uses to organize diagnostic assessment and therapeutics. In effect, the clinician seeks to map what he or she has learned about the patient's illness onto the conceptual framework of clinical psychiatry. [ibid: 391]

The only positive role cultural factors can then play are as contingent resources:

> The aim is to summarize how culturally salient themes can be used to enhance care and health promotion strategies (e.g., involvement of the patient's family, utilization of helpful cultural values). [ibid: 399]

The one factor model of cultural variation

The two factor model requires a distinction between surface appearance and underlying pathology. But it may be that this distinction cannot be drawn. That is, the various ways one might want to flesh out the contrast between underlying pathology – for example as biological or some other underpinning notion of universal human nature – and surface appearance might fail.

It is, however, unlikely that there is *no* such thing as biological human nature. Some such notion, corresponding to what John McDowell calls 'first nature', might come free with our identity as an

animal species [McDowell 1994: 183]. But it might not, unaided, determine mental pathology because it might not – without education and enculturation, for example – determine the kind of mindedness that mental illness threatens. Mental illness might be a feature of our second nature, or *bildung*. Perhaps learning a language is necessary for some, at least, forms of mental illness.

A one factor model *need* not imply that there is any cultural variation of mental illness. It might be that our second nature, or rather that aspect of it relevant for the formation of mental illnesses, is universal. If so, mental illness would be akin to cardiology, varying only in external features such as rates. (Apparent variation would be a mark of our ignorance, our misdiagnosis.) So one version of the one factor model likens mental illness to heart disease with no significant space for cultural variation and no need for a cultural formulation.

But it is also possible that, because second nature depends on enculturation and because cultures vary, second nature also varies. If so, the richer notion of human nature now in play, beyond mere biology and sufficient for a conception of mental illness, might simply fail to be universal. Cultural variation might go 'all the way down'. This version of the one factor model is more radical than the two factor model even though both agree on the need for some sort of cultural formulation. A one factor model of a cultural formulation is more radical than a two factor view because it does not enable one to dig beneath surface difference to find underlying common pathologies but would instead be an articulation of the genuinely different ways people can be ill in different cultures. Interestingly, Mezzich et al. ignore this possibility.

One versus two factor models, mental illness and values

Thus a two factor model and two versions of the one factor model – according to one of which (the radical version) there is radical cultural variation all the way down and according to the other (the conservative version) there is no cultural variation, akin to heart disease – are all possible. Given that the one factor model is coherent, at least, is there any reason to think the two factor holds good, as Mezzich et al seem to assume? To repeat, it postulates a set of invariant underlying pathologies which are overlaid by cultural variation in the way they are expressed. What support can be given to that notion?

One approach would be to adopt Jerome Wakefield's harmful dysfunction analysis of illness in which disorder is a failure of biological function and illness is a harmful disorder [Wakefield 1999]. On his picture, there are evolutionary facts about mental functions, and hence failures of function, which should apply universally. This approach might thus support the universal substrate necessary for a two factor model.

But, on reflection, it need not. It will only support a two-factor if the underlying disorders – identified via biological functions – can also be culturally moulded or shaped. If not, Wakefield's position supports the version of the one factor model in which there is no cultural variation: mental illness would be like heart disease in need of no cultural formulations.

Wakefield's position is a value-free, by contrast with value-laden, view of disorder. The opposing family of views holds that mental illness is evaluative through and through. Can such a 'values-in' view sustain a two factor model and its view of a cultural formulation? That is, can it sustain a notion of a universal pathological substrate?

Taking Bill Fulford's version of a 'values-in' theory, illness corresponds to an endogenous cause of a failure of ordinary doing, an inability to do the sort of things that one should just be able to get on and do [Fulford 1989]. That might be enough to ground a notion of a culturally invariant underlying pathology, even if evaluative rather than value-free. Such underlying pathologies would undermine 'ordinary doing' irrespective of surface cultural details.

But Fulford stresses a contingent difference between mental and physical illness which is relevant here. We typically disagree about the values relevant to mental illness, and hence of the sort of

impediments to ordinary doing, whilst we agree in the case of physical illness. We agree about the contribution of a heart to healthy ordinary doing and hence about heart disease but not mental flourishing and hence mental illness.

If Fulford is correct about that difference and its significance then his account might seem to undermine the universality of the underlying pathology necessary for a two factor model. (I suspect that that is what Fulford himself would think.) There would be no underlying universal substrate of pathologies because different cultures would have different values and thus quite different ways of failing to be able to act. This is the radical version of the one factor model again.

But that model is not a *necessary* consequence of a 'values-in' view of mental illness. One might think that mental illness and mental health are essentially evaluative notions but that, on a proper view, the values involved are (that is, *ought* to be) universal. On this view, there is a rich value-laden notion of the proper way for a human to be, for human flourishing, and deviations from it are value-laden mental illnesses. If the notions of health and illness are sufficiently descriptively rich then there will be no gap between underlying pathology and surface appearance and hence no room for cultural formulation. This is the conservative version of the one factor model, again.

This discussion suggests that there are connections between the view one should take of cultural variation and of mental illness fundamentally. But the connections are not simple.

Mental health and cultural difference

A final issue, implied by the parenthesis above, concerns not just whether there is agreement between cultures about mental illness or health but whether any such agreement would be more than contingent. If not, then it seems that the diagnosis of mental illness always depends on an implicit cultural formulation and diagnosis would change as human culture change. This point can be more easily illustrated, however, by looking at two recent discussions of mental *health* rather than illness.

First, in 'Positive mental health: is there a cross-cultural definition?' G.E. Vaillant outlines seven different empirical models of mental health.

> First, mental health can be conceptualized as above normal, as epitomized by a DSM-IV's Global Assessment of Functioning (GAF, 6) score of over 80. Second, it can be regarded as the presence of multiple human strengths rather than the absence of weaknesses. Third, it can be conceptualized as maturity. Fourth, it can be seen as the dominance of positive emotions. Fifth, it can be conceptualized as high socio-emotional intelligence. Sixth, it can be viewed as subjective well-being. Seventh, it can be conceptualized as resilience. [Vaillant 2012: 93]

He says that he contrasts them. But in fact there is no critical assessment of them. Instead:

> To avoid quibbling over which traits characterize mental health, it is helpful to adopt the analogy of a decathlon champion. What constitutes a "track star"? A decathlon star must possess muscle strength, speed, endurance, grace and competitive grit, although the combinations may vary. Amongst decathlon champions, the general definition will not differ from nation to nation, or century to century. The salience of a given facet of a decathlon champion, or of mental health, may vary from culture to culture, but all facets are important. [ibid: 93-4]

That is, also, pretty much all he says about the question of whether any or all of the approaches might serve as cross cultural definitions. But the paper implicitly raises a few questions about the very idea of this.

First, there is the distinction between a definition of mental health and an instance of the definition. Are the brisk accounts offered supposed to be definitions of what mental health is? Or are they supposed to be examples of the way in which mental health might be instanced? The former claims

generality. The latter may be 7 from a potentially infinite list. Vaillant's relaxed attitude to lumping them together suggests the latter but if so there's no attempt at the definition promised in the title.

Second, the obvious worry about a cross-cultural definition of mental health is parochialism. One may draw up an account that presupposes or expresses merely a local view of what matters. This worry is increased the more substance there is to it. Roughly, the more one says, the more likely it is to draw on a local view. But if one avoids this through greater abstraction, the risk is that of vacuity. One will end up saying very little about what mental health is. I will return to this point.

Third, one might succeed in arriving a cross-cultural definition which is merely contingently cross-cultural. One way of doing that would be to take as many locally specific conceptions of mental health as there are cultures and construct a disjunction of them all. That would then be a cross-cultural account (akin to a Tarskian enumeration of truths) but (like Tarski's account) would be subject to the counter-factual worry that had there been a further community it would not have been covered by the enumeration [Tarski 1944]. (The enumeration offers no inductive warrant for further extension.)

Given these points, and given the title of the article, one might expect Vaillant to offer some sort of theoretical backing for the substance he offers. For example, if one connected a concept of mental health to mental functioning underpinned by evolutionary theory, one would have the start of an account of what was essential (that is, on the temporary assumption that one gets a non-question-begging account of human mental functioning from evolutionary theory).

Failing that Nature's eye perspective, how else might one attempt such a justification? One possibility would be to offer a conception of human flourishing without appeal to a reductionist base. So one might offer a richly normative account of how humans ought to function in the way that Aristotle does (and Vaillant mentions). But now the worry returns that this is merely a local perspective. Let me sketch just one example of this from Vaillant's paper, not his Aristotle section in truth, but his sketch of Erikson's model of maturity.

> In Erikson's model, adult maturity is achieved over time through the mastery of the four sequential tasks of "identity", "intimacy", "generativity", and "integrity".
> Identity is not just a product of egocentricity, of running away from home, or of marrying to get out of a dysfunctional family. There is a world of difference between the instrumental act of running away from home and the developmental task of knowing where one's family values end and one's own values begin...
> Next, young adults should develop intimacy, which permits them to become reciprocally, and not selfishly, involved with a partner. Living with just one other person in an interdependent, reciprocal, and committed fashion may seem neither desirable nor possible to a young adult. Once achieved, however, the capacity for intimacy may seem as effortless and desirable as riding a bicycle... Career consolidation is a task that is usually mastered together with or that follows the mastery of intimacy...There are four crucial developmental criteria that transform a "job" into a "career": contentment, compensation (i.e., useful to others, not just a hobby), competence and commitment. Failure to achieve career consolidation is almost pathognomonic of severe personality disorder.
> Mastery of the fourth task, generativity, involves the demonstration of a clear capacity to care for and guide the next generation. Existing research reveals that sometime between age 35 and 55 our need for achievement declines and our need for community and affiliation increases.
> The penultimate life task is to become a "keeper of the meaning". This task, often part of grand-parenthood, involves passing on the traditions of the past to the future. The focus of a keeper of the meaning is on conservation and preservation of the collective products of mankind. Generativity and its virtue, care, requires taking care of one person rather than another. In contrast, keeper of the meaning and its virtues of wisdom and justice are less

> selective; for justice, unlike care, means not taking sides.
> The last life task is integrity, the task of achieving some sense of peace and unity with respect to both one's own life and the whole world, and the acceptance of one's life cycle as something that had to be and that, by necessity, permitted of no substitutions. [ibid: 95-6]

This seems a plausible account of the stages that instance good mental health in the UK now but also seem tied to biological underpinnings and the nature of societal living (hence shades of Aristotle). But at the same time, one can easily imagine someone for whom these stages of family, career and elder statesman seem a bourgeois strait-jacket and that other ways of going on would be more life affirming. Even if this does, as a matter of fact, instance good mental health for many of us now, there seems no reason to think it defines it. Especially for mental health, rational disagreement and new ways of living seem an ongoing possibility. This point can be reinforced by looking at a second paper.

In 'Mental Illness and/or Mental Health? Investigating Axioms of the Complete State Model of Health', C.L.M. Keyes suggests that we should think about mental health in the way we think of mental illness: as having particular symptoms which can be measured or assessed. A key further idea is that mental health and its opposite (flourishing versus languishing) may turn out not to have a simple relation to mental illness and its opposite. In fact, he argues, those who are mentally ill may not be languishing as much as some of those who are not mentally ill at all. The data he presents suggest that this is the case.

This possibility in part rests on the fact that he takes only four forms of mental illness into account ('(a) MDE, (b) generalized anxiety disorder, (c) panic disorder, and (d) alcohol dependence during the past 12 months.' [ibid: 542]']. One way in which this might not continue to be the case is if DSM V took the negations of his account of flourishing to be a new form of mental illness. Since that seems to be entirely plausible (given the history of the proliferation of mental illness diagnosis), or, rather, given that it seems merely contingent that that is not the case now, I am not sure how important that result is.

Although most of the paper is concerned not with a dimensional approach (which also, e.g., takes account of days worked versus days sick to measure flourishing versus languishing) there is also a sketch of a criteriological approach which, I think, makes the underlying issues of understanding mental health or well-being or flourishing a little clearer. It is this:

> <u>*Categorical Diagnosis of Mental Health (i.e., Flourishing)*</u>
>
> *Diagnostic criteria*
>
> Hedonia: requires high level on at least one symptom scale (Symptoms 1 or 2)
>
> Positive functioning: requires high level on six or more symptom scales (Symptoms 3–13)
>
> *Symptom description*
>
> 1. Regularly cheerful, in good spirits, happy, calm and peaceful, satisfied, and full of life (positive affect past 30 days)
> 2. Feels happy or satisfied with life overall or domains of life (avowed happiness or avowed life satisfaction)a Positive functioning: requires high level on six or more symptom scales (Symptoms 3–13)
> 3. Holds positive attitudes toward oneself and past life and concedes and accepts varied aspects of self (self-acceptance)
> 4. Has positive attitude toward others while acknowledging and accepting people's differences and complexity (social acceptance)
> 5. Shows insight into own potential, sense of development, and open to new and challenging experiences (personal growth)
> 6. Believes that people, social groups, and society have potential and can evolve or grow

positively (social actualization)
7. Holds goals and beliefs that affirm sense of direction in life and feels that life has a purpose and meaning (purpose in life)
8. Feels that one's life is useful to society and the output of his or her own activities are valued by or valuable to others (social contribution)
9. Exhibits capability to manage complex environment, and can choose or manage and mold environments to suit needs (environmental mastery)
10. Interested in society or social life; feels society and culture are intelligible, somewhat logical, predictable, and meaningful (social coherence)
11. Exhibits self-direction that is often guided by his or her own socially accepted and conventional internal standards and resists unsavory social pressures (autonomy)
12. Has warm, satisfying, trusting personal relationships and is capable of empathy and intimacy (positive relations with others)
13. Has a sense of belonging to a community and derives comfort and support from community (social integration) [ibid: 541]

One complication in debate about the connection between mental health and flourishing concerns an ambiguity. In the context of a connection to mental health, it might mean having the *capacity* to flourish as we normally think of that. Or it might mean *enjoying* that normal capacity. Point 12 has both aspects of this. The second aspect is reflected in the idea that someone 'has warm, satisfying, trusting personal relationships' whilst the first is reflected in 'is capable of empathy and intimacy'. Someone whose partner has left them is probably not flourishing in one sense. But they may have the capacity for such relationships and so have mental health and hence flourish in the more technical sense.

A feature of lists such as this, however, is that it always seems to be possible to think of contexts in which failing to meet a criterion was still consistent with mental health where mental health equals well-being equals flourishing. So, for example, Algerian revolutionaries may not have felt that 'society and culture are intelligible, somewhat logical, predictable, and meaningful' but they still had good mental health. This suggests two nested dilemmas.

First: do such examples (or counter-examples) work by presupposing 1--(n-1) and (n+1)—13 of the criteria to put criterion n under pressure? Or do they rely on an antecedent grasp of mental health or flourishing, which is not reflected in these criteria, to put all under threat at the same time? Whilst the first seems readily possible, the second may also be the case. The criteria do not seem necessarily true and so in a particular extreme context there seems to be the standing possibility of flourishing which fails to fit these culturally expected norms.

Second: this suggests a more general worry. Do we have a substantial grasp of mental health construed as well-being or flourishing at all? We might trade across those equivalences but that seems merely truistic. But if not, any substantial account seems likely to be false. The worry is that any account of mental-health as well-being or flourishing is either false or vacuous.

Conclusions

Different models of mental illness rationalise different views of cultural variation. On what I have called a 'two factor model', common underlying pathologies are overlaid by cultural variation in such a way that they are differently expressed and a cultural formulation is necessary to reverse engineer the underlying pathologies. On a one factor model, by contrast, that separation between substrate and expression cannot be drawn. There are then there are two options. It may be that mental illness is really more like paradigmatic physical illness than it seems and thus there is no space for fundamental cultural variation. If so, apparent variation must merely be a mark of current ignorance. Or it may be, more radically, that there are no universal ways of being mentally ill but as many ways as there are legitimate ways of failing to flourish.

Looking to health rather than illness flags a further issue. Even if there were agreement between cultures about ways of flourishing that might be merely an accidental feature of a shared current view of well-being. This worry threatens to generalise. Any substantive understanding of mental health or human flourishing may be an expression of a local, even if universally shared, perspective. But avoiding that threatens vacuity instead.

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