

CONTRIBUTIONS OF MEDICAL ANTHROPOLOGY TO THE PSYCHIATRIC PRACTICE: CULTURAL AND LINGUISTIC COMPETENCE IN MONO- AND MULTICULTURAL SOCIETIES

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Cultural competence tends to become more and more important for the clinical practice in many European countries where the recent migration flow has created bigger demographic, ethnic and cultural heterogeneity. Yet, it has been promoted especially in the countries that, already for several decades, have evolved also on the political plan, from monoculturalism to bi- or even multiculturalism, such as Australia, New Zealand, Canada, UK or USA. Situated in the larger context of globalization, of the economic development still unequal between North and South, of the various changes of the policies regarding the labour right in the EU Members, but also of the international armed conflict areas leading to forced migration towards zones that can provide basic surviving conditions, Romania participates to the same population flow in which immigration and emigration are more and more dynamic. It can be foreseen that both the economic migration and the forced one will create also in our country a much higher ratio of communities with different cultural and linguistic origins (*CALD – Cultural and Linguistic Diversity*). Under these circumstances, providing competent and efficient mental health services and equal access to medical services will involve the development of training programmes for health professionals in order to offer them the cultural knowledge, the abilities and skills necessary for communicating with patients from other cultures. In this regard, an essential role is played by the medical anthropology whose potential is still unexplored in Romania. The purpose of this article is to present some debates in the scientific literature, dedicated to cultural competence and its role in the field of clinical psychiatric practice, with a special focus on some of our contributions to modelling a culturally competent approach in the case of patients suffering from various mental disorders.

Key words: Medical anthropology; Cultural competence; Cultural diagnosis; Medical record; Clinical anthropological report; Cultural psychotherapy.

INTRODUCTION

One of the central components of cultural competence is *communication*, together with accepting the cultural differences and diversity, with overcoming the ethnocentrism, with providing equity and equal access to health resources for the patients with different cultural and linguistic origins (CALD). Fitzgerald *et al.* (1996) consider that a practitioner in the medical field is culturally competent if: understands the concept of culture and the way it can influence the

human being, including the emotions generated by intercultural interactions; shows the ability to identify the culturally appropriate strategies that help him/her work with patients from other cultures (Fitzgerald *et al.*, 1996). These abilities and knowledge are necessary especially in the field of psychiatric practice, where verbal (but also non-verbal and paraverbal) communication is essential for the interaction between doctor and patient. In order to overcome the language barriers during clinical consultations, or encounters of cultural psychotherapy, professional interpreters

are often used. They represent an important resource as they allow the patients unable to master well enough the language of their adoptive country to express their thoughts and feelings in their own language.

These are some of the new competences that are not yet acquired in the traditional medical schools and that should be added through special training programmes for the medical students, for the young practitioners as well as for all other health professionals that interact with patients coming from other cultures. Moreover, the cultural knowledge and skills can be also successfully used for patients from the majority culture, as it happened in many other countries (I. Rossi, 2000). Thus, it has been noticed that the recognition of the cultural identity, of the influences that culture has on each human being, but also the acceptance of the anthropological truth that people are not only biological but also cultural beings change profoundly, for better, the quality of the professional relationships between practitioners and patients and increase the quality of communication between them, enhancing the therapeutical compliance and improving, on a long term, the evolution of clinical cases. In this context, it would be much easier to understand and accept the statement that medicine and medical anthropology have many things to accomplish together.

CULTURAL COMPETENCE IN THE FIELD OF MENTAL HEALTH

We have been living, for several decades, in an age in which the psychiatric research, either clinical or population based (epidemiology etc.) is undoubtedly dominated by the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA). In our country and in many others alike, the issue of DSM-V is waited with a lot of hope. Of course there are many interested parties and for various reasons: clinical psychiatrists, medical anthropologists and specialists in transcultural psychiatry to name but a few... Obviously, those concerned with cultural or transcultural psychiatry have higher expectances especially as regards the recognition of the role that culture plays in the shaping of clinical pictures, in various contexts, more or less "exotic", but also as concerns the acceptance of the scientific evidence supporting the conclusions

of many anthropologists and even of some biomedical researchers – who claimed that biology itself, the intimate structure of human brain, down to the level of neuronal genetic material, is deeply influenced by the social and cultural context in which the brain as a living organ develops during the ontogenesis of each member of the *Homo sapiens sapiens* species (e.g. E. Kandel, 1998).

It is well known that, the first edition in which culture became a relevant issue for the standard American Manual (that has become meanwhile an international manual of reference, a trend considered by many people as excessive and imperialist) was the DSM-IV, released in 1994. In the spring of 1991, some of the most important personalities in the field of cultural psychiatry met in Pittsburgh to seriously discuss what should be included in the next reviewed edition of DSM out of the cultural material existent in the specialised literature, mostly anthropological (L.J. Kirmayer 1998: 339). For this purpose a *Culture and Diagnosis Group* was set up that included over one hundred clinicians and researchers from the social sciences. They worked for three years screening the scientific literature and eventually proposed several texts, and also certain modifications of the diagnostic criteria, meant to be introduced in the new edition, DSM-IV (ibidem). The working group in charge with editing the DSM-IV examined the proposals of the *Culture and Diagnosis Group* and decided which of these should be included in the final structure of the standard manual. The result is well known: the editorial committee of DSM-IV decided that the revision should be conservatory, so that categories and criteria could not be changed without "hard" scientific evidence, which in fact could not be brought, especially at that point of complexity and epistemological soundness reached by the research in the field of cultural psychiatry. Laurence J. Kirmayer explains the situation quite well: "the requirement that large-scale epidemiology and clinical-validation studies be conducted on culture-related diagnosis poses a challenge that the largely ethnographic record of cultural psychiatry can, in most instances, not yet meet" (L.J. Kirmayer 1998: 340). Moreover, Kirmayer shows, another delicate, even dilemmatic issue – raised also by the proposal to shift to a nosology validated by epidemiology, *i.e.* large-scale population studies – highlights the economic even the political aspects of the whole process of funding the research

projects in psychiatry: “large-scale surveys and clinical trials require a level of funding that tends to be available only for research on entities that are already widely accepted, with methods that are considered “standard”. This works against the sort of innovative and heuristic research needed to characterize and validate significant cultural variations. At the same time, precisely this reality of research funding was a major motivation for *NIMH Culture and Diagnosis Group* to try to get as much “culture” as possible, into the DSM” (L.J. Kirmayer 1998: 340).

In the end, Kirmayer shows, only approximately half of the specific proposals and recommendations of the *Culture and Diagnosis Group* have been incorporated in DSM-IV, being dispersed in four different areas: 1) a small commentary upon the importance of culture in the introduction; 2) several sections incorporating considerations on culture, age and gender, accompanying the text dedicated to specific mental disorders; 3) a scheme for the cultural formulation of psychiatric cases, included in the Appendix I; 4) a special glossary including about 25 culture-bound syndromes (L.J. Kirmayer 1998: 340). What does this mean? Kirmayer explains that “the omissions and elisions of the proposed text did not always reflect the lack of evidence for a claim, but involved a systematic rejection of material that would challenge the basic frame of the DSM” (L.J. Kirmayer 1998: 340).

We should not be surprised. In fact, it is understandable that those groups defending the DSM in its current form don’t want a revolution at all. As long as the tool they proposed has dominated the mainstream of clinical research and practice for several decades, this could be considered as a proof that it is solid, coherent, objective, with a strictly scientific base... However, if we leave apart the discourses, full of ideology, which only preserve the *status quo* in the world of psychiatry¹, we tend to agree with those who say that DSM itself has become a “commodity” as it is a part of a very well structured technical system that transforms in goods the mental disorders and their treatments, especially the psychopharmacological ones (L.J. Kirmayer 1998: 342).

¹ An analysis of this phenomenon, in the specific case of the Netherlands, for example, has been published in the extremely interesting article by Els van Dongen (2005) *Repetition and Repertoires: The Creation of Cultural Differences in Dutch Mental Health Care*, *Anthropology & Medicine*, Vol. 12, N°. 2, pp.179–197.

What can be done in this situation? We need to understand that one should not expect too much cultural knowledge and too many socio-cultural perspectives in DSM-like nosological schemes (L.J. Kirmayer 1998: 342). Some would call this pessimism, others resignation, but we consider it to be a realistic and common sense position. The fight is far from being over. On the contrary, it has just begun... Why? Because the genuine interest in the most complex, social and cultural aspects of psychopathology, deriving from the clinical practice itself, especially in multicultural societies, is continuously increasing.

In this context, it was quite predictable that the working groups in those research centres around the world dedicated to cultural psychiatry would propose assiduously, but also with a lot more coherence, several programmes of cultural and linguistic competence for the practitioner psychiatrists, which solely on the basis of the cultural draft recommended by the DSM could only offer to their patients at most a culturally-informed assessment. These working groups have already established a number of special institutions², several training programmes³, culturally competent interview guides for psychiatric practice⁴ and assessment tools for the evaluation of the cultural and linguistic competence of psychiatrists (working in these institutions) as individuals, but also for the mental health services, as organizations. We can also mention here the researchers from the Division of Transcultural Psychiatry at McGill University in

² See, for instance, the article published by Meg Griffiths (2006) *Moving multicultural mental health into the mainstream: Building capacity and facilitating partnerships*, *Australian e-Journal for the Advancement of Mental Health (AeJAMH)*, Vol. 5 (2).

³ Such a well-structured programme has been organized annually, in November, since 2007 in Chennai (Tamil Nadu, India), due to the collaboration between University College London (UCL) and an important Indian NGO, set up in 1993, called *The Banyan*. This non-governmental organization founded The Banyan Academy of Leadership in Mental Health (BALM) aimed at filling up the gap between the theoretical knowledge and the clinical practice. This was achieved by organizing programmes of training, scientific research and cultural advocacy meant to produce a positive impact on the society, especially in the South Asian countries. The director of the course is Sushrut Jadhav, MD, PhD, senior lecturer at UCL.

⁴ See, on this topic, the following papers: Hans Rohlf (2001) *The Cultural Interview in the Netherlands: the Cultural Formulation in your pocket*, WPA Lecture, New York; Jill Benson (2007). *A Culturally Sensitive Consultation Model*, *Synergy*, N°. 1, pp. 5–6, 18–19.

Montréal (Canada) who periodically evaluate if, and how much, the *Cultural Consultation Service* (CCS)⁵, a mental health service they set up more than a decade ago, contributes significantly to the improvement of the offer of mental health services for a culturally diverse urban population, including immigrants, refugees, as well as other minority ethno-cultural groups. The conclusions the authors reach are quite optimistic, although there are still many things to do in this relatively new field: “the cultural consultation model effectively supplements existing services to improve diagnostic assessment and treatment for a culturally diverse urban population. Clinicians need training in working with interpreters and cultural brokers” (L. J. Kirmayer, D. Groleau, J. Guzder, C. Blake, E. Jarvis 2003: 145). This training will allow the clinicians to recognize the added value of cultural and linguistic knowledge as supplementary skills in comparison to the previous professional knowledge (L. J. Kirmayer, D. Groleau, J. Guzder, C. Blake, E. Jarvis 2003: 151). The specialists in the mental health field have yet to learn how to work with interpreters and this should become a standard procedure, for the students in Psychology and Medicine, for the resident doctors in Psychiatry and even for the General Practitioners (ibidem). In their turn, the interpreters need extra training in order to deal with the special requests of practice in the psychiatric clinics. They should be supervised and of course supported in the delicate situations, specific to Psychiatry, when conflicts or traumatic situations may arise (L. J. Kirmayer, D. Groleau, J. Guzder, C. Blake, E. Jarvis 2003: 151). According to the aforementioned study, a better cultural communication in the clinical context could be provided if alongside with the interpreters the cultural brokers will be employed, these having the role to mediate the clinical encounters between patients and psychiatrists. The brokers should also be trained to face the specific situations encountered in the psychiatric practice. This will happen also under supervision, with

⁵ This mental health service, covering the Montréal region, has its headquarters at Sir Mortimer B. Davis – Jewish General Hospital in Montréal. It was set up in 1999 with funds obtained from Health Canada’s Health Transitions Fund. This service, organized according to a *consultation-liaison* model, is focused on the integration of the perspectives of medical anthropology with the conventional psychiatry, the therapeutic approaches of cognitive-behavioural and family systems type (L. J. Kirmayer, D. Groleau, J. Guzder, C. Blake, E. Jarvis 2003: 146).

more attention paid to the formal assessment of their cultural competence (ibidem). Finally, the Canadian authors mention that: „there is a need to increase the awareness of cultural issues in mental health and corresponding clinical skills among primary care clinicians and social service workers. Specialized cultural consultation services can play a major role in educating clinicians and in developing innovative intervention strategies that can later be transferred to practitioners in primary care settings. The multiple perspectives, skills, and backgrounds represented in a culturally and professionally diverse team can facilitate critical analysis of conventional practices and case formulation and lead to creative intervention” (L. J. Kirmayer, D. Groleau, J. Guzder, C. Blake, E. Jarvis 2003: 151).

THE CLINICAL ANTHROPOLOGICAL ASSESSMENT OF THE MENTALLY ILL PATIENT IN THE SO-CALLED MONOCULTURAL SOCIETIES

After we have examined the various forms of the cultural assessment problem in the context of multicultural societies, we should see what happens when we apply concepts and methods derived from medical anthropology in those societies considered more or less culturally homogenous. From the very beginning any anthropological (socio-cultural) investigation raises the problem of the analytical delimitation of a unit of study (*i.e.* the *cultural unit* considered relevant for the type of research and for the aimed purposes). Is it recommended to assume that such an analytical unit is homogenous as regards the beliefs and the cultural practices taken into account? Not necessarily, especially in the modern post-industrial society. Is it necessary to use the traditional anthropological units: village *vs.* city⁶, ethnic group *vs.* majority population or other types of communities? It may be so, depending on the specific purpose of our study.

If the patient comes from a village how should we proceed? What if he/she comes from a city or from a certain district? Which is the relevant unit?

⁶ See the medical anthropological research in Perugia (1997) that uses the distinction village/city, cf. L. Lepore & M. Minelli *Il contributo italiano al Progetto internazionale della rete INECOM "Signs, meanings and practices related to mental health"*, AM Rivista della Società italiana di antropologia medica, 3-4, 337–345, Perugia, 1997.

If his/her family, or even the patient, has recently migrated from a village to the city, what is the culturally relevant unit⁷? The anthropologist should make decisions on all these important aspects, so that the analysis should be both objective and appropriate to his/her goals.

Another problem that should be solved according to the data the *clinical anthropologist* possesses can be formulated as follows: is it better to begin the clinical anthropological assessment from the patient towards the community or the other way round? We believe that the answer is: from the patient towards the community. We think that the process should begin with the individual patient's assessment. The patient will thus draw, during the first encounter with the anthropologist (that should be centered on a *life story interview*) the boundaries of his/her cultural world, presenting at the same time important elements of the social structure, starting with the description of the patient's social network, with him/her in the centre (i.e. *ego-centred* social network).⁸ In the particular case of a psychotic or incapable patient, who cannot – for any reason – properly participate to the clinical anthropological encounter, the discussion will be held with the caregivers or, in general, with a person very close to the patient (an important member of his/her social network).

When some *social roles* are identified, (during the first interview) that the person–patient played or is currently playing, the next step will be to systematically explore the whole *set of social roles* the person plays both in the community, and in the groups he/she is a member of. Some other steps of the analysis are: 1) it is drawn up a list with all the positions and social roles of that person; 2) it is explored in detail each social role, as well as the preferred and expected conducts in those roles; it is also explored the psycho-behavioural deviance, as it is perceived by the patient and by the other members of the group, the labeling and stigma associated with the deviance; 3) it is also explored the *sick role* and the way he/she adapts to or deviate from this social role; 4) the possible conflicts between the roles and the personal / cultural solutions to these conflicts are written down. It will be searched an answer to the following question: how are these social role

conflicts connected to the emergence / aggravation of the illness or of some of its symptoms? Is there any causality involved here?

After *the social network of the patient* is built and detailed – using also data from interviews with significant others – and the list of social roles and identities being built up, a close examination will follow of the typical relations and events, recurring within the network. At this stage, two technical instruments can be used, which don't exclude each other, but are complementary: a) we can get a lot of information through interviews, from the actors involved in the patient's network (family, friends, colleagues); b) we can observe, for a certain period, the interactions between the relevant members of the network. The analysis of these *social interactions* can be done, in our opinion, in three different manners, representing three complementary levels: I) *social structural analysis*, in terms of persons and roles, as well as interactions between multiple roles and social identities; II) *situational analysis* (a recommended model could be the *situational analysis* proposed by J. Van Velsen⁹ or the one proposed by K. R. Popper¹⁰) which is centred on the individual and on his/her *choices* between *concurrent* and *conflictual social norms*. We can thus get to what A. Wallace called a *mazeway*¹¹ – i.e. that „complex mental image, characteristic to an individual at a certain stage of his/her personal history. Among other elements, this includes ideas regarding the desirable goals and the undesirable traps, ideas about the self, about other persons and things, as well as ideas about the tools and techniques that can be used as means for attaining the goals. Thus it can be assessed the rationality of the patient's choice in various situations, as well as the motivation for this choices” (J. Clifton 1968: 35); III) this leads us to another level of analysis, more profound and more refined. Thus, by using the conceptual instruments offered by the philosophy of mind or the modern philosophy of action, we can reach a deeper interpretation in terms of intentional mental states and intentional individual and social actions; IV) the next level will be the *analysis of illness narratives* told by the patient and of the identifiable categories of lay

⁷ We are discussing here about patients from the majority culture, not from a certain ethnic group that would represent the unit of study par excellence.

⁸ Cf. J. C. Mitchell, in R. Ellen, 1998.

⁹ J. Van Velsen *The Extended-case Method and Situational Analysis*, in A. L. Epstein (ed.) *The Craft of Social Anthropology*, 1967: 129-152.

¹⁰ K. R. Popper *Mitul contextului. În apărarea științei și a raționalității*, Editura Trei, București, 1998: 218–230, 235–239.

¹¹ Cf. J. Clifton 1968, pp. 35, 45.

medical knowledge these narratives are based on. A useful model of such an analysis has been proposed recently by Laurence Kirmayer and L. Stern (2004).¹²

In 2006, a group of researchers from the McGill University in Montréal, who carried out a large number of qualitative studies, based on the *illness narratives* approach, set up a guide for qualitative semi-structured¹³ interviews called MINI. Even if this was created as a research instrument, it can be used successfully even in the clinical practice, especially in a transcultural context, but not only. The empirical data collected through these procedures can be then analyzed in different ways and for different purposes. One such purpose should be the establishment of the diagnosis, prognosis and therapeutical strategy. The data could be used also for clinically applied research projects.

We should keep in mind that all the above mentioned levels of analysis will be applied at a series of *typical social situations*, recurrent in the patient's day-to-day life and in which he/she is an actor, with identifiable social identities. Although there are also important recurrent social situations, not connected to the illness itself, the highest interest should be paid to those related to the illness experience in which either the actor (i.e. the patient) only feels inadequate, non-performing as regards the role prescriptions, or both the actor and other social actors with whom he/she interacts perceive him/her as inadequate.¹⁴ These

deviations from the social roles and obligations lead to a „label” designating either one of the deviance models corresponding to the roles and recognized by the community or one of the marginal “models of misconduct”¹⁵. As a general rule, these include the psychological suffering and its various forms, but are not confined to them.

THE MEDICAL RECORD OF THE PSYCHIATRIC PATIENT AND THE CULTURAL DATA

It is highly recommendable that all these data, belonging to the cultural assessment of the clinical case, should be included in the structure of the patient's medical record, in a special component, which we prefer to call the *clinical anthropological report*. In a previous work¹⁶, we highlighted the importance of this report due to the social and cultural data it brings and due to the levels of analysis and interpretation that add a plus of socio-cultural contextualization to the clinical case studied both synchronic (the examination of the current mental health status) and diachronic (the development of the patient's personality, the evolution of the social networks and social interactions during the patient's life course, the primary and secondary socialization, the enculturation, the multiple cultural identities etc.)¹⁷, as well as because it allows the establishment of the culturally differential diagnoses¹⁸, which are sometimes necessary,

paralysis, dizziness, anxiety etc. – make us unable to do things we usually do” (W. Fulford 2000: 100).

¹⁵ We should notice here the special importance that G. Devereux pays to these “models of misconduct”, and to their theoretical and practical relevance (G. Devereux 1977).

¹⁶ V. V. Toma (2006) *Cercetare documentară privind dosarul medical electronic. Dosarul clinic psihiatric organo-dinamic*, Editura Dominor, București (CD-ROM, 112 p). *Annex* (42 p.) contains the model of the psychiatric clinical record with copyright © 2008 Dr. V.V. Toma. Dr. Valentin-Veron Toma (Editura Dominor, București, 2008).

¹⁷ See also the monograph dedicated to the analysis of the organo-dynamic theory in psychiatry: V. V. Toma (2007) *Conștiință, Personalitate, Nebunie. Sistemul psihic normal și patologic în concepția organo-dinamică a lui Henri Ey*, Editura Dominor, București.

¹⁸ According to the results of the most recent studies in medical anthropology and transcultural psychiatry, such a report based on the cultural assessment, the analysis and anthropological interpretation of the patient's illness experience should contain in its structure at least the following headings: *the cultural formulation, the therapeutical history and the help-seeking pattern (previous diagnoses, alternative and complementary therapies,*

¹² L. J. Kirmayer, L. Stern (2004) *Knowledge Structures in Illness Narratives: Development and Reliability of a Coding Scheme*, *Transcultural Psychiatry*, Vol. 41 (1): 130–142.

¹³ D. Groleau, A. Young, L. J. Kirmayer (2006) *The McGill Illness Narrative Interview (MINI): An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience*, *Transcultural Psychiatry*, Vol. 43 (4), pp. 671–691.

¹⁴ Some authors (e. g. W. Fulford) define the concept of *psychological suffering* based on the patient's experience described as a „kind of failure of the intentional action” (W. Fulford 2000: 99). In the conventional perspective, says Fulford, developed also by Boorse among others, suffering derives from illness that, at its turn derives from the failure of the function. By contrast, according to a totally different theory, the failure of the action is the primary concept from which will derive both the suffering and the illness (W. Fulford 2000: 100). As medical anthropologists also recommend, the psychological suffering should be seen from the patient's perspective. Even if Fulford is not an anthropologist, he says the following: “Yet, from the patient's point of view, the importance of the suffering experience resides in the fact that it leads to incapacity. Directly or indirectly, the symptoms of psychological suffering – pain,

especially in psychiatry, but which can be extended also to other medical disciplines (V. V. Toma 2006: 73, V. V. Toma 2007: 216-221, 257).

For the first time in the Romanian scientific literature we proposed a model of *patient's medical record*, starting from the organo-dynamic theory of psychiatry¹⁹, which includes a *clinical anthropological report*.²⁰ It contains both data obtained from observation and comprehensive qualitative interviews. All these data should pass then through the processes of analysis and interpretation, specific to cultural psychiatry, in order to identify the explanatory models of the illness²¹, the patient's therapeutical history, the help-seeking pattern, and finally, the cultural formulation of the case. This is also the place where the *cultural differential diagnosis* is made: it helps for instance, to establish the cultural (*i.e.* „normal” from the point of view of the cultural community involved) or the pathological character of the hallucinations (cf. Henri Ey 1973: 1189); the pathological or cultural character of the beliefs and ideas considered to be delirious and of the apparently irrational behaviour (V. V. Toma, 2007: 257). In the clinical anthropological report the minutes of the cultural psychotherapy encounters are also described, in great detail, as well as the therapeutical strategies recommended to a certain patient. These data will become an essential complement to the other types of approaches for the prescribed. The advantage of using such an instrument is based on the fact that it allows to overcome the biological reductionism in the exploration of the clinical cases, offering important openings towards a complex, multi-dimensional, bio-psycho-socio-cultural approach of each psychiatric patient. In our opinion, this will prove to be fundamental not only for the

decisions for interrupting the psychiatric treatment outside the medical system), the cultural differential diagnosis, the abstract of the clinical anthropological encounter (description of the case, interpretation, recommendations), the possible encounters of counselling or cultural psychotherapy (V. V. Toma 2006 : 73).

¹⁹ Theoretical conception of synthesis for the whole psychiatry, formulated by the French psychiatrist Henri Ey (1900-1977), in the second half of the XXth century.

²⁰ See Annex of: V. V. Toma (2006) *Cercetare documentară privind dosarul medical electronic. Dosarul clinic psihiatric organo-dinamic*, Editura Dominor, București.

²¹ See also V. V. Toma (2003) *Narațiuni despre boală și modele explicative la pacienți cu depresie. Studiu de antropologie psihiatrică clinică (II)*, Psihiatria și psihofarmacologia prezentului, N^o. 1-2, 2003, pp. 46-59.

diagnosis but also for the therapeutical strategy, including pharmacology and psychotherapy.

This is why we should add a few words about the *cultural psychotherapy*, a field still unexplored in our country. Beside the usual professional abilities, the culturally competent psychotherapist should also demonstrate other special knowledge and skills, especially cultural knowledge and linguistic competencies.

SOME ASPECTS OF THE CULTURALLY COMPETENT PSYCHOTHERAPY

The cultural competence is not only a useful component of the current mental status examination or of the medical history taking in the case of patients coming from different cultures. It also proves to be an important help for ensuring the therapeutical success in some programmes of individual or group psychotherapy. As a base for further discussions on this subject matter, Lo and Fung (2003), for instance, suggested the differentiation of two fundamental dimensions, within the cultural competence necessary to psychotherapists: *generic cultural competence* and *specific cultural competence* (H.-T. Lo, K. P. Fung 2003: 161).

Although the distinction is much older, being in fact proposed by Georges Devereux (1977) and taken over by others ethnologists, psychiatrists and psychologists across the time, it is still used to to systematize the field of contemporary cultural psychotherapy²². In France, for instance, the accent on one dimension or the other led to important conceptual differences between Georges Devereux on the one hand – who defended the idea that the psychotherapist should understand especially the logic of culture in general, without getting into much details regarding the specific culture of each client – and Tobie Nathan on the other hand – who seems to be the adept of specific cultural competence, going so far that he himself, as a Western psychiatrist, repeatedly performed a whole bunch of complex shamanic rituals specific to the cultural groups to which his diverse patients belonged to. A noteworthy contribution to the

²² See also the article of O. Douville (2000) *Notes sur quelques apports de l'anthropologie dans le champ de la clinique „interculturelle”*, l'Évolution Psychiatrique, Vol. 65, pp. 741-61.

development of the modern techniques of cultural psychotherapy, in France, has been brought lately by the members of the transcultural psychopathology team from Hôpital Avicenne (AP-HP) within Université de Paris 13 (Bobigny).²³

In their study, entitled *Culturally Competent Psychotherapy*, the aforementioned authors Lo and Fung (2003) claimed that psychotherapy, one of the major instruments the modern psychiatry possesses, may not be directly applicable to other cultural contexts. That is why, in order to offer the best practice of efficient psychotherapy for the patients with different cultural origins, the therapists should acquire a high degree of cultural competence (H.-T. Lo, K. P. Fung 2003: 161). According to the two authors, as already mentioned, this cultural competence is composed of a sum of two different competences: the *generic cultural competence* and the *specific cultural competence*. The former includes the knowledge and skills proved necessary to work with patients belonging to any culture, in any trans-cultural encounter (*ibidem*). For each stage of the therapeutical process (pre-engagement, engagement, assessment and feedback, treatment and termination) should be taken into account the following chapters: therapist, client, client's family or the affiliation group and the work technique (*ibidem*). The second component of the cultural competence is the one that allows the psychotherapist to work directly with a particular ethnocultural community and this affects significantly each stage of the psychotherapeutic process mentioned previously (*ibidem*). Among the clinical implications of these conceptual distinctions, the authors insisted upon the following: taking into account systematically the cultural influences on a patient can increase the level of understanding and can facilitate the adoption of certain goals, processes and culturally adequate psychotherapeutical contents. Moreover, the therapists can significantly enlarge their perspective by using the cultural knowledge in order to generate new therapeutical hypotheses and strategies – all these though should always be verified and empirically tested against clinical data, in order to avoid any mistakes and stereotypes (H.-T. Lo, K. P. Fung 2003: 161).

²³ See also the excellent manual, which has already had two editions, published by Marie-Rose Moro and her colleagues from l'Hôpital Avicenne: M. R. Moro, Q. De La Noë, Y. Mouchenik (eds.). 2006. *Manuel de psychiatrie transculturelle. Travail clinique, travail social*, deuxième édition, La Pensée Sauvage, Éd., Grenoble.

CONCLUSIONS

In the field of medical anthropology, statements such as: culture has profound and subtle influences on the diagnosis, treatment and the degree to which the patients answer to various therapeutical strategies, have been representing for a long time an undeniable truth. The fieldwork studies, carried out either within certain cultural communities, certain ethnic or religious groups, or within biomedical institutions, have shown the importance of the cultural beliefs, values and cultural practices in the clinical presentation of illness episodes, during the communication process between doctors/healers and patients or in establishing solid and enduring therapeutical alliances. One can be surprised by the idea, but these cultural aspects are not only characteristic to the bicultural or multicultural societies, but also to the monocultural ones, where cultural homogeneity is most of the times taken for granted. Yet, the things are simple and non-problematic only for the minds that lack the exercise of reflexivity and the relevant knowledge necessary for the assessment of the patient's cultural identity, the socio-cultural context of his/her illness experience, as well as the ethnic, religious or socio-economic differences between patient and practitioner.

So, what we endeavoured in this article was to present first of all some of the data in the recent literature dealing, for a decade or so, with the limits of the current psychiatric practice, as it is based on a reductionist conception, often called even *a-theoretical*, in which the patient's social and cultural context is reduced to a negligible quantity and in which the concepts, theoretical constructions and anthropological methods can hardly find their place, at least for the moment. On the other hand, we wanted to highlight some of our personal contributions, from the past several years, to the clinical anthropological field. In our opinion, the cultural competence of the health practitioner in the field of clinical psychiatry represents a valued topic and with obvious opening towards future. Either we like to think that Romania represents a monocultural society, or we admit multiculturalism in its historical form but also in a more contemporary form, as result of recent migration, we should assume that in the near future, the cultural assessment of the patients, the cultural diagnosis and even the cultural psychotherapy for the patients suffering from various mental disorders

will be a part of the daily arsenal of common practices in the mental health centres, hospitals and specialised clinics. A large area of collaboration is therefore opened between the medical anthropologists and psychiatrists, where the most recent contributions of medical anthropology can be tested and hopefully confirmed as useful conceptual tools for solving an increasing number of practical problems arising in the mental health services.

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