Debating the First Principles of Transcultural Psychiatry: a project summary

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This document has a number of aims. Firstly, it introduces the project, "Debating the First Principles of Transcultural Psychiatry", which was supported by an AHRC Exploratory Award under the Science in Culture theme, and which ran from 14 February 2012 to 31 August 2012. After the brief, introductory discussion of the project and its methods, a substantial overview of important issues discussed in the project's online forum is provided. This summary account, although it uses quotations from the project collaborators, is written from the view of the Principal Investigator alone. For a more representative perspective, it should be taken in conjunction with the individual position papers (and podcasts) provided by the project's collaborators, and available on the project website. The summary of the forums is followed by a brief anticipation of future research questions informed by the project – again, this in the view of the Principal Investigator. Concluding the document are two appendices. The first provides information about the technical implementation of the forums (and the blog hosting them). The second attempts to give some practical guidance to researchers who may wish in the future to use on-line forums as a locus for discussion amongst collaborators.

Introduction to Project

Transcultural psychiatry – also called "cultural psychiatry" or "cross-cultural psychiatry" – deals with cultural factors in the cause, diagnosis, and treatment of mental illness. It is a field in which medical science and the humanities have collaborated since the post-war period, and it is growing in importance because of the encounter, diffusion, and mingling of cultures through globalizing forces such as migration and the mass media.

"Debating the First Principles of Transcultural Psychiatry" brought together a number of collaborators from different disciplines and backgrounds, and asked them to generate and reflect upon what they saw as fundamental questions for the field of transcultural psychiatry. The project had a total of eleven collaborators, both clinical and academic. They were:

Prof. Kamaldeep Bhui, Wolfson Institute of Preventive Medicine, Queen Mary, University of London
Dr Simon Dein, Mental Health Sciences Unit, University of London
Dr Glòria Durà-Vilà, Surrey and Borders Partnership NHS Foundation Trust
Dr Stefan Ecks, School of Social and Political Science, University of Edinburgh
Dr Chris Harding, School of History, Classics and Archaeology, University of Edinburgh
Dr Cheryl McGeachan, School of Geographical and Earth Sciences, University of Glasgow
Dr Gavin Miller (Principal Investigator), School of Critical Studies, University of Glasgow
Dr Matthew Smith, Centre for the Social History of Health and Healthcare, University of Strathclyde
Prof. Tim Thornton, School of Health, University of Central Lancashire

Dr Ross White, Institute of Health and Wellbeing, University of Glasgow
Dr Angela Woods, Centre for Medical Humanities, University of Durham
Further information about their interests and disciplinary specializations can be found on the collaborators' page of the project blog / website.

The collaborators were invited to an initial Launch Workshop (24 March 2012) and a concluding Stocktaking Workshop (18 August 2012), both held at Glasgow University. The Launch Workshop was an opportunity for collaborators to meet in person, and to generate ideas that would inform ensuing discussion. The Stocktaking Workshop was centred on presentation and discussion of brief "position papers" by collaborators. Between these two events, the main work of the project took place in multiple threads of discussion on a private online forum hosted within the project's website. In various subforums, the collaborators commented upon articles by researchers such as Sami Timimi, Mohammed Abouelleil Rashed, and Ivan Crozier, and were prompted by questions such as "How does transcultural psychiatry understand 'culture'?", "What is the colonial and postcolonial significance of transcultural psychiatry?", and "What are the politics of transcultural psychiatry?". They also had an opportunity to air their own work in progress, and to suggest further reading and useful weblinks. In all, around 22 000 words of forum content were generated by the collective activity of the collaborators.

Summary of Forum Discussions

The following sections organize and summarize material generated by collaborators in the project's private online forum – it must be understood that the material cited is evidence of a process, and not of finalized outcomes. Some degree of familiarity with transcultural psychiatry as a field will also be helpful in understanding the summarized discussions. Although the sections are centred on verbatim reports of the debates and discussions, they do not correspond to the division of topics in the subforums. Instead, the sections cut across multiple subforums, uniting separate, but thematically related material. There are six sections: "Globalization, Post-colonialism, and Counterflows", "Universal or Local?", "Culture and Identity", "Religion and Spirituality", "Disciplinary Unity and Boundaries", and "Clinical Aptitudes". As will be apparent, some material anticipates ideas presented in the position papers and podcasts produced by the project's collaborators. Where the name of the collaborator responsible for the quoted material is not clear from the context, then the collaborator is identified at the start of the quotation in square brackets.

Globalization, Post-colonialism, and Counterflows

Transcultural psychiatry was seen by collaborators as a medical movement that needed to be historically conscious of global political issues such as colonialism and its legacy. The potential for neo-colonialism in the Global Mental Health movement was identified by White:

> There is much talk in Global Mental Health circles (and in the WHO) about the need to "scale-up" services for mental health across the world. But a key question remains – what exactly do we scale-up? On one side you have the deductive, top-down, or etic, notion that evidence-based practices in high-income countries will work in low and middle income countries. This is of course based on the assumption that mental health difficulties across the globe have a universal cause; a biological cause. The universality of the cause presupposes that standard treatments can be readily applied across "cultures" with minimal adaptation. In contrast, an inductive, bottom-up, or emic, approach emphasizes the importance of considering local conceptualizations of mental health difficulties and focusing on local priorities.

Without the latter approach, White argued, "indigenous forms of helping, healing, and social integration which could contribute to positive outcomes could be marginalised". Indeed, challenges to the "scaling up" paradigm could emerge even within high income blocs. As Smith's comments on ADHD [Attention Deficit Hyperactivity Disorder] indicated, there was resistance to the exportation of putative expertise on this condition even within well-off "Western" countries: "Outside of the US, ADHD has been embraced or resisted in varying degrees, largely due to cultural and social factors. Even Canada and the UK […] have negotiated their own approaches to the disorder. Although Iceland consumes more Ritalin than any other nation, even the USA, per capita, ADHD is rarely diagnosed in Finland".

Transcultural psychiatry was seen, though, to frequently include currents of thought and practice that were an explicit post-colonial critique of contemporary Western society from the perspective of "the Other". Timimi's work on ADHD and Western child-rearing (Timimi, 2010) was, according to Miller, "one of those post-colonial counterflows that were flagged up in the first workshop. By looking to the 'Other Systems of Practice', he [Timimi] suggests, we will find (primarily) cultural solutions to the pathologies of Western childrearing". But although such critique was generally welcomed, there was concern that it could reproduce colonial thought patterns: "[McGeachan:] I would have liked to have heard more about different forms of resistance – in all its multiple and fluid forms – to this 'McDonaldization' of children's mental health, from perhaps the perspective of the single-parent families that Timmi mentions, from institutions, or perhaps even from children themselves". Woods saw a similar homogenization at work in Timimi's critique: "his article makes sweeping claims about 'Western society' being in the grip of narcissism and surveillance, and resorts to something bordering on cultural cliché in sections like the one comparing Japanese and German parenting styles".

Miller referred to work on so-called "capitalist spirituality" (Carrette & King, 2005) as an example of how apparent counterflows such as "mindfulness" involve abstraction of psychologized, subjectivized components of non-Western religions from their wider ethical, historical, ritual, and institutional settings. Both White and Harding, though, defended the Buddhist counterflows that had entered Western culture against the charge that they were merely Orientalist ideology made functional for late capitalism: "[White:] Mindfulness and acceptance based therapies (such as Acceptance and Commitment Therapy) are certainly very trendy at the moment. Some might argue that a large part of the appeal is that these approaches serve as an antidote to the specific pressures that we in the West face in our very driven, capitalist, consumerist, disposable society". White indicated that scholarly critique could be overly fastidious about the authenticity of such importations: "Maybe the particular form that the counter-flow takes is not the most important thing. Maybe what is really important here is that the counter-flow questions the perceived wisdom of the prevailing cultural norms. The 'counter' aspect of the flow may be a very powerful component". Harding, also, was concerned that academic denunciations of "capitalist spirituality" were unrealistic, since they overlooked the engagement of religious systems with particular, utilitarian needs:

> Show me a new religious practice, at any point in time, that was not in some way an instrumental response to the needs of that time and place […].
>
> I agree that we should be aware of where our practices come from (in the case of mindfulness, etc., a combination of western warpings and presentations by Asian practitioners – the classic example being D.T. Suzuki – very much geared towards a modern western audience) and that they should receive critical treatment, in terms of effectiveness and the sorts of worldviews and ethics that they might imply. But to denigrate these new practices simply because they're not like their counterparts in Thailand or Tibet, or wherever, is to imply an integrity on the part of those Thai or Tibetan versions which I don't think they necessarily deserve. One might suggest that the valorisation of such versions – complete with their ritual settings – is almost a species of Orientalism in its own right.

Miller was concerned that the post-colonial ideological dominant of transcultural psychiatry had confined it within a fundamentally nation-centred problematic. This he felt was apparent in the "cultural formulation" proposed by Mezzich and his co-authors (Mezzich, Caracci, Fabrega, & Kirmayer, 2009):

Ethnicity is defined […] as being the patient's "reference group", and it seems the prototypes for identification are religious, national, racial or descent groups. I wonder if it's helpful to investigate cultural difference by asking this kind of question, which seems to make "ethnicity" the centre of gravity for cultural difference, thereby representing other differences as accidental variations on the most substantial kind of cultural difference. (Might not cultural differences associated with gender or class be in fact larger than some ethnic differences?)

Their approach, in Miller's view, tended to depict the world as a relationship between peoples, each with their own identifiable culture (even if such cultures could blend and intermingle via migration). Indeed, the transcultural psychiatrist could be viewed as eliciting and encouraging ethnic-national identification:

[Miller:] There's an equivocation here between "culture" and "identity", between describing the cultural difference of an individual, and using cultural difference as a way of getting to the patient's sense of membership with certain social groups whose cultural differences are taken to demand recognition and respect. And, naturally, if the patient is fuzzy about their identity, then questions about it from a psychiatrist will incentivize them to "discover" it (a case of "productive power").

Universal or Local?

There was considerable scepticism about the extent to which psychiatry could find culturally universal accounts of mental health and illness. Amongst other concerns, Thornton argued that

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.

Moreover, even a usefully "thick" account of mental health might only be contingently cross-cultural:

[Thornton:] one might succeed in arriving at 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. (The enumeration offers no inductive warrant for further extension.)

Given such arguments, there was a general spirit of agreement with Mohammed Abouelleil Rashed's article on "Religious Experience and Psychiatry" (Rashed, 2010), as articulated, for instance, by Miller:

There was a very clearly articulated challenge to a supposed culturally universal notion of "function / dysfunction" in DSM [Diagnostic and Statistical Manual of Mental Disorders]. I think Rashed does a pretty convincing job of showing the parochialism of the DSM model here […]. It's about work, family / friends, and personal hygiene, to put it crudely. I really like Rashed's question not only about the meaning of "dysfunction" in these realms (e.g. they may be par for the course on a spiritual / ascetic mission), but also about all the other missing dimensions of "function", e.g. "aesthetic appreciation".

Such scepticism echoed concerns raised in the project's Launch Workshop about the validity of putatively culturally invariant concepts within psychiatric nosology. Harding, with reference to Rashed's article, emphasized for instance "the difficulty of applying criteria such as harm, positive action, or functionality where some forms of religious experience are concerned". Woods wondered, though, if sceptical examination of transcultural psychiatric nosology tended to prevent a broader interrogation of psychiatric diagnostic systems. With reference to Crozier's account of the culture bound syndrome, *koro*, as multiple (Crozier, 2012), she wondered if "multiplicity extends to virtually all psychiatric diagnoses. To put it differently, are there psychiatric categories which have persisted over time and across cultures with greater unity of symptomatology, aetiological explanations, degrees of cultural significance, and treatments?".

However, there was concern from Thornton that transcultural psychiatry was not always philosophically rigorous enough in its challenge to culturally universalist accounts. Thornton found Rashed's account, for instance, to be lacking: "What struck me most about Rashed's paper is how little he did to engage with and persuade those with an opposing – let me say simple-minded realist – view". Cultural relativism has perhaps become an *a priori* habit of thought within certain streams of transcultural psychiatry, rather than a rigorously examined thesis. Thornton suspected that this was because psychiatrists were minded to borrow a more general relativistic mindset from social scientists, even though this was, in fact, unnecessary to scepticism about the universality of mental illnesses (which would make enough headway by critiquing universalist accounts of conceptual pairs such as functional / dysfunctional, benign / harmful, etc.). It was, thought Thornton, an error "to inflate a kind of methodological scepticism about a particular domain (a particular set of putative facts or truths) to a worry about truth in general". There was, though, some support for a stronger relativist programme within transcultural psychiatry. Harding commented that "[p]utting psychiatric diagnosis in its place as a 'linguistic practice' might well horrify some, but on the other hand this is the kind of area where transcultural psychiatry might share fruitful territory with inter-religious dialogue and the discussions that go on there concerning language".

As well as noting the difficulty in providing culturally universal accounts of phenomena such as social function / dysfunction (with religious subculture providing a useful source of counter examples to everyday wisdom), collaborators also wondered about the latent functionality of mental illness – the extent to which "being mentally ill" is a way of coping, or, paradoxical though it may sound, a normative and / or normalised deviance. With regard to the individual, White noted that

> [a]s a psychologist working in an early intervention service I was very interested in the potential "functionality" of psychotic symptoms. Andrew Gumley and Mattias Schwannauer in their book *Staying Well After Psychosis* suggested that psychosis was a disorder of emotional regulation. They explore the possibility that people who experience psychosis may have particular attachment styles when younger which meant that they did not necessarily have adaptive ways of regulating emotions modelled to them from primary care givers.

Moreover, Woods argued that mental illnesses were far from invariably experienced as stigmatizing:

> Over the last thirty years there has been an explosion of popular interest in memoirs of illness, attended by an academic obsession with the study of "illness narratives". These bodies of literature highlight the way in which the illness experience is made meaningful and indeed valued not simply by individual narrators but within the wider culture, at least in the Anglophone West. To return to the specific case of psychosis, while it's true that many reject the diagnosis and indeed the category of schizophrenia, there are others for whom recognising that there are biopsychological factors involved goes hand in hand with valuing the complexity of their experience and the suffering it entails.

The concept of somatic and psychological "idioms of distress" that are culturally sanctioned was regarded as helpful in understanding historical and geographical variations in the canalization of suffering. White, for instance, cited Ethan Watters' hypothesis in *Crazy Like Us* (Watters, 2011) that

> because hysteria in Europe became so prevalent […] its discriminatory power for expressing distress began to wane. It was almost as if distress needed to find some other way of being expressed within the population. This "normalisation" of hysteria meant that the disorder failed to serve as a means of effectively communicating differing levels of distress within the population.

Also, Durà-Vilà introduced collaborators to her comparative research on idioms of distress such as "*susto* (fright), *nervios* (nerves) and *ataque de nervios* (attack of nerves)" in Spanish-speaking populations. Gender provided a fruitful focus for discussion of such idioms. Woods wondered whether the idioms studied by Durà-Vilà showed gender specificity: "you say that *nervios* 'occurs amongst those who are subject to disadvantage or subordinate social roles such as women or the poor' – is it therefore seen as feminised, as some 'nervous complaints' have been in English-speaking contexts?". White proposed fitting the conceptual frame of "idioms of distress" to Crozier's discussion of *koro* (Crozier, 2012), and postulated a specifically masculine pathogenesis that might underlie presentation of the condition amongst men:

> at the heart of *koro* there are some age-old themes namely masculinity / power and death. Whereas *koro* might not pop up in every culture (in so much as discrete and homogenous "cultures" exist) concerns about masculinity, power and death tend to more omnipresent. Circumscribed groups of people who are united by shared geography, language, religious beliefs, and history will act as an incubator for the particular forms in which distress can be expressed and communicated.

Culture and Identity

Recent literature in the field of transcultural psychiatry showed considerable progress from reified, monolithic, and essentialized models of culture. Nonetheless, having largely abandoned simplified models of culture – at least on paper – transcultural psychiatry still had to come up with a plausible positive account of deviance from culturally specific norms of mental health. Mohammed Abouelleil Rashed's article on "Religious Experience and Psychiatry" (Rashed, 2010) prompted discussion in its ambition to articulate properly the logic of cultural (in)congruence via the case vignette of "Femi", a young man who could be seen not as psychotic, but rather as undergoing a particular kind of religious experience peculiar to his culture. Rashed proposed a more systematic attempt to articulate the presuppositions of a culture's epistemology, rather than to rely upon the opinion of a single community member acting as informant. Miller, however, remained unconvinced by "this revision of the 'cultural congruence' criterion, from 'validation' (ask one or more informants from the patient's 'group', whatever that may be), to 'epistemology' (articulate the epistemology of the patient's 'group'". Miller's reservations arose because there still seemed an alienation of culture from the agency of persons. Whatever the "epistemologies" of Native Americans and "white" North Americans (populations referred to by Rashed), were they really so *bound* to such presuppositions?: "I'm still not clear also on why […] the white North American hearing the voice of the dead is having a pathological experience, while the Lakota is not. If it really is a matter of cultural congruence, why not introduce the white North American to some Lakota, or to some other white North American voice-of-the-dead-hearers?".

Nonetheless, there was general sympathy for the effort to provide a more "patient-centred", rather than "expert-led", ontology of mental illness. This was felt to fit well with clinical practice, which (in White's experience) relied upon sensitive work from multidisciplinary and multi-agency teams:

> Having worked in an early intervention service for psychosis, the most crucial aspect of the work is being able to engage with the young person. Community Psychiatric Nurses, Psychologists and Psychiatrists working within these services are very adept at taking time to explore young people's interests and validate their experiences and the distress that they are experiencing. In this way, as Rashed might put it, they try to create "linguistic resonance" with the young person. Early intervention services "embrace diagnostic uncertainty".

Smith saw a resonance with historiography of health, which had increasingly attempted to discover and authorize (although not uncritically) the "voice" of the patient:

> If we accept that mental illness is at least somewhat culturally determined and if we accept […] that culture is more of a place for debate than agreement, then we are perhaps left with studying individual patients' experiences to get a sense of the many meanings of mental illness and how it has changed across time and place. The lessons gleaned from such an approach to the history of mental illness might serve not only to help us come to grips with the epistemological issues at hand, but might also inform contemporary debates about mental illness and the mentally ill.

Discussion of Crozier's historical account of the culture bound syndrome, *koro* (Crozier, 2012), also prompted debate about a possible tendency within transcultural psychiatry to downplay the cultural specificity of the West and / or psychiatry. Harding noted that "western psychiatry's view of *koro* seems tacitly to perpetuate the colonial-era euphemism of 'culture' to denote backwardness". Miller wondered about a genealogical continuity between ideas of "racial mind" and the tendency to allocate cultural pathogenesis to non-Western populations: "Culture as pathogenesis accordingly gets less of a role in explanations of disorders in Western patients / populations (because Western culture is, of course!, more developed / evolved / rationalised — again, this conceptual cluster standing in for racial explanations)". White indicated the other side of the coin in the cultural specificity (Western, scientific, medical) of psychiatric nosology:

> Is it not the case that we fail to appreciate the CBS [culture bound syndrome] nature of the majority of the diagnoses in DSM-IV because we view these disorders through the same cultural lens that psychiatrists producing the diagnostic criteria saw the world around them when producing this taxonomy? In essence things don't seem so culture-bound to those living in the West because we eat, drink and sleep this way of understanding human behaviour.

Harding agreed with Crozier's identification (Crozier, 2012) of a colonial tendency to use psychiatric pathologization as a way of exerting power over colonized populations, identifying a "reification of culture by colonising powers, sometimes via psychiatry, as a way of devaluing (anti-colonial) political discourse – British amateur psychoanalysts in 1920s India did this, for example, by explaining away Indian nationalism in terms of psychological dysfunction arising from various Indian religions and their troubled interactions with one another". However, he thought that Crozier's argument overlooked the interest of

> local actors in developing and propagating ideas about their own cultural specificity, and in doing so – to expand Dipesh Chakrabarty's phrase – "provincializing" Euro-America, as having "culture". Presumably we need to pay attention to the reasons why such actors – psychiatrists, anthropologists, cultural theorists – have found it in their interests to press the claim for psychiatric conditions or psychological tendencies that are linked to local culture.

Harding pointed, as further exemplification, to the way in which "Japanese psychiatry prides itself on having contributed 'new' terms and conditions to the international lexicon – not least

the *Ajase Complex* and *Amae*". Such phenomena demonstrated that there was an incentive for decolonizing societies to invest in an armoury of psychopathological cultural distinctiveness, thereby bolstering the case for a distinct "national character", and hence a separate and autonomous nation state. Harding argued that historians could make an important interdisciplinary contribution to the understanding of this interplay between medical diagnosis, Orientalism, and de-colonization: "there's good evidence (not least from Japan) for psychiatrists, cultural commentators and others participating in the 'creation' and publicization of anything from national psychological quirks to full-on psychiatric conditions. This is one area where historians can really make a contribution, I think: in tracing these processes, and offering clinicians an account of them".

In a related discussion, there was speculation about the extent to which non-national identity groups might, as it were, condense and nucleate around psychiatric diagnoses. In such cases, the diagnosis itself would be the essence of a putatively cultural difference. Miller asked about "the extent to which identity politics mingle with the (putatively) strategic alliances that exist in patient groups, particularly those groups that have a 'de-pathologizing' intent". He wondered:

> Could there be something like the formation of transnational identity groups, that nonetheless bear certain reworked similarities to nation formation? It's interesting when one sees, for instance, the creation of a canon of a literature of madness, particularly of first-person testimony. […] it does seem rather like the kind of activity that goes on in the early phase of "romantic nationalism", a bit like collecting together your Border ballads.

Woods saw this as an issue relevant to her own research on voice-hearing identity, as it sought to explore the "contours of this identity as one that seeks simultaneously to politicise, reconfigure and transcend the world of mental illness in general and the 'label of schizophrenia' specifically".

Religion and Spirituality

One foundational question in the discussion of religion and spirituality was whether religion (and perhaps spirituality) was really a mode of arbitrary cultural difference (analogous to, say, phonological systems in different languages), or whether it was in some way an autonomous enterprise, with particular modes of validity that might extend across cultures. Dein argued that religion was often represented as an "an autonomous subject in the social sciences (psychology, sociology, anthropology). What separates religion from other cultural themes is its focus on 'transcendence' and its supra empirical nature. It is assumed that it exists 'beyond' culture". Thornton, in a similar vein, wondered what the response of a robust theological realist (perhaps one in the Christian tradition) would be to a transcultural psychiatry that tended to lump together all modes of religious and pseudo-religious experience. The well-intentioned transcultural perspective might adopt a non-realist account of belief (like that of, say, the Anglican theologian, Don Cupitt), and so fail to recognize a religious claim to universality across cultures: "what happens is a kind of tacit translation into the language of Don Cupitt in a way that the protagonists would themselves think a piece of cultural imperialism, of not taking their beliefs seriously. 'We don't mean mere metaphor', they might exclaim: 'Don't patronise us.'" Harding, however, expressed some concern about whether it was in fact possible to correctly talk of "religions" in other cultures without misrepresenting such phenomena;

> to reach into the lived experience of individuals or communities and extract a constellation of elements that then get called "religion" can be a rather loaded and unhelpful move in the first place. There's plenty of historical and anthropological writing that points to the fallacies of doing this, not least since it is often a semi-privatised,

propositional Christianity that gets used as a basic yardstick. In the psychiatric context, is there perhaps a danger of clinician and patient talking at cross-purposes here, sometimes to the detriment of the latter?

Concerns about the claim to universality of a religion (and whether this is lost in certain transcultural analyses) might reflect the preoccupations of textualized and universalist Abrahamic monotheism. Miller expressed a similar point, when he argued that

only so much of what goes in religion is really about theism, and supposed cognition of God. As well as non-theistic systems, there are also other aspects of religion than the cognitive, such as the experiential and ritual sides. With these, pathologization would again seem to be more about the cultural impropriety of them (e.g., seeing the dead when one is a WASP and not a Lakota), than anything to do with the truth or falsity of propositions that might be extracted from them.

The fashionable term, "spirituality", was also interrogated. Dein briefly explained the word: "Some people claim to be spiritual, i.e. have a connectedness to something be it naturalistic or transcendent. For them it is individualistic and non-ritualised and provides a source of meaning". He noted that although the term was much used, there was a gap in the research base:

To date spirituality's impact on MH [Mental Health] has attracted less attention than conventional religious beliefs and future work in TP [transcultural psychiatry] needs to examine the MH correlates of spirituality. We need more detailed phenomenological descriptions of religious and spiritual experiences before we can compare such states with what psychiatrists define as "psychosis".

Woods wondered whether, without greater clarity, "spirituality" would end up functioning as a "kind of repository for all sorts of modes of being (affective, existential, relational) that aren't recognised or recognised sufficiently in dominant biomedical understandings of the self". In response to these and related concerns, Miller attempted some clarification of this admittedly amorphous term:

There's a fairly well-developed literature in religious studies on the religion / spirituality distinction. The ideal type of the latter would be: eclectic (there's pick 'n' mix from different traditions, old and new); subjectivized (such and such a belief or practice etc. "rings true" for the individual); mobile (spirituality involves "seekership" — moving through different practices etc.). There's also the so-called "spiritual revolution" thesis (Heelas and Woodhead) which proposes that spirituality sacralizes some kind of search for greater authenticity.

Despite these scholarly scruples about the use of the term, the religion and "spirituality" of practitioners of various stripes was seen as motivating a series of negotiations and contestations with psychiatric expertise. For instance, Woods noted that "the idea that psychosis can be reconceptualised as a 'spiritual crisis' has been argued by people like Isobel Clarke". Voice-hearing was a paradigm, at least in Christian and post-Christian culture, of an experience that could claim a theological, spiritual, or religious autonomy:

[Woods:] the theological significance of voice-hearing seems more strongly associated with Christianity than with other religions (where God or the Gods communicate through dreams, visions, or through other signs). Anyhow, at the heart of this interest seems to be a set of assumptions that are seldom interrogated: (i) anomalous experiences, such as hearing the voice of God, are either spiritual or psychotic; (ii) psychotic experiences are not meaningful in spiritual terms; and (iii) spiritual and religious experiences warrant special recognition compared to other forms of experience or systems of belief.

Collaborators agreed that the relationship would not necessarily be a straightforward "turf war" between spiritual / religious and psychiatric understandings. Harding, for instance, speculated on the possibility of therapeutically rationalized forms of religious life supplanting traditional forms:

I wonder whether Buddhism will eventually lose some ground in the UK and elsewhere as a standardized, neuroscience-backed (and NHS-sponsored) version of mindfulness gains prominence. Perhaps the Dalai Lama's Mind & Life Institute, where Buddhists and neuroscientists get together, will eventually shoot Tibetan Buddhism in the foot: just as Buddhism (amongst other religions) went through a "rationalization" process in the late 19th century, with rituals / cosmologies dumped and practices / metaphors retained.

Harding also argued that religions increasingly recognized the need for mental health expertise in order to distinguish psychopathological pseudo-spirituality:

Allowing a given community such a powerful voice […] in a discussion about someone's mental health seems to risk psychiatry losing its potential as a critical voice where this relationship is concerned – the importance of which a great many religious communities clearly now appreciate, whether it's Christian monasteries or clergy houses worrying about the mental health (and the related behaviour) of monks, nuns, and priests, or psycho-spiritual subcultures bringing in psychiatrists and psychotherapists to help see where an "existential" crisis might actually be something more prosaic.

Miller indicated some perhaps surprising forms of negotiation with psychological therapy in Christian pastoral care and counselling:

CBT [cognitive behavioural therapy], for instance, can get quite a good reception because it resembles the tradition of "spiritual direction", and has a lot of emphasis on mental, spiritual, and even bodily discipline (don't slouch – you'll only make yourself more depressed!). Person-centred counselling can be seen as a bit iffy – too much emphasis on self-sufficient finding yourself, not enough on dependency on a higher power for transcendence of fallen nature.

Finally, as Woods noted, the borderland between psychiatry and religion / spirituality was one inhabited not just by patients, but also by psychiatrists: "The issue of whether psychiatrists could, or should, pray for and with their patients has apparently been hotly debated, and perhaps reveals just how cherished 'our' model of the dispassionately secular and scientifically authoritative psychiatrist really is".

Disciplinary Unity and Boundaries

Although transcultural psychiatry has been a recognized subdiscipline since the mid-1950s (Bains, 2005), it was suggested that the term, and its cognates ("cultural psychiatry", "cross-cultural psychiatry"), implied a greater degree of ideological and organizational unity than was in fact the case. The claim was all the more persuasive since it issued from Bhui, currently President of the World Association of Cultural Psychiatry:

I think we are assuming that transcultural psychiatry or cultural psychiatry is an organised body of thought and action with clear and consistent boundaries and objectives. […] It attracts many people who perhaps share an interest in critical perspectives on clinical practice, and take into account sociological and psychological and humanistic perspectives, as well as revealing hidden power relationships and narratives; but the exact centre of gravity if you like moves around from different topics, interests, and fashions (race, religion, diversity, culture, inequalities, disparities).

There was some implicit disagreement though about whether transcultural psychiatry was a political activity. Bhui implied that it was not: "the subject tends to generate some quite strong feeling among colleagues who are not familiar with the subject who seem to see it as a political activity". Miller, on the other hand, perceived a strong political urge within transcultural psychiatry for a diagnosis of social pathology (particularly of the West). Transcultural psychiatrists, although they might have a more limited professional audience, were engaged in something akin to public-intellectual commentary:

Alongside the clinical relevance of the cultural psychiatry movement, there's also something rather like the traditional role of the public intellectual on social matters via the discussion of "race, religion, diversity, culture, inequalities, disparities" – and we might add to the list "childhood", "consumerism", "high / middle / low income countries". The difference is that this wider cultural authority is addressed to a more distinctly bounded professional audience.

Sami Timimi's critique of Western child-rearing (Timimi, 2010), and, by extension, Western culture and society, was taken as a case in point:

[Miller:] I wonder if Timimi is a kind of Daniel Bell / Christopher Lasch in psychiatrist's clothing. I've suggested that certain kinds of TCP [transcultural psychiatry] literature might offer inadmissible kinds of gratification. Perhaps Timimi's critique is really cultural critique smuggled into psychiatric literature. It makes me wonder if the TCP subdiscipline is a kind of carnival where normal disciplinary boundaries are surrendered. (A bit like debates about the "anthropic principle" in cosmology).

The blurring of generic boundaries was also apparent in the tactical deployment of mental health in universalizing, global narratives. McGeachan cited her ongoing examination of the *World Happiness Report*, commissioned and promoted by the United Nations Conference on Happiness in April 2012: "It has some interesting sections on mental health and the promotion of 'evidence-based psychological therapies' that are intriguing. Plus, for a document that is supposedly talking about such issues on a global scale I am not sure how much 'cultural sensitivity' is being employed here". Miller was concerned that the *Report* deployed medico-scientific rhetoric as a veil of neutrality and objectivity to present what was, in truth, a highly contentious vision of universal History:

Happiness was, I think, being presented as the central element in a culturally invariant axiology that would allow us to measure (and plan) for universal progress. […] in this supposed universal history, to hinder or resist treatment of anxiety and depression using those "evidence based psychological therapies" is to stand in the way of progress itself. It's striking to find such a vast historical vision […] woven into very specific debates about mental health, particularly depression and anxiety.

Scepticism, it is fair to say, was the prevalent attitude of collaborators to proposed medico-scientific accounts of culturally universal positive mental health, with Woods citing Sarah Ahmed's *The Promise of Happiness* (Ahmed, 2010) as a useful challenge to such visions.

Clinical Aptitudes

As Woods noted, a focus on the coherence and rigour of abstract philosophical formulations could perhaps function as a distraction from the complex realities of the clinical encounter: "Psychiatry is not simply a set of philosophically fascinating statements in a diagnostic manual; it's also an embodied practice. I'm always left wondering […] about the difficulties faced by early intervention teams in responding to people's distress, and how these are a matter of interpersonal negotiation as much as the application of theory". Harding made a similar point: "In my own so-far limited research on psychiatry in India and Japan I've been struck by the number of times psychiatrists – in documents and in interviews – allude to aspects of understanding and alleviation of difficulties that don't bear any kind of theorizing but are bound up in a purely personal dynamic". Discussion of Mohammed Abouelleil Rashed's article on religious experience (Rashed, 2010) prompted suggestions about relevant clinical competences. Harding noted that there appeared to be a need for humanistic expertise that would complement biomedical accounts of the patient:

one aspect of our launch discussion that isn't quite touched on in Rashed's piece but I think is implied, is the range of personal qualities potentially required of mental health professionals in addressing the difficulties

raised by Rashed. […] If, as Rashed says, a mental health professional might well find herself at the hub of a multi-party discussion aimed at some kind of "linguistic congruence" there are surely skills – perhaps "characteristics", rather – of empathy, diplomacy, cultural literacy, etc., that become not merely desirable but essential.

An idiographic, hermeneutic sensibility that grasped the active, interpretative engagement of the patient seemed to Smith a desirable achievement for the clinician:

Getting back to Rashed, […] this is an article about seeing mental illness not in a universal, essential, DSM-ish fashion, but rather as a phenomenon that should be interpreted in the context of individual people living unique lives in specific times and places. Sometimes, the biomedical model might fit the bill; other times, other paradigms, be they religious, psychodynamic, psychosocial, are more instructive.

Harding agreed, citing a mental health professional who "spoke recently about his preference for clinicians more or less trying out a series of narratives on patients (the psy, the biological, the religious, the caring-uncle, etc), to see what resonated".

There was, though, concern on the part of White about the way in which such cultural sensitivity could be implemented in well-intended protocols. White was particularly disquieted by the proposal for a "cultural formulation" made by Juan E. Mezzich and his co-authors (Mezzich et al., 2009), which seemed to have transcultural awareness as a "bolt on" element, rather than a guiding principle from the beginning. The approach betrayed a lingering cultural parochialism in assumptions about how to create such guidelines, and how to interact with patients:

asking questions about culture and ethnicity is intended to help the clinician to see the patient better – a cultural lens that the clinician can look through. I would be much happier however if the ultimate goal was to help the clinician to see the situation through the patient's eyes. This for me is a key issue. The article does not explore the issue of *process*. What are the key processes by which the unique cultural circumstances of the individual have contributed to them becoming unwell?
The article focuses a lot on what should be asked and has comparatively little on how it should be asked. What about exploring alternative modalities for gathering information that are less intrusive and confrontational than direct questioning? This might be more appropriate for certain ethnic groups, or individuals who have been subjected to traumatic interrogation in the past. Not sitting in a room talking, but instead using art, picture books to construct stories, music, poetry to facilitate someone to express distress.

Nor could White find any *prima facie* engagement with the involvement of relevant service users in the formulation of such guidelines:

An additional concern for me relates to validity and authenticity. Where has this approach been derived from? Has this approach been developed through consultation with stakeholders who come from non-western cultures and have experience of going through psychiatric services? It is interesting to note that all the authors are based at universities in North America. Or is it a western perspective on what we assume are the key issues? Mention is made of the fact that questions quoted have been developed from the authors' "clinical experience" but how representative is this? Is this sufficient?

Future Research Questions

The following provisional account of future issues and questions arises from the Principal Investigator's perspective upon the discussions generated by the project's activities. There is no one-to-one correspondence with the thematic categories provided in the summary of forum debates.

As a general point, it seems desirable to expand research beyond "transcultural psychiatry" into the wider area of "cultural mental health". This recognizes the diversity of health professionals (and non-professionals) involved in mental health care, as well as the

service user perspective. It is a conceptual move in harmony with the wider aspiration towards "health humanities" rather than physician-centred "medical humanities". The modulation of "transcultural" to "cultural" may also help to motivate a shift away from a post-colonial, migration-focussed ideological dominant.

Four specific foci for transformative humanities-informed research on "cultural mental health" may be as follows:

1. *How can the field be advanced by further dialogue with advanced humanities and social science perspectives on culture and identity?* There would seem to be a need to shatter the prototypical and still somewhat reified model of "culture" within the field, where it is too closely imbricated with a post-colonial and / or globalizing paradigm of nation, ethnicity, and religion. Greater recognition and investigation is required of distinct axes of cultural variation and creation – such as gender, sexual identity, cultural capital, (popular) subculture, professional culture, and so forth. The limits of explanation in terms of cultural difference (in isolation from political, social, and historical factors) need also to be more fully interrogated. Furthermore, the "gestalt switch" whereby putative mental health pathology becomes the cultural ground for a new identity – as with voice hearing – requires much greater investigation.

2. *What are the global political and ethical issues that permeate cultural mental health*? There are anxieties about the neo-colonial potential of the well-intentioned "upscaling" model that has been promoted within the global mental health movement. Furthermore, there are real and / or purported counterflows to the expertise exported by high-income countries. Such counterflows make claim to an interrogation from the perspective of the Other, whether this be, for instance, through Buddhist wisdom traditions, or through an articulation of less explicit practices, such as child-rearing. Cultural mental health is a fruitful focus for wider debates about the significance of developments in global health, and their potential to repeat the errors of colonization within a trans- or supra-national paradigm in which "objective" professional expertise authorizes collective action.

3. *What are nature and validity of the disciplinary border traffic and disputes in cultural mental health*? Cultural mental health frequently encounters tensions with the more universalist tendencies of biomedical science, but it also enters into uneasy relationships with other fields that claim a dignity and autonomy beyond mere "cultural difference". Religion is one such area, and there may be others. As well as investigating such "turf wars", it will also be fruitful to consider cross-border traffic, whether legitimate or contraband – as, for instance, in the impact of psy disciplinary expertise upon religion. A further aspect of such "border crossings" appears when cultural mental health discourses enter the public sphere. They risk appearing as a locus for scientistic cultural authority, but not all such expansions result in scientism. What are the ingredients for success, as with, for instance, Franz Fanon's work?

4. *How should care be modified in light of such interrogations of the field of cultural mental health*? Even to think of this dialogue with practice as a matter of "clinical" impact may be overly presumptive, since it neglects more diffuse, less professionalized modes of care. Nonetheless, lingering biomedical presuppositions do appear to be an obstacle to fuller knowledge exchange on this issue. Psychiatric responses such as a descriptive "cultural formulation" in addition to other axes of clinical assessment would seem to neglect the active engagement of service users and others, who may acquire and transform culture materials, as much as they are formed by them. How might a genuine dialogue be facilitated with all stakeholders in cultural mental health, and what might its results be?

The concrete implementation of questions such as these, with the use of appropriate disciplinary methodologies and objects, is consciously deferred to a future programme of investigation.

Appendix 1: Technical Implementation

The Transcultural Psychiatry site was built using the WordPress blogging software, installed on a typical Apache web server running PHP and MySQL. A modified version of a pre-existing Glasgow University theme was used to style the site, with modifications required to override some conflicting CSS rules inherited from the University's content management system, and to ensure that the forums and links to other sites were properly displayed. A number of plug-ins were used to augment the site, including "Akismet" and "Select Really Simple CAPTCHA" to reduce spam comments, "Contact Form 7" to facilitate enquiries from visitors, "Jetpack" to provide visitor statistics and other enhancements, and the "Members" plug-in to provide more granular access to site features.

The site also makes use of the bbPress plug-in to power the discussion forums. While this forum solution was chosen due to its official affiliation with the WordPress project, it did prove to be somewhat basic in its implementation. A lack of certain features necessitated the installation of additional plug-ins to meet our needs: the aforementioned "Members", which allowed for custom email alerts when forum posts were made, and the "Simple Local Avatars" to allow straightforward customization of forum users' on-screen avatars.

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Appendix 2: Reflections on the Online Forum as Research Tool

The central methodological innovation in the project was the implementation of an online forum (as described in Appendix 1) as a means for asynchronous discussion between the widely distributed collaborators. What follows are the Principal Investigator's necessarily selective account of the procedure, and of opinions (including his own) taken from the project's collaborators.

Following the Launch Workshop, collaborators were registered on the project blog and forum as contributing authors. Although the forum included a public side, collaborators were directed to contribute to the private side of the forum. The decision to make the discussions *sub rosa* was taken by the Principal Investigator, who was concerned that the collaborators – particularly the clinicians – should feel that they were in an environment where they could communicate frankly. The private forum contained ten subforums, primarily inviting responses to selected reading, and on a number of thematic topics. There were also subforums for significant weblinks, further reading, and collaborators' own work-in-progress. A total of around 22 000 words of contributions were received in the four months of forum activity from mid-April to mid-August 2012.

The most notable feature of the online conversations was that commentaries on the selected reading tended to generate most activity. Collaborators indicated that more specific questions or tasks were easier to respond to than more open thematic questions. Future online forums may work better with more specific questions generated by the Principal Investigator. Alternatively, if the aim of the project is to generate questions as much as to respond to them, then it may be possible to allocate a thematic area to each collaborator, and thus to delegate the responsibility for generating specific questions.

A further feature of the forum was that contributions tended towards a non-conversational tone. Lengthy postings of several paragraphs dominated. A variety of reasons were given, including academic habit when working in written discourse, and the preference to set aside a substantial block of time for forum engagement (rather than "a little and often"). The representation of conversations in the forum may also have contributed to the more formal tone of the discussions. The linear conversation structure meant that each new addition appeared to be responding to the one directly preceding, although in fact the collaborator may have intended to address an earlier contribution. Some collaborators adopted the expedient of using the address "To So-and-So" in order to reply to a contribution further up a thread. Forum software that allowed each contribution to be a node with more than two connections (something like a "mind map") would have been helpful.

Some collaborators also expressed the view that the asynchronous online debates could have been complemented not only by face-to-face workshops but also by regularly scheduled synchronous on-line meetings using the kind of online seminar room implemented in many Virtual Learning Environments.

A final consideration is that there appears to be no single national-level resource to guide academics in the humanities and social sciences who wish to use new technologies in the way that this project has. Some central point of co-ordination would be desirable. It might contain, at the very least, a repository of contributed reflections (such as this one) upon technologically novel methodologies for research collaboration in the humanities and social sciences.

References

Ahmed, S. (2010). *The Promise of Happiness*. Durham, NC: Duke University Press.

Bains, J. (2005). Race, culture and psychiatry: a history of transcultural psychiatry. *History of Psychiatry, 16*(2), 139-154.

Carrette, J., & King, R. (2005). *Selling Spirituality: the silent takeover of religion*. London: Routledge.

Crozier, I. (2012). Making Up Koro: Multiplicity, Psychiatry, Culture, and Penis-Shrinking Anxieties. *Journal of the History of Medicine and Allied Sciences, 67*(1), 36-70.

Mezzich, J. E., Caracci, G., Fabrega, H., & Kirmayer, L. J. (2009). Cultural Formulation Guidelines. *Transcultural Psychiatry, 46*(3), 383-405.

Rashed, M. A. (2010). Religious Experience and Psychiatry: Analysis of the Conflict and Proposal for a Way Forward. *Philosophy, Psychiatry & Psychology, 17*(3), 185-204.

Timimi, S. (2010). The McDonaldization of Childhood: Children's Mental Health in Neo-liberal Market Cultures. *Transcultural Psychiatry, 47*(5), 686-706.

Watters, E. (2011). *Crazy Like Us*. London: Constable & Robinson.