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***Editorial***

# The 'New Cross-Cultural Psychiatry'
## A Case of the Baby and the Bathwater

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Epistemology has been one of the buzz words of the 1980s. The *Oxford English Dictionary* defines it as "the theory or science of the method or grounds of knowledge". As Dr Roland Littlewood explains in his review article in this issue, the epistemological approach to psychiatry is a major component of the new cross-cultural psychiatry. It generates a view of psychiatry as a cultural product of Western societies in the same way as are the diatonic scale and Coca-Cola. These products can be exported all over the world and may be appreciated by the local populace, but are no more valid than indigenous music or beverages. This view of psychiatry strikes at the heart of its claim to be a branch of medicine, which has provided ample evidence of the universality of its disease categories. Let us consider the example of smallpox. This disease, which used to occur world-wide, was recognised locally and incorporated into indigenous belief systems. Thus, the Yoruba of Nigeria believed that smallpox emanated from the goddess *Shopanna*, while in North India it was ascribed to the goddess *Sheetla*, and the corpses of victims were cast into the holy Ganges instead of being cremated. In the 18th century, the folk belief in Gloucestershire about smallpox was that it would not affect milkmaids who had developed cowpox. Jenner examined this indigenous belief, considered it to be correct, and instituted the practice of vaccination, which has now totally eradicated smallpox from humankind. Had Yoruba or North Indian practices been exported to other countries, smallpox would have remained a major cause of death and disfigurement.

The domination of the Third World by Western biomedicine is primarily due to its manifest success in treating diseases like smallpox. Different systems of medicine compete together in an open market throughout the world. Although Western methods of promoting pharmaceutical products give biomedicine an edge, all available systems are utilised by clients, who gravitate towards the one which shows evident superiority in relieving the suffering and morbidity produced by any particular disease. Thus alternative systems to biomedicine flourish in the West for conditions which biomedicine is relatively ineffective in treating, namely musculoskeletal and psychiatric disorders (Leff, 1988). As an example from psychiatry, not only is the outcome for schizophrenia superior in Third-World compared with Western countries (World Health Organization, 1979; Sartorius *et al*, 1986), but the better prognosis does not appear to rest on the use of maintenance neuroleptic drugs (Leff *et al*, this issue, pp. 351–356).

The other major obstacle that psychiatry faces in claiming to share medicine's universal applicability is the lack of any demonstrable pathology which is culture-free and which can be used to define disease entities. As a result, the boundaries of psychiatric conditions are constantly shifting, much more often in response to socio-political pressures than to the accumulation of scientific evidence. A striking example is the majority vote of the American Psychiatric Association to exclude homosexuality from DSM–III.

In the 1970s, the remedy for the bewildering multiplicity of diagnostic systems appeared to be the use of structured interviews, such as the Present State Examination, to ascertain the basic phenomena of psychiatric pathology. This held out the promise that a less rickety superstructure of diagnosis could be built on this solid foundation. Indeed, the series of international collaborative studies conducted by the World Health Organization was developed on this premise. However, this approach has come under heavy criticism from advocates of the 'new cross-cultural psychiatry' for imposing Western concepts of psychopathology on non-Western peoples. This is seen by the more politically minded critics as psychiatric imperialism, enforced by the power of the economic and technological resources of the West.

An extreme reaction of some critics has been to advocate the abandonment of diagnosis or even "the notion of 'pathology'" (Littlewood, this issue). When this is linked with the suggestion "that psychosis may generate alternative world views which may at times become generally accepted" (Littlewood, 1984), we seem to hear reverberations down the decades of the anti-psychiatry movement of the '60s and of Laing's assertion that schizophrenia is not a break-down but a break-through.



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There is, however, a less nihilistic solution, although it is one that involves a daunting amount of work. This approach ascribes equal value to folk beliefs about mental illness and its categorisation as to the Western biomedical system of psychiatry. It necessitates the study of people who are considered to be mentally ill by the local population, most of whom would be treated by traditional healers in the first instance. The healers themselves need to be interviewed to ascertain the diagnostic systems they use, which may well vary considerably from one healer to another. Through these means, a native lexicon of disease terms and the patterns of behaviour to which they refer can be constructed. Ideally, this work should not be done by someone with a Western psychiatric training, whose perceptions of abnormality will already have been determined. An anthropologist who is familiar with the local culture would be a possible choice.

The resource demands of this endeavour are such that it has been attempted in only a handful of cultures; in particular, the Serer people of Senegal (Beiser *et al*, 1972) and rural Iranians (Good & Good, 1982). Yet again, we are faced with the paradox that has bedevilled cross-cultural psychiatry throughout its history. The societies that are culturally most different from the West, and hence of greatest interest, are those with the least resources available to carry out the necessary research themselves. Historically, they have been 'exploited' by Western research workers, who are often blinkered by their own unconscious cultural assumptions. To advocate waiting until such societies become wealthy enough to invest in research themselves would almost certainly mean losing the opportunity to study a traditional culture before it changes irrevocably under the onslaught of Western technology. Genuinely collaborative studies are therefore needed between Western research workers, who can provide the resources, and indigenous personnel, whose understanding of the local culture is essential to the success of the enterprise.

Is it necessary for such demanding exploratory work to be done before *any* cross-cultural psychiatric research can be attempted? If so, then most of the cross-cultural papers appearing in this issue are invalid! If this argument is used to reject research that has already been completed, representing as it does a vast investment of time and energy, there is a grave danger of throwing out the baby with the bathwater. A compromise has to be reached which takes due account of the practical difficulties of conducting psychiatric research.

Criteria need to be established for two purposes: firstly, to judge which previous comparative cross-

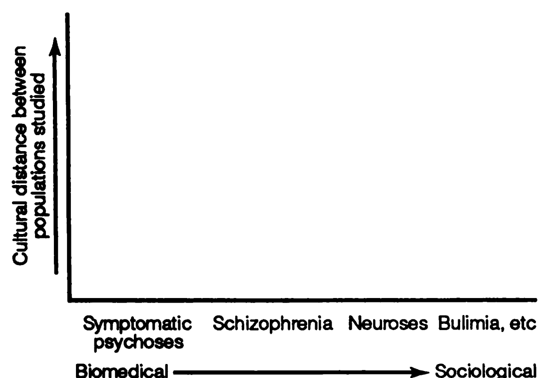


FIG. 1 Criteria for judging cross-cultural studies.

cultural studies can be given reasonable credence; and secondly, to enable research workers to decide whether or not to explore indigenous belief systems before embarking on comparative studies. Littlewood's review has provided a partial basis for such judgements in the form of a spectrum (his Fig. 1, p. 318) extending from the symptomatic psychoses at one end, through schizophrenia and the neuroses, to conditions such as bulimia, school refusal, and overdoses at the other. A theoretical bipolar dimension underlies this spectrum, with the biomedical paradigm at one pole and the sociological paradigm at the other. There is an implicit assumption that culture exerts a stronger influence at the sociological than at the biomedical pole.

In order to provide the criteria we are advocating, a second dimension has to be added, namely the cultural distance between the populations being compared. In a study of patients in London and Salford, it is unlikely that differences between folk concepts of mental illness need to be taken into account, *as long as minority ethnic groups are excluded* – their cultural distance from the indigenous population demands the preliminary ground work described above.

If the two dimensions selected are represented graphically (Fig. 1), then studies falling in the upper-right quadrant certainly require an investigation of folk categories of mental illness before cross-cultural comparisons can be considered valid. Given the nature of the dimensions and the problems of measurement, these criteria can only constitute a rough and ready guide. However they should help to prevent uninterpretable data being collected in the future, while distinguishing what is to be valued in past cross-cultural research from what should probably share the fate of bathwater.

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### References

Beiser, M., Ravel, J-L., Collomb, H., *et al* (1972) Assessing psychiatric disorder among the Serer of Senegal. *Journal of Nervous and Mental Diseases*, **154**, 141–151.

Good, B. J. & Good, M-J. D. (1982) Towards a meaning-centred analysis of popular illness categories: 'fright-illness' and 'heart distress' in Iran. In *Cultural Conceptions of Mental Illness and Therapy* (eds A. J. Marsella & G. M. White). Dordrecht: Reidel.

Leff, J. (1988) *Psychiatry Around the Globe* (2nd edn). London: Gaskell.

Littlewood, R. (1984) The imitation of madness: the influence of psychopathology upon culture. *Social Science and Medicine*, **19**, 705–715.

Sartorius, N., Jablensky, A., Korten, G., *et al* (1986) Early manifestations and first-contact incidence of schizophrenia in different cultures. *Psychological Medicine*, **16**, 909–928.

World Health Organization (1979) *Schizophrenia: An International Follow-up Study*. Chichester: John Wiley and Sons.

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