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Advances to identify and treat mental disorders may not be possible unless the issue of the stigma of mental illness is tackled.

(4) Stigma of mental illness

While data are lacking, those of us who have worked with different cultural groups will probably agree that the problem of stigma is greater in non-Western than in Western cultures. Advances to identify and treat mental disorders may not be possible unless the issue of the stigma of mental illness is tackled. There is almost no research into cultural differences in relation to stigma, or the reasons for such differences. Stangor & Crandall (2000) have postulated that stigma may be related to a perceived threat which is amplified by social communication and sanctioned by societal mores. Is the stigma of mental illness greater in China than in the USA because it is perceived as a greater threat, or because social communication tends more often to exaggerate such threat, or because societal customs more often sanction such beliefs? I believe the need to study the stigma of mental illness is urgent.

Conclusion

I am not suggesting that, for instance, providing a 'Balint group' experience for a trainee from the 'Third World', or training in the genetics of mental illness, would lack benefit or utility. Nevertheless, these are not the appropriate experiences needed to orientate the trainee to the 'greater' needs of the non-Western world. For all its intellectual challenges and fascinations, recent advances in psychiatry as reflected by research and practice in the Western world cannot be applied directly to meet the mental health needs of the non-Western world. Perhaps the Royal College of Psychiatrists can champion efforts directed at the four areas I have outlined.

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THEMATIC PAPER – CULTURAL VARIATIONS IN THE PERCEPTION OF PSYCHOPATHOLOGY

How 'culture bound' is 'cultural psychiatry'?

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Stated provocatively, with a few exceptions, the discipline remains confined to the cultural boundaries of Euro-American countries, and predominantly serves the careers and social interests of their scholars.

Cultural psychiatry as a clinical specialty sprung mainly from Europe and North America, in order to respond to growing concerns of ethnic minorities in high-income countries. Academic psychiatrists pursuing comparative international studies on mental health, together with medical anthropologists conducting clinical ethnographies, contributed to its theoretical basis (Kleinman, 1987; Littlewood, 1990). What at first appeared to be a marginal specialty is no longer so. For example, the UK alone has witnessed a steady growth of the field, as evidenced by its mandatory inclusion in mental health training curricula, and the existence of several taught masters courses, academic positions in universities and three dedicated journals, as well as, more recently, lead papers in mainstream publications that have debated the cultural position of 'biology' itself (Timimi & Taylor, 2004). Additionally, with a proliferation of clinical jobs for 'ethnic minority' services in hospital trusts across the country, there is ample scope for employment. The overall evidence indicates that 'cultural psychiatry' in the UK is now a specialty in its own right.

Stated provocatively, with a few exceptions (see *Anthropology and Medicine*, special issue, vol. 8, no. 1, April 2001), the discipline remains confined to the cultural boundaries of Euro-American countries, and predominantly serves the careers and social interests of their scholars. In most low-income countries, the specialty and its methods ironically retain the label 'cultural psychiatry' (rather than just plain standard local psychiatry). Moreover, scant teaching and research output from the latter countries is related to a more worrying scenario: psychiatry in low-income nations continues for the most part to rely on inappropriate texts, teaching and research designs imported from high-income countries. The large number of 'outsourced' mental health professionals from low-income countries working in the UK (and the ease with which they do so) is testimony to their psychiatric training, which in turn is predicated upon received wisdom from high-income countries.

Consider, for example, India – a nation of 1.4 billion people, which has produced Booker Prize winners but not yet a single textbook of psychiatry that is genuinely predicated on local psychology and social problems. The latter would include social suffering related to dowry, caste, marital and ethnic violence, corruption, kinship systems, famine and crop failures, and suicide. In such settings, phenomenologies of rich bodily experiences are commonly pushed into a black box of 'somatisation'. Furthermore, these 'somatic' experiences are recorded in English by local mental health professionals on (Maudsley-derived) mental state examination pro formas. In this situation, local worlds, their core moral and cultural values, and the rich (non-English) vocabulary associated with bodily problems (Lynch, 1990) are often glossed over or pruned to fit into conventional psychiatric nosology (i.e. that espoused in ICD–10 and DSM–IV). This process of systematically acquiring a culture-blind ability is considered credible and meritorious, both locally and internationally. The exclusion of culture then systematically abolishes the ability (and sensibility) to consider the role of major social and cultural 'variables' that may well provide a phenomenological template to shape appropriate nosologies of distress (Kirmayer & Young, 1998).

To proceed further would entail three key stages:

First, study is needed of the lived experiences of everyday suffering and recourse to help, through local narratives and language. It would identify key constructs and examine the cultural logic of constructing illness experience in both Western and non-Western settings. The 'semantic illness network' is one such approach. It has revealed the local distress models of the Punjabi community in Britain (Krause, 1989) and of Shiite Muslims from Iran (Good *et al*, 1985).

Second, such locally generated models would validate local experience on its own terms. They could then be operationalised and validated against Western phenomenology and psychopathology for congruence or goodness of fit in form, content and quality. It is likely that some patterns of distress may not fit with Western descriptions of psychopathology and disorders, and may therefore need separate and distinct class/category representation. Examples of these are: the Japanese concept of *taijin kyofusho* (fear of embarrassing others) in the official Japanese diagnostic system for mental disorders; and the *qi-gong* (excess of vital energy) psychotic reaction and *shenjing shuairuo* (neurasthenia) as represented within the Chinese classification of mental disorders. Alternatively, some patterns (mainly the psychoses) may well reveal common universalities (but not necessarily in the same configuration), which would further enrich the debate on cultural validity.

Third, instruments need to be developed, both quantitative and qualitative, with which to measure such distress patterns. This will contribute towards the development of higher-order categories or syndromes. *Only then* can such 'categories' be comparable with Western psychiatric concepts, to allow an examination of their cross-cultural equivalence and validity. For example, a study of the 'life events' that contribute to mental health problems would require, initially, a full picture of what 'life events' mean to the population under study. What is their relative perceived threat to marriage, kinship ties and integrity of the community, on the one hand, versus economic risks or unemployment on the other? Should a life event questionnaire not be recalibrated by local members of the population, who might choose to rearrange the hierarchy of events? Similarly, how healthy rather than pathological are 'expressed emotions' such as 'overinvolvement' in societies where extended kinship ties are valued and energetically pursued? Overinvolvement in this context might well be the very 'glue' that bonds together families with sick members.

Mental health professionals, particularly those from low-income nations, have often expressed surprise at the manner in which scholarly discourses on cultural psychiatry and medical anthropology remain confined to the academic institutions of high-income countries, and have little impact on changes in everyday clinical practice in their own settings. It is in this context that anthropologically informed methods of enquiry have the potential to help establish clearer links between personal suffering and local politico-economic ideologies. Such methods can generate alternative cannons of culturally valid psychiatric theory and practice, and contextualise them in both time and space. Although ambitious in its aims, research that will critique Western psychiatric theory and practice, and reveal its ethnopsychiatric premise, will also broaden the debate on the cultural validity of psychiatric disorders in general (Jadhav, 1995). Moreover, this process could stimulate local interest in indigenous taxonomies and provide a meaningful framework within which both professionals and patients from low-income countries could reclaim their local cultural and political histories. Such a framework would also inform the development of a valid 'text': one that is indigenously grounded and offers a concrete solution to free this specialty from its current Euro-American confines. Until then, the debt of uncritically importing an epistemology will continue to mount and worsen existing psychiatric alienation from local suffering.

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