All sciences are equal, but some sciences are more equal than others

Oloyede revisited

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In zijn commentaar op Oloyede's betoog pleit de auteur voor een meer cultuur-sensitieve psychiatrie. Antropologische studie van de psychiatrie-cultuur zou hier een bijdrage toe kunnen leveren. Drie thema's worden met name besproken: de verschillende doelstellingen van de twee disciplines, trans-culturele onderzoeksinstrumenten, en het ontbreken van een 'gouden standaard' in de psychiatrie.

[cultuur-sensitieve psychiatrie, gouden standaard, cultureel relativisme, cultural critique]

In his rich theoretical overview on mental illness and culture Oloyede (this volume) does not only discuss the relationship between culture and illness. In fact, his main argument deals more with the complex and often tense relationship between two scientific disciplines: anthropology and medicine with a particular emphasis on the relationship between medical anthropology and psychiatry. In his essay he criticizes the limited biomedical and universalistic view held by many psychiatrists. Students sent into the field in South Africa felt very much ill at ease with the psychiatrist who supplied the students with questionnaires. The discomfort these students experienced inspired the author to write his theoretical paper in which he tried to depict the theoretical background of their intellectual (and undoubtedly emotional) discomfort.

They experience difficulties in applying questionnaires with 'universal labels' like 'headache' that, according to their knowledge is in fact not universal at all since when translated into Xhosa the term 'headache' carries multiple meanings that are very different from the Western concept.[1]

The theoretical analysis Oloyede conducts in order to explain these students' discomfort is rich in content, but his conclusion is rather disappointing. It is not unsatisfactory in the sense that there is no truth to his final statements in which he urges psychiatrists "to understand the meaning of the said behaviour within the cultural setting in which it occurs'. By acknowledging the fact, as Oloyede does, that an illness can only be understood within the cultural context in which it is produced (language, belief system, social roles, culture-specific behaviour, etc.), the author offers us an 'emic' or

'experience-near' (Hollan 2001) solution. Few anthropologists would object to this conclusion. Oloyede points out very clearly, and I agree with him, why the cultural context of illness is essential. The unsatisfactory part of his analysis is that (medical) anthropologists have been giving these kinds of answers to doctors for a long time now. Even before medical anthropology established itself as a scientific discipline, eminent anthropologists like Malinowski, Boas, Benedict and Mead already emphasized that mental illnesses are culture specific and can be understood only from within the cultural context itself (Laungani 2002). Why is it that psychiatrists, like the one in South Africa, still seem to ignore the lessons taught by anthropologists in the past? Do they not read ethnographic texts, or are they intellectually deaf or blind? Anyhow, supplying psychiatry with an additional anthropological understanding of mental illness (contextual, relativistic and particularistic) seems insufficient to convince them, at least not sufficient enough to influence their 'universalistic' practices.

There are three aspects, all of them briefly touched by Oloyede in his paper that I would like to expand on:

– The different objectives of the two disciplines;
– The problem of cross-cultural research with questionnaires;
– The missing 'gold standard' in psychiatry or 'do witches exist?'

I will discuss these three issues with the same goal that Oloyede undoubtedly had in mind: looking for ways to find a more fruitful cooperation between medical professionals and anthropologists.

Differences of interest between the two disciplines

Is it not about time that we, as medical anthropologists, stop portraying doctors as an enemy we have to fight or whose shortcomings we must at least expose? For a long time now we have often used physicians as an out-group in order to establish or expand our own in-group identity. We ought to be able to conclude that medical anthropology is a mature and well-established discipline and that we have passed the developmental stage of puberty. We do not need to criticize the medical profession anymore in order to gain some self-esteem. This will free our mind and allow us to devote more attention towards studying the medical profession: their goals, habits and needs, or in short, their professional culture. By constantly showing doctors what they do wrong or miss we are still busier with ourselves than with them. It leads to characterizations of the medical profession that are far beyond reality.

What is needed is to grasp the 'native's point of view' held by psychiatrists. Psychiatrists are far from 'bio-medically driven'. With the exception of a few highly productive scientific authors, most psychiatrists are working with their patients from a bio-psycho-social perspective. In fact, certain aspects of their work very closely resemble the encounter between an ethnographer and his key informants. Psychiatrists pay attention to the experience-near aspects of illnesses and try to come to an understanding of the 'whole' as far as their allocated time permits them to do so. Describing and analys-

ing the psychiatrist's 'native point of view' far exceeds the space limits of this comment on Oloyede's paper. Thus, I restrict myself here to one aspect that explains much of the miscommunication between anthropology and medicine in general, as well as between medical anthropology and psychiatry in particular.

Psychiatrists, like most doctors, are programmed (or better: enculturated) during their academic training to become healers. Their primary goal is to cure people. That is why they received their training, that is what people expect them to do and that is what they get paid for. It is their primary and fundamental social role; it is needless to say that this is the major factor that determines their thinking and actions.

Psychiatrists have to rely on the medical knowledge they received during their medical training and afterwards. This (Western-based) knowledge system is all they have, and in a cross-cultural context they still must rely on this system. Culture can be seen as an object of research or as a disturbing factor. Given their primary goal (to act, that is to try to cure, and not to investigate culture) they stick to their acquired knowledge since this knowledge gives them a hypothesis on which they can act (prescribe a treatment) in the doctor-patient encounter. It appears then that they act on a 'universalistic' basis, but in fact it is more of an 'ethnocentric' reasoning since this perspective is all they have got. Choosing a relativistic position would mean that most of their diagnostic thinking and therapeutic acting would no longer be rational and applicable. Such a choice would paralyse them.

On the other hand, the ethnographer does not see culture as a distortion but as an object of research. The ethnographer has a very different *raison d'etre*. He or she is encouraged to look for unique patterns of behaviour and thinking. Ethnographers receive credit for 'discovering' a new culture-bound syndrome.

In my opinion, dichotomies like universalism versus particularism reflect this conflict of interests between medical professionals and anthropologists. Recognizing this means a start for a better cooperation, an example of which is the 'cultural formulation' presented for the first time by the American Psychiatric Association in 1994. It gives the psychiatrist a practical instrument to explore the patient's cultural background as far as needed for a more culturally-sensitive diagnosis and treatment. These kind of initiatives in which anthropologists and psychiatrists work closely together would prove more fruitful than a continuous criticism of psychiatrists.

Cross-cultural research instruments

Oloyede stresses the fact that anthropology is a Janus-faced discipline, facing both human universals and cultural particulars. Psychiatry is a Janus-like discipline as well: 'the psychiatrist as a scientist' and 'the psychiatrist as a medical practitioner' are two distinct entities united in the same discipline and often within the same person as well. The discomfort felt by the students in the field in South Africa is more a negative reaction felt towards the psychiatrist as a scientist. They mainly criticise the research method used (indeed 'psychiatric scientists' use mostly quantitative research methods) and is in fact a discomfort felt towards other disciplines as well that use quantitative

methodologies. Quantitative research techniques reduce (social) reality into variables, dependent and independent, and try to decontextualise these variables from the sacred 'whole'. This is considered a sin for many anthropologists. I already mentioned that 'the psychiatrist as medical practitioner' uses a strong contextual view and methodology (bio-psycho-social) in his or her practice. On the other hand, the 'psychiatrist as a scientist or researcher' sticks very closely to quantitative measures and procedures that are no longer considered appropriate in anthropology. It is obvious that using ethnocentric Western-based questionnaires causes a lot of bias and leads to serious misrepresentations and misinterpretations (cf. Kortmann 1990). Not surprisingly, translating 'headache' into Xhosa will cause a lot of trouble. Another example is using Western-based questionnaires with questions like "do you get a lot of penalties for exceeding speed limits while driving in your car?" A positive answer indicates anti-social personality disorder. Additionally, this would be a question difficult to ask to Peruvian Indians not owning a car at all (Flaherty et al. 1988). However, should we refrain from using qualitative research methods because of these problems? I think they could be useful in a universalistic and comparative analysis. Here again a lot of fruitful cooperative work could be done, and has been done already, in looking for productive solutions without pressing psychiatrists to fundamentally change their perspective. The authors of the aforementioned informative and helpful publications are good examples. They made very clear what kind of problems researchers face in trying to apply instruments cross-culturally. Five kinds of equivalences should be considered in trying to overcome the fundamental methodological problems in using psychiatric questionnaires cross-culturally. They tried to adapt the questionnaire in a way that is acceptable even for particularistic anthropologists because they take into account local and context-bound issues.

The missing 'gold standard'

Oloyede poses a very important question about diagnostic concepts and their transcultural applicability. He asks "Y would it [Y] not be the case that the universality of psychiatric disorder is problematic" and "when are two conditions found in different cultural settings equivalent?" (Oloyede, this volume).

Oloyede's solution is the position taken by Peter Winch (based on Wittgenstein, in his later period) in the 'rationality debate'. The truth cannot be obtained in general but only within the culture-specific language game (Ulin 1984) or the language-specific meaningful *form of life* (Van Binsbergen 1999).

Again, choosing this solution would mean that Western trained doctors become powerless and useless practitioners within non-western language games or forms of life. Let's examine this issue more closely.

Within the area of somatic medicine there are lot diseases with a known aetiology, pathogen and pathophysiologic substrate. Even Oloyede implicitly admits this. He states the following when explaining some Ndembu diagnostic categories: "Y for example, *mbuba yaluzong'a*, a disease that cause people to lose their toes and fingers

(most likely leprosy in the biomedical classification), *kaseli kamashi*, a disease with bloody urine (most likely schistosomiasis), and *musong'u wachingongu*, a disease that leaves pockmarks (most likely smallpox)" (this volume). By explaining in parenthesis the probable biomedical diagnoses, we can infer that Oloyede admits that we are talking about the same disease/illness. This point is essential because stating that *mbuba yaluzong'a* is most likely leprosy makes it possible to compare leprosy among the Ndembu with leprosy among, for instance, a Papuan tribe. As soon as we have a basic agreement that we are investigating the same phenomenon that could have very different cultural expressions, we are able to make comparisons. As soon as a doctor knows the illness is leprosy or schistosomiasis, additional cultural information could be helpful in developing an appropriate treatment strategy. There is ample space for anthropologists to investigate the sociocultural contributions towards aetiology, the possibly culture-specific expression of symptoms and the culturally appropriate illness-behaviour and treatments.

For psychiatrists, however, the issue is far more complex. Contrary to their somatic colleagues, they have to do without the usual 'gold standard'. A 'gold standard' indicates a description of "any method of evaluation based on a known disease pathophysiology that is also known to be an excellent indicator of true disease status" (Faraone & Tsuang 1994: 652). Of course we could even question the true disease status of leprosy of schistosomiasis, like some South African politicians questioned the disease status of HIV-infected patients, but let us assume for the moment that leprosy and schistosomiasis are actual diseases. Based on certain symptoms, doctors assume that a patient is suffering from leprosy or schistosomiasis. In both diseases, the gold standard that confirms the diagnosis of the doctor is a laboratory test using a microscope. The presence of micro-organisms of a certain kind reveal whether the doctor was right or wrong. However, notwithstanding the progress in brain imaging-techniques and all the scientific work of psychiatrists and neuroscientists, there is no 'gold standard' for any psychiatric disease. In other words, within the spectrum of diseases that are usually associated with the discipline of psychiatry, like 'depression' or 'schizophrenia', there is not a single disease that is observable as such: All psychiatric syndromes are 'latent', not directly assessable and observable. This means that psychiatric diagnostic categories are based on diagnostic agreement between psychiatrists: "let us call a person with these and those symptoms as a person suffering from depression". Depression itself remains hidden. This makes it almost impossible to look for depression in cultures other than that to which those psychiatrists belong that constructed a diagnostic agreement. It means that psychiatry, in terms of diagnosis, is in a state of the art that is comparable to the situation some 500 years ago when clinicians tried to diagnose diabetes mellitus by tasting the urine. In a situation like this, it becomes clear that culture within the medical profession has a profound influence on the formation of disease concepts and theories. Even more profound than in the theory formation and construction of disease concepts in somatic medicine on diseases with a well-known organic etiology. As anthropologists, we are used to describing and analysing emic concepts of disease, and when considering psychiatrists as the main focus of research we could be very helpful to psychiatrists in analysing their native point of

view in this respect. Psychiatrists tend to reify their diagnostic constructs and even impose those constructs on patients in other cultures, making it even more complex. Studies like those by Allan Young on post-traumatic stress disorder (1996) and by Mary Boyle (2002) who deconstructs the concept of schizophrenia and states seriously that for purely rationalistic and scientific reasons the concept 'schizophrenia' should be abandoned immediately, are much needed in order to clarify the influence of tradition and culture within the psychiatric discipline itself.

Concluding remark

Instead of mainly urging psychiatrists to become (partly) ethnologists and try to grasp the full meaning of the culture in which their patients participate, anthropologists should offer different advice. Doctors are not trained to conduct ethnographies, nor do they have sufficient time to do so. Even anthropologists become experts in one or at most two different cultures. My main argument is that anthropologists should try to understand the basic characteristics of the psychiatric discipline and what their needs are, in order to offer concrete solutions to them that are realistic and applicable. Only in this way can anthropologists make a real and fundamental contribution towards culturally-sensitive and culturally-competent mental health care. Changing the emphasis from criticism, which is easy, towards offering realistic alternatives, which is difficult, would probably cure psychiatrists in the sense that they may begin to read anthropological material and that their deafness and blindness appears not to be a disease with a concrete anatomical lesion but a hysterical blindness and deafness in the Freudian sense of the term.

Notes

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1 Undoubtedly there is more than just *one* Western meaning of 'headache' as well.

References

Boyle, Mary
2002 *Schizophrenia: A scientific delusion?* Hove: Routledge. 2nd edition.

Faraone, S.V. & M.T. Tsuang
1994 Measuring diagnostic accuracy in the absence of a 'gold standard'. *American Journal of Psychiatry* 151 (5): 650-57.

Flaherty, J.A., et al.
1988 Developing instruments for cross-cultural psychiatric research. *Journal of Nervous and Mental Disease* 176 (5): 257-63.

Hollan, Douglas
2001 Developments in person-centered ethnography. *In*: H.F. Mathews (ed.), *The psychology of cultural experience*. Cambridge: Cambridge University Press, pp. 48-67.

Kortmann, Frank
1990 Psychiatric case finding in Ethiopia: Shortcomings of the self reporting questionnaire. *Culture, Medicine & Psychiatry* 14 (3): 381-91.

Laungani, Pittu
2002 Understanding mental illness across cultures. *In*: S. Palmer (ed.), *Multicultural counselling: A reader*. London: Sage, pp. 129-56.

Oloyede, Olayide
2002 *Mental illness* in culture, *culture* in mental illness: An anthropological view from South Africa. *Medische Antropologie* 14 (2): 248-71.

Ulin, Robert C.
1984 *Understanding cultures: Perspectives in anthropology and social theory*. Austin: University of Texas Press.

Van Binsbergen, Wim
1999 *Culturen bestaan niet: Het onderzoek van interculturaliteit als een openbreken van vanzelfsprekendheden*. Rotterdam: Erasmus Universiteit.

Young, Allan
1996 *The harmony of illusions: Inventing post-traumatic stress disorder*. Princeton: Princeton University Press.