Debating the First Principles of Transcultural Psychiatry: Invited Position Paper

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Where does pursuit of the term 'transcultural psychiatry' lead? To the synonyms (or are they?) of 'cultural' and 'cross-cultural' psychiatry. To research centres at McGill, Harvard, Toronto, UCL and UCLA, and to a prestigious international journal publishing research in cultural psychiatry, psychiatric epidemiology, medical anthropology and cross-cultural psychology. Back, to Arthur Kleinman's call for a new cross-cultural psychiatry (1977); forward, following Laurence Kirmayer, to a future 'beyond the new cross-cultural psychiatry' (2006). 'Transcultural psychiatry' in the context of globalisation encompasses cognate ideas of cosmopolitanism, cultural complexity and creolization (Bibeau, 1997; Nie 2012). It leads to heated recent debates about the role and responsibilities of the Global Health Movement (Bemme & D'souza, 2012). And it delivers us, perhaps, to the claim that in practice "All psychiatry is cross-cultural" (Mullen, 2012).

As I see it, transcultural psychiatry requires us to think seriously about *situatedness* and *specificity*; it requires us to acknowledge that a position paper cannot be offered as a point of view from nowhere but rather must declare its author's positionality. This in turn raises complicated questions about what counts in constituting my 'position.' Within the context of an interdisciplinary academic workshop on transcultural psychiatry, how relevant is it to declare my gender, race, ethnicity, sexual orientation, religious convictions, physical or mental health status? As a researcher concentrating particularly on schizophrenia, voice-hearing and depression, I tend to focus on the theoretical, textual and discursive; the problems I tackle have been conceptual more so than the practical or applied. So is 'my position' circumscribed as much by a *lack* of clinical expertise and experience as it is by the positive announcement of my disciplinary affiliations to literary and cultural studies, and, more recently, medical humanities? At a time when the looming publication of DSM 5 has brought into focus public and scholarly debates around what, and who, constitutes mental disorder, my participation in a number of networks and events, including this year's International Philosophy and Psychiatry conference on 'Culture and Mental Health', has highlighted to me the breadth and complexity of 'transcultural psychiatry' as well as the fact that I am outsider to the field.

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What follows, then, is necessarily a partial and provisional 'position paper'. In it, I want to address the question posed, but conspicuously never answered, by this network's 'What is "culture"?' discussion forum. (This was also a question posed, but again not satisfactorily addressed, at the above-mentioned philosophy and psychiatry conference, most memorably by a retired South Indian psychiatrist living in New Zealand, who asked why it was necessary to seek the advice of a cultural expert in his clinical consultation with people of Maori, but not, say, Ukrainian descent).

Janis Jenkins and Rob Barrett offer the following succinct and illuminating definition of culture as "A resource of shared symbols and meanings that shapes experience, interpretation, and action, and orients people in their ways of feeling, thinking, and being in the world" (2004: 5). Adopting this view of culture throws in to relief a lingering problem for transcultural psychiatry, namely that its existence as an independent field implies, at least for some, areas and aspects of psychiatry to which 'culture' does not apply. The somewhat pernicious idea that culture is relevant to some people, systems, practices, entities and encounters, and not to others, finds expression across a number of domains: the study of 'culture-bound syndromes' as set against presumably universal diagnostic categories; the way in which culture is seen first and foremost as a property of the patient, rather than the provider; the focus in transcultural psychiatric research on the experience of those whose ethnicity or migration experience distinguishes them from a majority who are implicitly positioned as not possessing a distinctive culture. Beyond the field of transcultural psychiatry, culture is conspicuous by its absence, omission or reduction to stereotype, particularly in clinical and scientific research contexts where it is recognised only in certain circumstances (for example, in the idiosyncratic expression of underlying biological processes, or when assigning subjects to categories, such as 'Christian,' which themselves are heterogeneous, multiple and contested). Finally, the culture of psychiatry itself is seldom recognised, much less interrogated. If, as Jubilee Rajiah has argued, "Psychiatry is highly bounded, highly powerful, extremely defended, and ethnocentric" this failure is grave indeed.

For Jenkins and Barrett (2004: 6-7) culture can be neither dismissed nor quarantined. With reference to schizophrenia, they show persuasively that

> Culture is critical in nearly *every* aspect of schizophrenic illness: the identification, definition and meaning of the illness during the prodromal, acute, and residual phases; the timing and type of onset; symptom formation in terms of content, form, and constellation; clinical diagnosis; gender and ethnic differences; the personal experience of schizophrenic illness; social responses, support, and stigma; and, perhaps most important, the course and outcomes of disorders with respect to symptomatology, work, and social functioning.

And this list could surely be extended. As I have argued (Woods, 2011), cultural factors have contributed to the definition and development of schizophrenia as psychiatry's 'sublime object', they continue to influence the way in which schizophrenia is researched (and that it is schizophrenia, and not particular symptoms or experiences, being researched in the first place), and profoundly shape the way psychosis is portrayed in other academic and popular discourses. The challenge comes not simply in recognising or paying lip service to the idea that 'culture is everywhere,' but in examining the way 'culture' functions to produce, regulate, celebrate, and punish difference.

This leads me to a final observation: more often than not, transcultural psychiatry seems to assume that culture is fundamentally good for you, that it is something to be recognised, respected and honoured, that it is essential to individual identity and to group belonging, that it must be valued and not evaluated. Clearly, this tendency bears the legacy of decades-old debates in anthropology and postcolonial studies about the dangers of cultural imperialism. But I wonder if such enthusiasm for culture, especially for what are perceived as minority cultures, detracts attention from the ways culture is not always benevolent or conducive to flourishing, that it might be something that actively contributes to or even causes our distress, or encourages us to interpret such distress as a properly psychiatric problem. It's here that I see an opening for disciplines more centrally concerned with the critique of culture – for scholars calling upon critical and cultural theory, mad studies, feminist, queer and postcolonial studies – to engage more actively, more passionately, with debates as they unfold in this clinical and conceptual arena.

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