Race, culture and psychiatry: a history of transcultural psychiatry
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History of Psychiatry 2005; 16; 139
DOI: 10.1177/0957154X05046167

The online version of this article can be found at:
http://hpy.sagepub.com/cgi/content/abstract/16/2/139
The term 'transcultural psychiatry' has encompassed changing notions of race, culture and psychiatry and, as a result, it is a difficult concept to define. For a long time psychiatrists and social scientists have been commenting on how the psyches and psychiatric illnesses differ in non-White populations. However, transcultural psychiatry was not created as a distinct discipline until after World War II. This article will attempt to tell the story of transcultural psychiatry, charting its genesis in the aftermath of World War II, and then go on to describe how it has taken different forms in response to developments within psychiatry and wider sociocultural changes.

**Keywords**: cross-cultural; history; psychiatry; race; transcultural

In April 1956 the Department of Psychiatry and the Department of Anthropology at McGill University, Canada, under the guidance of Eric Wittkower, jointly published the newsletter *Transcultural Research in Mental Health Problems* (Editorial, 1956), marking the beginnings of a new field within psychiatry. I will now introduce the key characters involved in the creation of this new discipline and examine their lives in the sociopolitical context of their time.

**Post-war optimism**

With the death of Eric Wittkower on 6 January 1983, the first formative phase in the development of transcultural psychiatry as a distinct, interconnected, and interdisciplinary field can be said to have come to a close. (Murphy, 1983).

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Wittkower was a key figure in early transcultural psychiatry and he was representative of the discipline. He was born in Berlin in 1899, the son of Jewish parents from whom he inherited British and German citizenship and consequently, during World War I, he was mistrusted by his German comrades for having British nationality. Following the war he studied medicine. Wittkower witnessed the rise of Nazism and because of this he moved to Switzerland in 1933. Later he moved to England where he received his formal psychiatric training at the Maudsley Hospital and also worked at the Tavistock Clinic (a clinic that fostered an approach to psychiatry which embraced both the mainstream biological perspective and Freudian psychodynamic psychology) (Dicks, 1970). His adherence to psychodynamic psychology would facilitate the creation of transcultural psychiatry.

While at the Tavistock Clinic he came into contact with J. R. Rees, a psychiatrist who had spent much of his career working with the British military (Rees would be instrumental in establishing the World Federation of Mental Health) (Rees, 1945). Rees was also a keen Freudian who thought that conflict was the main cause of mental breakdown and ‘the experiences of life, derived from environment and human contacts, [were] responsible for the warpings and distortions of personality’ (Rees, 1929). Both Wittkower and Rees entered World War II as psychiatrists; this time Wittkower served with the British and was mistrusted for having German citizenship. Wittkower (1949) took the opportunity to study the impact of stress on the different personality types that he saw around him. Rees (1945) saw that the war-time experiences of soldiers could result in them breaking down and falling victim to battle neurosis. While Wittkower and Rees were busy with the war, Ewan Cameron – a psychiatrist whom Wittkower was soon to meet – was studying the adverse effects of stress and ‘wartime pressure’ on Canadian workers. The increased stress, which was caused by the need for greater efficiency, was leading to mental distress in susceptible individuals (Cameron, 1944). Wittkower, Rees and Cameron were interested in the effects of environment on the individual, albeit in very different contexts. Wittkower’s life reflected many themes that would be of relevance to early transcultural psychiatry. He was a member of British and German cultures, had emigrated, had seen the distorting effects of environment on personality, and he used psychodynamic psychology to explain the phenomena that he had observed.

The end of the war heralded a period of great optimism, an optimism that is evident in the ambitions of the practitioners of the social sciences. The war-time experiences of psychiatrists, such as Wittkower and Rees, and other social scientists had led them to believe that much of the mental illness which they encountered in individuals, communities and nations was related to the wider sociocultural environment, and might yield to concerted multidisciplinary action (Mead, 1959). As a consequence, psychiatry was proving to be a ‘social science as well as a medical science’ (Menninger, 1948: 93–4) and ‘almost too popular’ (Henderson, 1950). There was a new global approach
to the world’s mental health problems, and psychiatrists occupied some of the key administrative positions.

The ambitions of this global approach to mental health were summarized by the influential anthropologist Margaret Mead. Firstly, it would be a framework within which cross-cultural comparisons could be made. Secondly, it would offer a forum within which the knowledge gained in one part of the world could be made available to other parts of the world. Thirdly, it would provide an overarching institutional framework within which the mental health aspects of various international programmes could be integrated and harmonized. Fourthly, it would allow global mental health problems to be considered at a global level, bringing together relevant authorities from around the world (Opler, 1959). Some of the areas of particular concern for these professionals were the supposed causes of what had ‘given this second half of the 20th century an air of unrest and crisis’; these were issues such as rapid sociocultural change (particularly in the more rapidly developing countries), migration and the problems of refugees (Editorial, 1956).

An example of their work was the Mental Health Society of Holland persuading the relevant authorities to evacuate children from rural areas to other rural areas in order minimize their sense of dislocation during the floods in Holland in 1953 (Opler, 1959). Similarly, following the devastating earthquake in Greece (1953-54), mental health workers applied their appreciation of the importance of discussion and participation with those affected, resulting in a relief programme that addressed their basic needs, for example, for tools and materials to manage their threatened crops (Opler, 1959). The aims of these post-war social scientists were infused with the optimism of the era and were global in perspective.

The world was recovering from a war that had revealed to psychiatrists the effect of stress on personality types. Psychiatrists and social scientists believed that their insights into how culture/environment interacts with personality and mental illness could be utilized to solve major problems, in essence the problems caused by World War II, such as migration, rapid sociocultural change and tensions between nations.

**Culture and the individual**

In the latter half of the nineteenth century scientists talked of the temperament, ideas and beliefs of peoples. This general notion became known as culture, and the field of cultural anthropology was made possible. The character of this culture was influenced by the prevailing paradigm of Darwinian theory. ‘Cultural evolutionism’ held that ‘primitive’ people and ‘advanced’ Westerners possess the same singular culture, but the culture of advanced Westerners was at higher level of evolutionary development. Cultural evolutionism was replaced in the early twentieth century by a fundamentally different form of culture. The anthropologist Franz Boas advocated this new
culture and, whereas ‘cultural Darwinism’ was singular, absolutist and progressive, the culture of Boas was pluralist and relativist. Boas’s culture could affect its members by shaping their perception of the world and hence their behaviour. The numerous disciples of Boas – these included Ruth Benedict, author of *Patterns of Culture* (1934), and Margaret Mead – promoted this relativist culture. By the 1930s Boasian culture was the most generally accepted concept of culture among biologists, social scientists and the public (Stocking, 1982).

In the early twentieth century this concept of culture brought the disciplines of anthropology and psychiatry intellectually closer. Boasian culture could affect personality and behaviour by emphasizing different aspects of personality, for example by encouraging aggressiveness or repressing sexuality (Mead, 1974). From this position it was a relatively small mental leap to ask whether culture could cause mental illness. The success of Freud’s psychological theories bought the disciplines of anthropology and psychiatry even closer. Culture, when it caused intrapsychic conflict, could via the ‘mechanism’ of primitive psychological defences (such as transference and projection) alter individual human thought and behaviour and result in psychological disturbances or mental illness. Both psychiatry and anthropology could use its theories to explain nature.

As Europe approached World War II, anthropologists were calling for the disciplines of anthropology and psychiatry to form a union that would be the basis of a complete science of human behaviour. For the anthropologist Edward Sapir, the role of the psychiatrist was to explain how the cause of culture, the individual, could through interaction with other individuals create a culture (Mandelbaum, 1949). Anthropology, on the other hand, could assist the psychiatrist by defining the norm within a given culture, and hence help to delineate the deviant behaviour of the mentally ill. With the link of psychoanalysis, the two subjects had a common ally.

Following World War II Wittkower joined Cameron – who was the Departmental Chairman in Psychiatry – at McGill University. Cameron (1944: 170) summarized the mood of the time:

> I think it is reasonable to say that all those groups who before the war had been concerned with various aspects of human behaviour at once started out to see what they could contribute. Prominent among those groups were the social workers, the psychiatrists, the psychologists.

Wittkower went on to make contact with the Department of Anthropology (for the reasons discussed earlier), and their collaboration resulted in the creation of a newsletter: *Transcultural Research in Mental Health Problems* with Wittkower and the Assistant Professor of Anthropology, Jacob Fried, as its editors. The newsletter was first published in April 1956 and in 1963 became the *Transcultural Psychiatric Research Review*. 
An uneasy alliance

From its genesis in 1953 transcultural psychiatry was concerned with the 'basic problem of whether the same or different illness entities are found cross-culturally' (Editorial, 1959). In 1965 members of the network of individuals, united by the journal Wittkower founded in 1956, convened at the CIBA Foundation Symposium in Transcultural Psychiatry held in England. During the final group discussion, H. B. M. Murphy (Department of Psychiatry, McGill University) said that there was a general consensus among the psychiatrists that mental illnesses were universal, with the culture the individual experiences exerting a pathoplastic effect (De Reuck and Porter, 1965: 357–8). Others were even more forthright in their universalist stance. The more discussions Professor Margetts (Department of Psychiatry, University of British Columbia, Vancouver) listened to on the subject of transcultural psychiatry, the more he came 'to believe that there was no such thing'. For Margetts 'psychiatry [was] the same all round the world: the signs and symptoms of mental diseases [were] the same, the diagnoses [were] the same' (p. 22). Similarly, the anthropologist DeVos (University of California, Berkeley) stated that 'because of the universality of human nature, it is perhaps not necessary to assume that there is such a thing as transcultural psychiatry' (p. 54).

For some, this uncompromising stance was unacceptable. Fortes (Faculty of Archaeology and Anthropology, Cambridge) argued that the assumption of universal disease entities being obscured ‘by the unfortunate phenomena’ of culture was an oversimplification (p. 365). ‘We seem to have accepted, at this meeting, that psychiatric disorder is much the same all over the world’ lamented Leighton, a member of a select group of social scientists trained in anthropology and psychiatry. To him and other anthropologists this was presuming too much (p. 370).

Despite the inherent tension in the psychiatry-anthropology alliance, there was much optimism. Anthropology had the potential to provide the psychiatrist ‘with some straightforward information’ which could inform whether a belief or behaviour was likely to be a symptom of mental illness (p. 379). The alliance had resulted in the recognition that native healers were often more effective than Western-trained physicians, that culture determined preference for certain forms of treatment and that psychotherapeutic procedures needed to be modified in accordance with the the patient’s cultural orientation (Wittkower and Dubreil, 1970). The alliance had also uncovered the problematic manner in which culture interferes with the doctor-patient relationship (De Reuck and Porter, 1965: 357–8). According to Aubrey Lewis (Institute of Psychiatry, Maudsley) it was ‘the joining of forces by psychiatrists and anthropologists’ that had made ‘such a difference in the past twenty years’ (p. 3).
The alliance shatters

The tension between psychiatry and anthropology was present from the beginning of the transcultural psychiatry-anthropology alliance. Differences in perspectives and paradigms were abundant. To anthropologists, culture was protective and nurturing, whereas psychiatrists perceived individuals as the victims of culture. Anthropologists conceptualized the time-frame of their discipline in epochs of thousands to millions of years. Psychiatrists treated patients whose episodes of illness were considerably shorter. Anthropologists tried to remain objective and not interfere with subjects, whereas to psychiatrists these subjects were patients, patients that needed to be accurately diagnosed and usually treated (Brodsky, 1970). Despite these philosophical tensions between anthropology and psychiatry, the two disciplines were united by the prevailing idealism, optimism and the bridging language of psychodynamic theory. This was about to change.

For a variety of reasons the early twentieth century had witnessed a decline in biological psychiatry, particularly in North America – a decline that had coincided with the rise of psychodynamic psychology (Nathan, 1995). In contrast to biological psychiatry which offered little but clinical description and ‘therapeutic nihilism’, psychodynamic psychology offered ‘therapeutic optimism’ (Pichot, 1983). Most psychoanalysts viewed all psychiatric symptoms on a spectrum of normal behaviour, neurosis merging imperceptibly into psychosis. However, with what has been called the ‘therapeutic revolution’ (Lumley, 1968) and in particular the ‘discovery’ of antipsychotics, lithium and antidepressant efficacy in specific psychiatric disorders, nosology once again became important. It needed to be ascertained for which diseases treatments were effective and therefore how to identify those diseases. Diagnostic criteria for diseases such as schizophrenia were developed, and the rates of illness in different countries compared (WHO, 1973). This work ultimately led to the introduction of the World Health Organization’s *International Classification of Diseases 9 (ICD-9)* in 1979 and the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders III (DSM-III)* in 1980. The manuals decreed criteria for psychiatric illness, creating categories which facilitated cross-cultural comparison by a process of standardization. These processes eventually resulted in the reformation of psychiatry in a post-analytic and neo-Kraepelinian direction (Pichot, 1983).

The antipsychiatry movement eloquently led by Szasz and Laing encouraged this drift of psychiatry towards a more biological paradigm (Laing, 1967; Szasz, 1961). The result was ‘the development of a schism between an antipsychiatry movement and a defensive medical reaction’ (Kirshner and Johnson, 1982). Psychiatry was becoming increasingly biological and therefore emphasizing the universality of mental illness categories, this being reflected in the development of tools such as ICD-9 and DSM-III
reifying the view that psychiatric disorders were distinct disease entities. Psychodynamic psychology had offered a common paradigm linking psychiatry and anthropology. The shift of mainstream psychiatry towards science and medicine and away from psychodynamic psychology made this link no longer tenable. In addition, the success of the antipsychiatry movement resulted in anthropology itself examining the nature and ‘culture’ of psychiatry. The anthropologist Sue Estroff (1971) has argued that, as a consequence, anthropology became ‘too antipsychiatry’.

In 1977 the anthropologist Arthur Kleinman (Harvard, Department of Psychiatry) published ‘Depression, somatization and the “new cross-cultural psychiatry”’. Reflecting the prevailing paradigm of cultural relativism, Kleinman argued that in the cross-cultural comparison of diseases it is not disease entities which are being compared but rather explanations, and that these explanations are culturally determined. Moreover, he argued that Western psychiatry dispenses with local illness categories, designating them the status of cultural phenomena, but then imposes Western categories as if they were not also culturally derived. He encouraged psychiatry to ‘learn from anthropology that culture does considerably more than shape illness as an experience; it shapes the very way we conceive illness’ and that ‘a true comparative cross-cultural science of illness must begin with this powerful anthropological insight’. Psychiatry and anthropology were moving towards opposite philosophical poles, with the term ‘transcultural psychiatry’ now laden with different meanings for the two disciplines. It was no longer a reasonably coherent concept, the product of two disciplines uniting with common objectives and a common psychodynamic language. Transcultural psychiatry to the ‘new’ psychiatry emphasized the universal nature of disease entities. Transcultural psychiatry to the ‘new’ anthropology emphasized the importance of understanding disease in the terms of the patient’s culture within the framework of cultural relativism.

The emphasis of anthropology on cultural relativism resulted in a re-interpretation of ‘culture-bound syndromes’. Perhaps the most interesting example of a so-called culture-bound syndrome is ‘amok’, an outburst of a murderous frenzy which has been interpreted in a many ways (Carr, 1978; Murphy, 1972). The modern mainstream psychiatric concept of culture-bound syndromes is attributed to the transcultural psychiatrist Pow-Meng Yap who conceptualized them as a ‘culture determined variance of known psychiatric disorder’, with the local culture exerting a pathoplastic effect on a universal disease entity (Howells, 1950). The 1978 edition of *Culture, Medicine and Psychiatry* contained a number of interpretations of the culture-bound syndromes. One was a reflection of Yap’s biomedical stance (Manschreck and Petri, 1978). However, another interpretation conceptualized the culture-bound syndromes as culturally specific behaviours determined by the cultural ‘norms’ of the society in which they occur. Consistent with this model, it was argued that amok was a common behavioural pathway of multiple possible
precipitation (which may or may not include disease pathology), related to
the social learning practices and beliefs of the Malay (Carr, 1978). Moreover,
the prevailing assumption that illnesses which occur frequently in Western
cultures were ubiquitous was challenged. Anorexia nervosa, multiple
personality disorder and chronic fatigue syndrome were re-interpreted as
Western culture-bound syndromes. The ‘new’ transcultural psychiatry was
challenging the legitimacy of applying Western psychiatric concepts to non-
Western cultures.

In 1990 the British Journal of Psychiatry published Roland Littlewood’s
article ‘From categories to contexts: a decade of the “new cross-cultural
psychiatry”’ in an edition dedicated to transcultural issues (Littlewood,
1990a). The edition was prefaced by Julian Leff’s editorial commenting in
particular on Littlewood’s article (Leff, 1990a). Leff and Littlewood
exchanged a series of acrimonious letters illustrating the growing ideological
gulf between psychiatry and anthropology (Leff, 1990b; Littlewood, 1990b,
1991a). The same paper was reviewed in the Transcultural Psychiatric
Research Review with its editor Raymond Prince (1991) commenting that the
ultimate objective of ‘scientific medicine’ was an aetiologically based classi-
fication system based upon causal connections determined ‘by such methods
as double-blind randomised, clinical trials of treatment modalities or
laboratory examinations of neurotransmitter substances in brain samples’.
The reply from Littlewood (1991b) was swift and forthright:

Prince argues that context and meaning are quite irrelevant to
conventional psychiatric diagnosis. Of course they are. The question for
comparative theory is however, should we go along with this. … Of course
I agree with Prince and Kleinman that anthropological psychiatrists and
cultural psychiatrists are now in the same corner against a resurgent
biological determinist psychiatry. But I believe we have to sharpen our
tools. Simply modelling all our phenomena on something recalling
disease entities is not the way. There is nothing inherently wrong with
searching for ‘universals’; it is however quite another thing to presume
that we have found them.

In 1971 the anthropologist Estroff had published an article entitled ‘The
anthropology-psychiatry fantasy: can we make it a reality?’; by the early 1990s
the answer to the question was clear.

Race and transcultural psychiatry

If the scholarly journals of the early twentieth century are examined, there
are many articles which comment on the ‘psychology’ of non-White peoples
(Lind, 1917). Given the prevailing paradigm of cultural Darwinism, the
psyches of non-White peoples were perceived as being inferior because they
were less evolved (Bean, 1906). The success of Boasian culture resulted in
the cause of these perceived differences being re-evaluated. In her 1942 work *Races and Racism* the anthropologist Ruth Benedict argued that psychological differences between races were due to the effects of differences in the culture of nations. Although the book discussed many cultures and races, because of its timing it became particularly associated with the effects Nazi persecution on the Jews (Bradford Transcultural Unit, 1995). Race and racism became more prominent political issues in the 1950s and 1960s with the rise of anti-colonialism and the American Civil Rights Movement.

Given the success of ‘Boasian’ culture it was reasonable to argue, as Benedict and others had, that disadvantage and prejudice could distort personality. This is evident in Kardiner and Ovesey’s monograph *The Mark of Oppression* (1951). Kardiner (an anthropologist) and Ovesey (a psychiatrist) contested that the psyche of the American Black had been distorted and damaged by years of oppression. During the American Civil Rights Movement the effects of the culture of oppression on the Black psyche was re-interpreted by the Black psychiatrists Grier and Cobbs. While they agreed with Kardiner and Ovesey’s postulate that the Black personality had been distorted by oppression, to them this distortion was generally a positive adaptation and not a pathological process (Grier and Cobbs, 1969).

Psychiatrists, allied mental health professionals (for example the Association of Black Psychologists), social scientists and the Black community were involved in a ‘Black backlash’ directed against research and research findings which could be used to justify the oppressed status of Blacks (Comer, 1970; Harrison and Butts, 1970; Poussaint, 1969; Sabshin, Diebsenhaus and Wilkinson, 1970; Szasz, 1971; Thomas and Sillen, 1972).

Similarly, with the movement towards anti-Colonization, Boasian culture – often via the mechanism of psychoanalytic theory – was used to understand the effects of the culture of oppression on both the oppressor and the oppressed. This is particularly evident in the work of the influential Black psychiatrist and political activist Frantz Fanon (1968). He analysed and ‘revealed’ the political and psychological deceptions practised by Whites and Blacks, and in his short life of 37 years was influential in the anti-Colonization movement in Algeria and the African continent (Butts, 1979).

With the success of anti-Colonization movements in many countries, some practitioners in these countries began to question the validity of applying Western psychiatric principles to other countries, particularly if the manner of application resonated colonial overtones. The Indian psychiatrist Chakraborty (1974) was very critical of foreign experts using developing countries as ‘happy hunting grounds’ for their work and for referring to local culture as ‘native customs’, and of transcultural psychiatrists trying to implement services which [were] of ‘questionable value in Western culture in other cultures’.

Cultural Darwinism had positioned the psyches of non-White/European peoples higher up the evolutionary ladder than their non-White brethren. The success of Boasian culture attributed this perceived difference in psychology as
being due to differences in culture, because the culture of non-Whites was inferior, so was their mental landscape. The presence of racism within the culture experienced by non-Whites could further distort their personalities. The pride and self-realization that enabled the American Civil Rights Movement and anti-Colonialism culminated in these distortions being re-invented as positive adaptations and in objections to the colonial ways of thought that were all too apparent in the writings of many experts in transcultural psychiatry.

**British transcultural psychiatry**

In the mid 1970s Transcultural Psychiatry Societies were established in England, France, Italy and Cuba (Cox, 1986). British transcultural psychiatry developed its own ideology, reflecting the sociocultural environment. Britain had witnessed a wave of immigration from the former colonies, and issues of race and racism had become important (Layton-Henry, 1992). These early British transcultural psychiatrists were individuals who practised in areas with significant populations of ethnic minorities, were themselves of an ethnic minority and interested in the subject, or were converts of the anti-psychiatry movement. The new Society became a forum for psychiatrists and anthropologists interested in the subject of race and racism in psychiatry, and from its inception it took on an anti-racist posture (Burke, 1984). In 1984 the Transcultural Psychiatry Society (United Kingdom) changed its aims and objectives: it would promote equality of mental health irrespective of race, gender or culture and was committed to having a multiracial, multicultural and multidisciplinary membership. Although the word ‘culture’ was retained in the Society’s title, it was the effects of racism that were to be recognised as the primary problems which the society [aimed] to correct’ (Transcultural Psychiatry Society (U.K.), 1985). This form of transcultural psychiatry was concerned with ‘revealing’ the racism within psychiatry. By ‘culturising the problem of racism’, psychiatry (it was argued) had assisted in preserving the racial status quo and power differential. There were several areas of particular concern. The Society considered that members of ethnic minorities were preferentially ‘psychiatrised’, with excessive numbers receiving the diagnosis of schizophrenia in particular, and once diagnosed with schizophrenia, disproportionate numbers of patients were detained involuntarily and admitted into secure hospitals. In addition, practitioners of transcultural psychiatry, for example Fernando (1988), considered that disadvantages such as disease, ways of expressing illness (such as somatization of symptoms), and not benefiting from treatment (by not speaking English, for example) were attributed to the culture of ethnic minorities. Thus he contested that by ‘culturising the problem of racism’, both the power structure within psychiatry and the power of white over black is maintained because the remedy is looked for in the “alien cultures”’ (Fernando, 1988: 130).

Apart from contesting that modern psychiatry in keeping with its history is
racist, the British transcultural psychiatrists – as mentioned in the earlier change in the Society’s constitution – were advocates for the rights of ethnic minorities. In contrast to earlier forms of transcultural psychiatry, this form of transcultural psychiatry did have a practice; procedures and ways of thinking within psychiatry that were potentially biased and therefore detrimental to ethnic minority populations were examined. This critical attitude fostered many studies examining practice in psychiatry and, particularly, areas of concern such as the purported high rates of diagnoses of schizophrenia in Blacks, higher rates of compulsory detention and concerns about mis-diagnosis (Bebbington, Feenay, Flannigan, et al., 1994; Cole, Leavey, King, et al., 1995; Dunn and Fahy, 1990; Littlewood, 1992). An emphasis was placed on the development of appropriate research tools, such as scales and questionnaires that were culturally appropriate. Transcultural psychiatrists also lobbied for greater resources to be devoted to the mental health problems of ethnic minorities (Bradford Transcultural Unit, 1995).

By way of comparison, American transcultural psychiatry had become more concerned with attempting to objectively delineate diagnostic entities. Particular concern surrounded the pigeonholing of particular behaviours or syndromes from some cultures into the diagnostic framework of DSM-IV. This concern was in part acknowledged in the inclusion of ‘cultural considerations’ sections (which systematically consider possible differences in the manifestation of symptoms in each diagnostic category across cultures) and a glossary of culture-bound syndromes – developments that reflected the difficulties in meaningfully locating cultural syndromes in conventional nosology and the non-pathological nature of some of them, as well as the value of their local explanations (Hughes, 1985). It is possible that future editions of DSM will have a specific axis devoted to cultural concerns which will emphasize the importance of the cultural identity of the patient, cultural explanations of the patient’s illness, cultural factors relating to the psychosocial environment and cultural aspects of the relationship between individual and clinician (Kleinman, 1996; Mezzich, 1996).

The current practice of transcultural psychiatry is the practice of a racially and culturally sensitive psychiatry, especially in areas where there are high populations of ethnic minorities. This is evident in the work of a number of ‘transcultural units’ in London and elsewhere in the United Kingdom. Health care professionals within such units are often from the ethnic minority populations they serve and are therefore ‘culturally competent’, understanding which beliefs and practices are normal, therapeutic or protecting within that population and which are not. Nonetheless, there is an appreciation that culture can be a pathogenic agent as well as a pathoplastic influence on underlying psychiatric conditions (Alarcón, Westermeyer, Foulks, et al., 1999). Practitioners can then train others in the team to become more culturally competent for their particular ethnic minority. Treatment is modified in accordance with cultural variation; for example, to
some members of the Indian population, psychotherapy emphasizing autonomy and independence may not be appropriate, as Indian culture emphasizes interdependence and family unity. Similarly, medication doses may need to be adjusted, given the possibility of interethnic variation in therapeutic response and propensity to develop side-effects (Lin, Anderson and Poland, 1995). An emphasis is placed on the appropriate use and understanding of indigenous healers (Bradford Transcultural Unit, 1995). The practice also includes considerations relating to service delivery, for example, having separate groups for men and women, keeping men and women separate in the building, and even having separate mental health services for different ethnic minorities (Bhui and Sashidharan, 2003). At the core of this transcultural psychiatry is an approach with its history in the anthropological psychiatry discussed earlier. Kleinman had called for the cooperation of anthropology and psychiatry to produce an anthropological psychiatry in order to achieve ‘culturally appropriate, human, integrated practice of clinical care’ (Chrisman and Maretzki, 1982: 387).

The practice contains a major theoretical paradox. As psychiatrists working in the field, a belief in the universality of the major psychiatric illness and disease categories – such as schizophrenia, bipolar illness, major depression, and the major anxiety disorders – would be considered essential by most psychiatrists. However, as Kleinman has argued, these concepts are culturally derived explanations. Nonetheless it appears that these concepts are to variable degrees reliable and valid constructs reflecting ‘universals’ present in all cultures, as indeed Kleinman (1996) himself has indicated. Many adopt the form/content model in which the form of the illness is universal, but the content in terms of the individual ‘colouring’ of the illness is affected by the patient’s experience and his culture (similar to the pathogenic/pathoplastic dichotomy). This essentially universalist perspective has been much maligned by the ‘new’ transcultural psychiatry. However, the perspective gained by adopting a more meaning-centred paradigm affords advantages and insights of potential benefit to the practitioner and patient. The practitioner is able to appreciate the patient’s experience more completely and to place that experience contextually into the patient’s life, leading to a more sensitive formulation of the patient’s difficulties. Patients and their healers are sophisticated beings, and the paradox is one that makes little difference to the practice of transcultural psychiatry: the practitioners are far from bewildered (Bradford Transcultural Unit, 1995).

**Conclusion**

The creation of transcultural psychiatry as a discipline was the result of several coincidental events. Psychiatrists had witnessed the effects of culture and environment on the individual. Developments in anthropology with the redefining of culture along a Boasian model had facilitated the union of
psychiatry and anthropology, aided by the bridging paradigm of psychodynamic psychology. The period after World War II was one of profound optimism, and the social scientists of the era aimed to use their insights to create a better world, with the new discipline of transcultural psychiatry being a vehicle for this objective.

Developments such as the antipsychiatry movement, the increasing biological perspective adopted by psychiatry and the decline of psychodynamic psychology led to a dissolution of the alliance between psychiatry and anthropology. The dominant biological mainstream of psychiatry practised transcultural psychiatry by using new tools such as the operational criteria contained within DSM and ICD in an attempt to standardize psychiatric diagnosis and to create a network of individuals and institutions that would stabilize the prevailing paradigm. The anthropological approach grounded in relativism was meaning- and culture-centred, and therefore the antithesis of mainstream biological psychiatry.

The migration of the subject from its North American birthplace to the United Kingdom in particular resulted in its transformation into a practice which continued to challenge the dominant psychiatric culture on issues relating to racism, and it developed an organized practice combining the biological perspective of the mainstream with the insights gained from a more meaning-centred approach.

Therefore transcultural psychiatry is many things, and different things to different people. Firstly, to some biological psychiatrists it is the attempt to apply modern Western concepts of disease to non-Western civilizations, as is evident in ICD and DSM based on the assumption that most mental illnesses are at their core identical, with local culture exerting a pathoplastic effect (although ICD and DSM have made attempts to integrate more appropriately the influence of culture to psychiatric diagnosis). Secondly, it is the approach espoused by Kleinman, an anthropological or cultural psychiatry which advocates understanding illness in terms of the local cultures – and therefore attempts to understand the complex and subtle ways in which culture relates to mental function and particularly distress – and acknowledges that diseases are essentially explanations, which are themselves culturally derived. Thirdly, it is a form of psychiatry which is related to the concept of racism and the rights of ethnic minorities. It monitors psychiatry for signs of racism, advocates the rights of ethnic minority patients and ensures there is rigour in research results that may have implications for ethnic minorities. Finally, it is also a form of practice, a practice that in some senses fuses all the above, encourages the development of research tools and measures that are culturally appropriate, emphasizes the importance of cultural competence in the clinical setting and advocates adequate provision of services for ethnic minorities.
Acknowledgements
I would like to thank Dr Andrew Cunningham and Professor John Forrester of the Cambridge Wellcome Unit for the History and Philosophy of Science.

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Bradford Transcultural Unit (1995) Dr Daudgee and Dr Greenwood in discussions with the author.


