1

Ethnopsychiatry: The Cultural Construction of Psychiatries

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It doesn't matter whether your
sunglasses are off or on;
you only see the world you made*
Bonnie Raitt

...we see the lives of others through
lenses of our own grinding and...they
look back on ours through ones of
their own**
Clifford Geertz

Introduction: Ethnopyschiatry and the New Ethnopsychiatry

Psychiatric systems, like religions, kinship systems, or political systems, are culturally constructed. Each mirrors a culturally constructed reality, as Raitt (with John Hiatt's words) and Geertz suggest; but each sees itself as a reflection of an ultimate one. As such, folk and professional psychiatries are equally cultural, or ethnopsychiatries, the psychiatric edifices expressive of particular cultures. In this volume the reader will find a variety of ethnopsychiatric studies focusing on their actors, ideologies and institutions. Serving as foci of the papers are professional, scientific psychiatric systems of Europe, the Caribbean, South Africa, the United States and Asia, as well as the folk systems of those and other areas such as India, the U.S., Mexico and France. In the present chapter I will: 1) introduce the reader to the "new ethnopsychiatry," 2) provide an overview of the vol-

*"Thing Called Love" (John Hiatt), From: *Nick of Time*, Bonnie Raitt. Capital Compact Disc 7912682, (1989).
**Clifford Geertz, Anti-anti-relativism (1984).

ume's contributions, 3) briefly describe "cultural constructivism," a new paradigm for ethnopsychiatry and other ethnomedical research, and 4) briefly consider the future of the new ethnopsychiatry in terms of traditional and nascent topics of research.

Ethnopsychiatry: Old and New

Our field of study was first delineated by Hungarian-born, French and U.S.-trained anthropologist-psychoanalyst-classicist George Devereux (d. 1985). While Devereux should be credited as the architect of our field of study, its name-giver is Dr. Louis Mars, Haitian psychiatrist extraordinaire (see Farmer, this volume). As Devereux saw it, the field of ethnopsychiatry is, properly speaking, one of two forms of research. First, as he states in his groundbreaking book, *Mohave Ethnopsychiatry* (original 1961), ethnopsychiatry is:

> ...the systematic study of the psychiatric theories and practices of a primitive (sic) tribe. Its primary focus is, thus, the exploration of (a) culture that pertains to mental derangements, as (locally) understood. In this sense, (it) is comparable in its orientation to monographs entitled, e.g., "Ethnobotany" or "Ethnogeography" that deal respectively, with the botanical or geographical ideas, beliefs, and practices of some aboriginal group, but *are primarily contributions to anthropology rather than to botany or to geography*. (1969:1) (emphasis added)

And, in this sense, *Mohave Ethnopsychiatry* could be seen as:

> ...in simplest terms...a kind of "Mohave textbook of psychiatry," dictated by Mohave "psychiatrists" to the anthropological fieldworker. (1969:1

The second focus of work properly labeled ethnopsychiatry is:

> ...the recording of all obtainable information on psychiatric illnesses in the Mohave tribe and an analysis of their social and cultural setting. In this sense this work is a contribution to the study of "culture and the abnormal personality," or, as this field of inquiry is presently called, ethnopsychiatry. (Devereux 1969:1)

This second approach I refer to as "cross-cultural" or "transcultural psychiatry." It uses Western categories and looks for what are believed to be local permutations, but assumes that Western categories and nosologies are universally applicable (e.g., Simons and Hughes 1985). I take the field ethnopsychiatry to have as its focus mental derangements as locally understood, treated, managed, and classified. Traditionally, the field focused on folk psychiatry almost exclusively. Here, however, a "new ethnopsychiatry" is proposed. It takes as its subject all forms of ethnopsychiatric theory

and practice whether folk or professional. The perspective of the present volume, then, represents an updating of Devereux's original conception(s) of the field.

As an example of the old versus the new ethnopsychiatry, one may consider the application of U.S. or French or English psychiatric knowledge to other cultures. In the new ethnopsychiatry, such would be seen as providing insight and data *both* on the psychiatric system from whose perspective(s) the study is conducted as well as that system or systems serving as the object(s) of study. We differ from Devereux in that all medicines and their psychiatries are seen here as cultural medicines, one no less culturally constructed than another. As a consequence, the distinction between folk and professional medicine is here seen as one of (culturally constructed) degree, not of kind. The term *folk psychiatry*, then, refers not to one kind of system relating to abnormal ethnopsychology and its treatment(s), but simply to a less formalized system than those represented by professional ethnopsychiatries. Professional, "scientific" ethnopsychiatries of the United States, France, Japan or Germany are, then, to be seen as formalized, professionalized, folk systems; they are epistemological siblings of their respective folk psychiatries. As such, all forms of psychiatry, whether formal or informal, professional or popular, are equally ethnopsychiatries. All may be considered and encompassed in the same discourse. Within specific cultural traditions, popular and professional ethnopsychiatries represent the same cultural discourse with different voicings. This is the distinctive, emergent position I term the new ethnopsychiatry and which is reflected in the volume before the reader. The new ethnopsychiatry, unlike the old, has relevance not only for anthropology, but for professional (ethno)psychiatries as well.

In reading these essays, the reader quickly will discover that there is no universal psychiatric reality, no firm external base beyond culture on which stands a given ethnopsychiatry or upon which it reflects. The knowledge and practice of none are privileged. Rather, each professional and folk system is recognized as a reflection of a constructed world. With this view, we can begin to understand our own and others' systems for we will know enough of lenses and sunglasses to seek understandings in terms of the local knowledge that generates, validates, and perpetuates ethnopsychiatric systems in their ontological, epistemological, and social dimensions.

Each ethnopsychiatric system of beliefs and practices may be seen as a historical dynamic process ever under construction, with its building blocks deriving from key local conceptions. These conceptions are local versions of reality related to "mental derangements" and their loci. Members of Western society (and others) and its medical professions commonly assume that their medical knowledge and practice are "scientific," neutral, and set apart from the conventional beliefs and practices of the society in which they are found. This same point of view is argued by various political

economic writers, albeit for slightly different reasons. Nonetheless, they demonstrate their epistemological kinship with European scientistic thought. However, here we argue, and present much evidence to demonstrate the view, that both folk and professional systems are equally culturally constructed, equally cultural forms of psychological medicine. In this, we recognize and affirm that sciences and medicines (e.g., of the United States, China, India) are preeminently cultural constructions.

This volume serves a dual purpose. First, it presents the ethnopsychiatric knowledge and practice of a number of cultures, as one might expect in a volume on ethnopsychiatry. Second, since the contributors to the volume recognize the culturally constructed realities of professional ethnopsychiatries, the volume simultaneously serves as a "cultural critique" (Marcus and Fischer 1986), of popular and professional ethnopsychiatries. Interpretive approaches provide the means by which these ethnopsychiatries can be *deconstructed,* exposing the made nature of that which appears to be natural and independent of human constructive action. The contributors reflect upon the constructed nature of such systems and demonstrate their formative cultural contexts. Largely as studies of scientific psychiatric medicines, this collection additionally provides an opportunity to reflect upon our own discipline of anthropology, one of the key rationales for the study of these scientific medical systems (Gaines and Hahn 1985).

The articles in the present volume do not stereotype professional or folk psychiatries by assuming or asserting homogeneity or the primacy of one form over another. Rather, these essays show that discussions of scientific, *cosmopolitan* or traditional, local psychiatries belong to the same interpretive discourse on cultural systems. In this sense the present volume serves to update the founding conceptualizations of the field and forthrightly presents a new ethnopsychiatry. In doing so, it should be noted that since the essays in this volume were not commissioned, but rather represent independent work, we are really recognizing a presence rather than creating one.

While updating, even reinventing, his founding conceptions, the present works also recall Devereux's formative studies. Many contributions focus on institutions as did some of his early work (e.g., 1944, 1949). Also recalled is the classic study of Caudill's (1958). However, the present volume largely uses interpretive perspectives while the early studies of Caudill, Devereux, and others (e.g., Goffman 1961), were more concerned with institutions as stable systems and with their maintenance and their effect on patients (see Hershel, this volume). In contrast, this collection generally evidences a concern for the diachronic interpretive apprehension of psychiatric knowledge and action. Professional knowledge and action are considered as problematic, to be interpreted as cultural constructions, thus to be "deconstructed" (the disassembly and revelation of their constituent cultur-

al elements). There is also room in these studies for consideration of both healers and patients as parts of the *same* wider cultural dramas and fields.

Although contributors do not necessarily address causes of illness, their critical view of biological, and other empirical, explanations is fairly clear, if sometimes unstated. The essays in the present volume eschew the universalist, synchronic and positivist forms of explanation characteristic of so-called "critical medical anthropology" (CMA) (e.g., Baer, Singer and Johnson 1986; Singer 1986; Frankenberg 1988; Morgan 1987). Because there are in fact a number of distinct approaches under this rubric (Morgan 1987), the plural acronym will be used (CMAs). Like medicine itself, such approaches produce understandings of sickness that are "thin" indeed (Gaines 1991; Press 1990).

While seeing folk ethnomedicines as cultural (and dominated by biomedicine), CMAs argue that there is a single (Western) professional medicine and psychiatry set apart and opposed to society. Its knowledge is said to be ideology, in the pejorative sense, and is held to be distinct from that of society. Psychiatric (and medical) ideology and practice are asserted to be consciously (sometimes unconsciously) constructed to serve solely as a means of social control, i.e., CMAs commonly propose varieties of functionalist equilibrium theory. Such perspectives suggest that the ideology, the beliefs, and knowledge of psychiatry are not problematic. Rather, they portray all medical and psychiatric knowledge as interest-generated rationalizations, consciously constructed fictions employed to control society (e.g., Baer 1982; Frankenberg 1988; Ingleby 1980, 1983; Singer, Baer and Lazarus 1990; Waitzkin 1979, 1981). Questionable, too, are the reified notions of power found in CMAs (see Rhodes 1991, this volume; Gaines 1991).

Were such assertions accurate, one would not expect to find cultural conceptions and formulations encoded in professional or popular ethnopsychiatric knowledge and practice that are hundreds, in some cases, thousands of years old. However, such demonstrably *is* the case with respect to U.S., Chinese, German, French or other ethnopsychiatric system one might care to investigate (see Foucault 1965; Gaines 1992; Gilman 1988a; Kirmayer 1988; Kleinman 1986; Menninger et al. 1963; Simon 1978). And, any close look at folk or professional psychiatric practice clearly demonstrates the extraordinarily complex webs of significance and meaning that are woven into both thought and practice. Analyses reveal the constructed nature of knowledge and praxis and their local cultural genesis (DelVecchio Good 1988; Gaines 1982a,b,c; Lock 1987; Lock and Gordon 1988; Ohnuki-Tierney 1984; Townsend 1978; Turkle 1978; Weisberg and Long 1984; Young 1988, 1991). But the constructions and their bases are to be seen as shared with the wider society of a particular ethnopsychiatry except when imposed (see Swartz, this volume, for an imposed colonial ethnopsychiatry). CMAs will be critiqued further below.

Ethnopsychiatric beliefs and practices appear under the anthropological gaze as complex, historically constructed cultural tapestries which both cloak *and* reveal fundamental understandings about life, disorder, experience, person and cultural voice (Conner 1982; Devereux 1969, 1980a,b; Gaines 1985a, 1989, 1992; Kirmayer 1988). Although, it is not their specific primary intent, the essays in this volume demonstrate the inadequacy of CMAs' views and their misrepresentations of professional medicines and psychiatries. While the studies here focus on the realities of ideology and praxis of folk and professional ethnopsychiatries, critical medical anthropological perspectives are grounded in nineteenth-century ideology that is and was, on the theoretical level, deductivist positivism, usually of the functionalist sort. And, on the level of fundamental assumptions, such perspectives also may be seen to be andro- and/or Eurocentric (Tomm and Hamilton 1988; see Morsy [1978, 1991] for a CMA view of the latter point).

Ethnopsychiatries are properly considered as demonstrations of modal realism for they reflect their respective underlying ethnopsychologies focused on the domain(s) of abnormal (ethno)psychology. This should seem obvious, but oddly, while most researchers now accept the fact that culture shapes normal human behavior, even many culturally cognizant authors explicitly or implicitly, and contradictorily, assert that abnormal behavior is somehow exempt from the impress of socialization, training, and experience. That is, they suggest that while normality is cultural, abnormality is acultural and universal. Such is the basis for the biological approaches to mental illness (e.g., Simons and Hughes 1985; Yap 1974; and Prince and Tcheng-Laroche 1987).

As the essays collected here show, illness varies in its nature and seriousness with each culture, as do the criteria determining the nature of the problematic ideation and/or behavior (e.g., Westermeyer and Wintrob 1979). In line with a new paradigm in medical anthropology, "embodiment," advocated by Csordas (1990),[1] there needs to be a recognition that ethnopsychiatric systems are embodiments of their respective ethnopsychologies' concerns for, and delineations of, the normal and abnormal self and the Other (Devereux 1969, 1980a; Gaines 1992; Lutz 1985; Obeyesekere 1985).

Boundaries and Representations

The papers in this volume were selected to represent a variety of places and topics, but also a variety of voices in terms of characteristics generally excluded from consideration but which, nonetheless, greatly affect our representations of cultural and social realities. That is, the contributors represent various ethnopsychiatries from a variety of vantage points in terms of sex, ethnic and national origin, native language, disci-

plinary training, age, stage in career, type, or lack, of institutional affiliation, and in terms of clinical/healer experience. In this sense, the contributors "traverse boundaries" (Good, Gordon and Pandolfi 1990) not only in their research but also in their being-in-the-world.[2] This heterogeneous group extends our vantage points beyond the usual "intellectual niches" of normal (i.e., customary) academic research and thought (see Geertz 1983). This diversity works against the andro- and Eurocentric norms and the academy-centeredness and is seen here as a crucial component of the new ethnopsychiatry, an aspect of the social organization of its work. Here it is perhaps more brought to consciousness than fully realized; we can say we have made but a second beginning in the normalization of a multicentered, multivocal professional discourse. Twenty years ago, in ethnopsychiatry, we had a series of studies from Hawai'i exemplary in this respect (see Caudill and Lin 1969; W. Lebra 1972, 1976)

In addition, the new ethnopsychiatric discourse presented here in a substantial way considers issues of communalism (e.g., racism) and gender as part of its normal discourse. Usually, such considerations lead to a separate, i.e., segregated, discourse with separate publications, audiences, reviews, and the like. Such work should appear unexceptionally as part of normative, diversified, disciplinary discourse. Communalism is an aspect, not the central concern of many of our contributions. While this is merely as it should be, an integration of concerns in a single focal discourse is strangely uncommon.

The contributors are united by their interests and, to a certain extent, in their approaches. While most contributors were not aware of the formulation of cultural constructivism, which is presented below and which emphasizes culture, meaning and history in medical anthropology, appropriately absent are the contrasting functionalist paradigms and totalizing ideologies of positivist social science. In their stead, we find here sensitive treatments of history, persons, and processes. The studies not only begin to unravel the extraordinarily complex webs of meaning and significance which constitute particular ethnopsychiatries, but they also portray the culturally constitution of knowledge and experience of actors (patients *and* healers).

Overview of the Volume

The contributions to this volume offer a variety of studies of ethnopsychiatric ideologies and institutions around the world. The first section, "Orientations," contains the present chapter and a second by anthropologist Lorna Rhodes. Her work considers the notion of power in medical anthropology. The two chapters of the section focus largely on theoretical issues, but the second embeds this in the context of an ethnographic study.

Specifically, Rhodes's contribution analyzes power in psychiatric and

medical anthropological theory and in a particular clinical setting on the East Coast of the United States. Her chapter continues her work on U.S. psychiatric institutions (e.g., Rhodes 1986), and is drawn from her recently published book (1991). She finds that the diagnosis and disposition of a particular patient becomes problematic and in so doing exposes for us the nature of power, its limitations, and the outlines of the local system. Rhodes critiques CMA perspectives on power using Foucault's insights as important tools. But she sees these very tools as needing some modification. Rhodes shows the problematic nature of critical medical anthropologists' view of power. They see "it" as an external and autonomous force wielded by psychiatrists and their associates. In her sensitive portrayal of the case of "the Judge," Rhodes shows that many forces are at work. Most of these are clearly local and impinge not only on patients, but on healers as well. The article clearly shows that the simple dichotomy, however implicit, of controllers and controlled, poorly represents clinical, or other, realities.

Rhodes's paper contributes to further questioning of Foucault's body of work as it relates to medical and state power (Gilman 1988a; Skultans 1979). His work on the state and its omnipotence and his *panopticon* are in fact based on French culture and history. Salient features of French culture include its historically, extraordinarily centralized and authoritarian state organization, with a religious tradition to match. Given these cultural realities, one could regard Foucault's work on the state, and its control of bodies and spaces between them (1973, 1975, 1979), as largely ethnographic rather than as of general applicability to other countries lacking France's level of centralization.

The first paper in "Section II: Illness, Experience and the Problematics of Ethnopsychiatric Knowledge," is by anthropologist Charles Nuckolls. He focuses on the standard of sanity and insanity in an Indian village. He shows the importance of cultural models of insanity as standards against which deviations are measured. As has been noted earlier by Devereux (1980b), ethnopsychiatric judgements in point of fact are not based upon the observation and measurement from an abstract, absolute standard of normalcy. Rather, they are made by comparison to (cultural) models of disorder/disease.

Naidu, the central figure of the article, is found to possess "social mass," after Devereux's formulation, but is without the expected dynamics of authority, i.e., appropriate kinship affiliations, political power, religious position or wealth. We find that Naidu serves as a standard allowing the calibration of the crucial local diagnostic domain of psychopathology; he is the embodied model of madness. Nuckolls concludes by comparing South Indian and U.S. diagnostic practices, showing the similar use of cognitive models build from remembered experiences in Indian folk and United States professional ethnopsychiatry to make diagnostic judgements.

The second paper in section II, Kathryn Oths's study of Chiropractic,

is the first of two contributions focusing on seemingly ancillary ethnopsychiatric figures; the second is Dwyer's study of nineteenth-century women attendants in New York. In this chapter, anthropologist Oths gives us a detailed account of the ethnopsychiatric aspects of Chiropractic in the United States. Her ethnographic research in the office of a U.S. chiropractic healer shows the use, unintentional and intentional, of psychotherapeutic techniques. She compares *spiritist* healing with Chiropractic, to highlight the latter, and compares both with U.S. psychiatry, especially its biological forms. She shows how the care of chronic problems allows for the development of a (psycho)therapeutic relationship. Oths's paper, from a practitioner of musculoskeletal manipulation, takes a biocultural view unique to the volume. Her paper contributes to our understanding of Chiropractic and to its role in the total ethnopsychiatric system of the United States. The paper is included here to oppose the tendency of CMAs, and others interested in professional ethnopsychiatry, to focus on these presumably high status and powerful professionals to the exclusion of other formal or informal ethnopsychiatric resources. These forms, in fact, overlap with both professional medicine and popular society, thereby demonstrating their kindred epistemological spirits.

Anthropologist Thomas Csordas extends his 20 years of work on ritual and charismatic religion, suffering, and embodiment (Csordas 1983, 1990) in "The Affliction of Martin" (chapter 5). Csordas is concerned to elucidate the relationship between religious and secular clinical embodiments of human suffering in a case of demonic oppression. He first presents an extended account of Martin's condition and the knowledge and practices of a charismatic healer, "Peggy," who cares for him. After this presentation, he contrasts critiques elicited from mental health professionals and charismatic healing ministers of Martin's affliction and of Peggy's healing strategy and ideology.

Csordas's work provides a critique of the work and beliefs of the charismatic healer who took on the task of healing Martin. The critique is provided not by the anthropologist, but by a group of charismatic healers and a group of secular professional clinicians that are asked to interpret the case. The paper demonstrates how all three accounts are forms of the objectifications of meanings inherent in sensory experience. As well, the affliction of Martin embodies and reflects local cultural, as well as idiosyncratic, meanings. In this, Csordas enlarges upon his notion of embodiment as a paradigm for medical anthropology, including ethnopsychiatry, presented in his Stirling Award-winning paper (the award is given by the Association of Psychological Anthropologists) (Csordas 1990) (see also M. Johnson 1987).

Chapter 6, by the editor, an anthropologist with public health training, considers medical psychiatric knowledge in France and the United States. Extending his earlier work in those countries on professional

ethnopsychiatry and on social classification, Gaines's chapter initiates an examination of the ontological status of "biology" in the two psychiatric medicines. It considers biology as a cultural system. As one of several explicitly ethnological papers in the volume (the others are those of Nuckolls and Hershel), the paper suggests that biology is a central symbol rather than an external, discoverable reality. As a consequence, very different meanings and referents of "the biological" are discernable in French and U.S. psychiatry. Central to the analysis presented is his notion of "Sickness History." A sickness history is a culture's historical experience with particular diseases/illness and with the perceived social context thereof (e.g., women, "minorities"). The notion specifically refers to cultural categories of thought established over historical time which frame both folk and professional interpretations of and responses to contemporary sickness experiences (see Gaines 1991).

In chapter 7, Stirling Award-winning (Jenkins, 1991a) anthropologist Janis Hunter Jenkins considers schizophrenia and emotional overinvolvement of family members in the life of an afflicted person within the context of Mexican families. Her work not only shows us the family situation of and response to disorder in this cultural context, but also the folk ethnopsychological constructions of what biomedicine terms "schizophrenia." Her methodology includes the use of locals' critiques of other's behavior as the basis of the definition of the "overinvolvement" of particular family members. Her paper extends her work on *Mexicanos* and Expressed Emotion (1988, 1991a) which foreshadowed her work with Salvadoran refugees (see Jenkins 1991b).

In the papers by Csordas, Jenkins, and Swartz, we see the critical evaluation of the behavior of culture mates. These papers recall the editor's suggestion of the need for an "anthropology of cultural competence" (Gaines 1987a). Such an enterprise would not assume a homogeneous view of cultural enactment, i.e., that all people in a particular culture enact it equally well. In every culture, those who know the tradition, implicitly or explicitly, make judgements about themselves and others; that is, they critique the cultural competence/appropriateness of others' (and their own) beliefs and/or actions within the context of their common culture. Using the differences of opinion and/or perspectives within a culture, a critique of culture can be generated from *within* a cultural tradition. This renders moot the anti-relativist argument (see Geertz 1984) that construes cultural relativism as a barrier to the cross-cultural application of critical or ethical judgement(s) (e.g., Dan Gordon 1991; and see Morsy, 1991, for a fine critique of this sort of problematic humanitarianism, constructed biomedical pragmatism and implicit Orientalism).

In the first chapter in section III, "Professional Ethnopsychiatric Ideologies and Institutions," South African clinical psychologist Leslie Swartz

analyzes professional ethnopsychiatry in his native country and its misuses of the notion of relativism. Here relativism conceals racism, albeit not very well. Swartz provides a consideration of the sociopolitical uses of the concept. South African psychiatry, as an expression of institutionalized racism, distorts the notion of relativism to legitimize and support "white" minority authority and ideology. The concept of relativism is not invoked as a means of understanding cultural difference and developing a cross-cultural or culturally appropriate psychiatry, as is the case in Haïti (Farmer, this volume).

The psychiatry is, then, an expression of its South African context and attempts to justify a colonial elite, an imposed culture and ideology. We see also that South African psychiatric logic follows local cultural assumptions about social classification ("black, white, Indian and coloured"), as is also the case, but with a different and even less logical system, in the United States (see Gaines, this volume). Swartz cogently argues, as does this volume as a whole, that researchers should pay attention to hidden cultural ideologies (cultural assumptions, including "race" and gender assumptions/roles) of apparently rational and pragmatic expressions in professional psychiatric theory and practice. While closest to a reality asserted to be common by Critical Medical Anthropologies' notions of medicine and psychiatry, South Africa's situation is obviously a local cultural creation and is not typical. It is also a case where the ethnopsychology of one group is imposed on several others.

U.S. physician-anthropologist Paul Farmer provides us with an account of the "Birth of the *Klinik*" (chapter 9), Haitian *patois* (and a pun *in re* Foucault) for a history of Haitian professional ethnopsychiatry. In this poor land, where Farmer for years has been volunteering his medical and anthropological skills, we find a sophisticated professional ethnopsychiatry, not an impoverished one. It is cognizant of and pays attention to the cultural construction of illness, cultural variations in the conception of the person, and to the cultural shaping of the expression of psychopathology. It is likewise cognizant of the cultural biases of Western nosologies (see also Farmer 1980).

This professional ethnopsychiatric reality contrasts sharply with the characterizations of professional medicine from political economic or world systems approaches found in critical medical anthropologies. There, a unitary, culturally irrelevant ethnopsychiatry is seen as exerting hegemony and is said to have been created by extra-local economic forces (Frankenberg 1988; Ingleby 1980, 1983). One would expect these views to be presented in high relief in Haïti, but they are not. In Haïti, we also find irony; the local construction of professional ethnopsychiatric reality is substantially derived from George Devereux himself, through his roles as teacher, friend, and colleague of several of Haïti's psychiatrists. Not the least of these is Haitian psychiatry's founder, Dr. Louis Mars.[3] Perhaps uniquely, we here find a case

wherein the cultural history, and clinical and theoretical present, of a professional ethnopsychiatry embodies and expresses aspects of the very discipline for which it is now an object of study; a rare instance of truly reflexive anthropology. The role of racism is also considered central there.

Naoki Nomura presents an account of psychiatrist and patient interaction in Japan (chapter 10). Nomura, a Japanese-born and United States-trained anthropologist, finds that cultural and psychological factors reported by researchers are useful points of departure for a consideration of the cultural bases of ethnopsychiatric interactions. This study considers only a segment of the total range of psychiatric interactions, specifically focusing on a psychiatrist interacting with patients in the outpatient clinic of pseudonymous Hiraoka Mental Hospital. The goal of the paper, and well met it is, is to elucidate cultural and interactional factors embedded in verbal and nonverbal exchanges between the doctor and his patients by analyzing actual interactions. The paper's interactional perspective recalls the earliest work on folk and professional psychiatry done from an interpretive perspective which incorporated aspects of interaction theory (see Good [1977] on Iranian and Gaines [1979] on the U.S.'s professional ethnopsychiatry, both also owing debts to V. Turner [e.g., 1964] and Geertz [1973]).

In chapter 11, U.S. historian Ellen Dwyer opens the section on "Ethnopsychiatric Ideologies and Institutions." Dwyer's chapter focuses on female attendants in several New York asylums of the nineteenth century. She explores their social roles and experiences, including their conditions of hiring, work, and discharge. She shows how the institutional roles were modeled on the Victorian family with the superintendent as the father and patriarch. The largely female attendant staff was defined as sorts of governesses, thus showing the projection of popular social ideals of gender and social roles into the asylum.

In their role(s), a result of sexist stereotyping of the time, attendants, while part parent, part domestic, and part caregiver, were nevertheless completely underpaid and underappreciated. Dwyer provides a fine institutional culture history focusing on overlooked but key ethnopsychiatric figures. In addition to providing excellent material on women and work from the last century, the chapter also allows us to see how the cultural context generates the roles in professional ethnopsychiatric institutions. This represents a tie to the anthropologically informed "new culture history" (see Hunt 1989), also called "anthropological " or "ethnological history" (see Le Goff 1980) but which we have seen in the earlier historical works by George Homans and A.F.C. Wallace in anthropology.

Chapter 12 presents results of a participant-observational study of several French and American mental institutions. Using Weber's notion of ideal types, sociologist and psychotherapist Helena Jia Hershel develops a schema for classifying mental institutions. Case studies of four institutions are pre-

sented. She shows that variation in treatment ideology, in the match of institutional norms with those of the larger culture, and patient-staff power relations determine specific rule structures. In turn, these structures engender particular levels of patient expressiveness, including aggressive behavior.

Hershel sees her findings as generating a scheme for analyzing problems in different institutions. While the closest to a functionalist study, Hershel's work acquires depth through the use of the concept of culture and her recognition of the importance of cultural context for institutional behavior. This is something also noted in Dwyer's (11) and Nomura's (10) chapters. These studies of the structure of hospitals and the wards within them demonstrate the validity of seeing psychiatries and their institutions in and of their cultural context(s). In Hershel's study, the French institutions, as do those in the U.S., reflect local cultural context, not universal ideological or organizational hegemony.

Anthropologist Amy Blue's chapter (13) represents one of the first anthropological accounts of professional ethnopsychiatry in Greece. Her study provides a historical account of the development of the profession of ethnopsychiatry. Her recent dissertation (1991) adds considerable detail on both history and current organization and practice. Here, Blue pays attention to the development of institutions which, after a fashion, serve the mentally afflicted. She also considers the development of the psychiatric profession itself in the context of Greek socio/political history. As an autonomous branch of medicine, psychiatry in Greece is only a little over a decade old. Its current organization is found to be a *potpourri* of elements borrowed from, and its psychiatrists trained in, other countries. From an outsider's viewpoint, it is ironic that the land that gave so many psychological conceptions to folk and professional medicines and psychiatries in the Old and New Worlds (see Menninger et al. 1963) should itself be so late in the development of an autonomous psychiatric profession, and that only with considerable pushing from other European Economic Community (EEC) countries (Blue 1991).

Pearl Katz's chapter (14) examines cultural conflicts within a state mental health system in the United States. An anthropologist with psychoanalytic training, Katz considers both the local and the state levels and their mutual influences. Bureaucratic institutional processes at the state level, such as the development of state mental health organizations and policies, and the evolution of two distinct psychiatric training subcultures are sketched. Also examined are the local-level institutional processes and structures in one state mental hospital. With reference to the latter, attention is paid to structural and organizational rigidity. Both local- and state-level forces of change are examined. Katz interprets cultural conflicts enacted on the local level in the context and under the influence of the wider, extra-local, state level which itself is seen as historical process.

In this chapter, we discern bureaucratic conflicts that are actually cultural and gender conflicts. That is, the hospital is staffed by Middle Eastern men and operates in terms of a Mediterranean family-centered, personalistic and androcentric ethos, seen briefly in chapters 6 and 13 and discussed below (also see Gaines 1982; Gaines and Farmer 1986). This ethos conflicts with the Northern European (Protestant) tradition that constitutes the ethos of the state, represented in Katz's article by a female psychiatrist placed in charge of the institution. We see here a conflict of cultures, ethnic and gender, such as we will surely encounter more of in the future in this, or the reversed, form.

In chapter 15, a senior medical anthropologist, Thomas Maretzki continues his work on the professional medicine of his natal land, Germany (also see Maretzki 1988; Maretzki and Seidler 1985). In his contribution, Maretzki describes the integrative therapies of Georg Groddeck who combined *psyche* and *soma* and developed somatic and psychotherapies (under the influence of Freud himself) tailored to individual patients in his private sanatorium which opened in 1900.

Maretzki's account clearly shows how creativity and innovation, as well a personal history, shape clinical reality and therapeutic practices in the context of a professional psychiatry. This historical paper adds to our understanding of demonstrated complexity and wide variations within a professional ethnopsychiatry even in a single place (Gaines 1979; Johnson 1985; Light 1980). The fact of this wide variation is increasingly clear in professional ethnopsychiatries, but it is also noteworthy, though often overlooked, in traditional ethnopsychiatries (see Gaines 1987b; Grim 1983; Devereux 1957). It is also evident that demonstrated personal variations as well as local resistance, creativity, and innovation, are not explainable by "macrocentric" critical medical anthropological views.

The last section, "Sources and Resources," contains the volume's final chapter by Blue and Gaines. It reviews and comments briefly on a large number of ethnopsychiatric and ethnopsychiatrically relevant studies. We hope to be extensive but cannot hope to be exhaustive. Some works are given special consideration while others are simply noted in passing. The chapter provides the reader unfamiliar with ethnopsychiatry an overview of the field and a substantial bibliography. And, it is hoped that some new, less available or well-known, material is provided for those familiar with the field.

Because the new ethnopsychiatry does not privilege any one professional or popular ethnopsychiatric knowledge, the number of works which could be included is virtually limitless. We could justify inclusion of every article or book ever published in psychiatry, clinical psychology, counseling, pastoral counseling and clinical social work as well as all social science works related to or on these and all other, popular, ethnopsychiatric forms.

The recognition in the new ethnopsychiatry of the direct relationship to psychiatric phenomena of nonpsychiatric phenomena, i.e., person concepts, forms of conflict resolution, terrorism, stress, etc., also contribute to the potentially infinite number of relevant works. Our primary interest there is to include studies by anthropologists, sociologists, historians, psychiatrists, and psychologists who are contributing or have contributed to the cultural and cross-cultural debates along with those works by others which are of use to such exchanges.

II. Cultural Constructivism

In this section, I wish to consider in more detail problems with certain approaches found in medical anthropology which are applied to medical and psychiatric issues. Historically, in sociology and in anthropology, the focus was on macrosystems, economy or notions of professionalization and the like. The focus on knowledge and experience, the means by which they are constituted, conveyed, and lived, may be said to be a new turn in the social science of medicine which is of cardinal importance. It leads directly from interpretive, here termed cultural constructive, research emphases. Contrasting with this are the critical forms of research which lead us away from human experience to attributions of needs, desires, and motives to extra-human, nonsentient economic systems, structures, and forces.

Research from critical perspectives seeks to attribute causes to higher order realities. In doing so, it produces a macrocentric view which excludes history, persons, meanings, and local-level realities. As a consequence, investigations of local-level realities do not bear out the predictions or expectations of critical medical anthropology (e.g., Castel, Castel and Lovell 1982; Gaines 1991; Morgan 1987). The contributions to this volume further demonstrate the discrepancy between critical medical anthropological views and local ethnopsychiatric realities while not neglecting extra-local phenomena.

The articles of this volume reflect perspectives I have elsewhere grouped under the rubric cultural constructivism (1991). The term both summarizes key distinctive ideas and serves as a convenient contrast to the various critical medical anthropologies (see Morgan 1987). Below, the perspective is briefly delineated for medical anthropology, and its points of difference with critical medical anthropologies are presented. (For an earlier account, see Gaines [1991].)

Cultural constructivism has a related perspective in sociology called "social constructionism" (Wright and Treacher 1982a, b). The term cultural constructivism is preferred for I am concerned to distinguish an anthropological enterprise from a sociological one and to stress the importance of the key concept of culture. Culture is seen from a historical, interactionist,

and semantic perspective. I suggest that theoretical paradigms developed before, or independently of, the modern notion of culture (i.e., "precultural" theories) have greatly limited, if any, utility for modern social science. These precultural forms of social science represent archaic, ethno- and Eurocentric forms and moments of Western social science.

Cultural constructivism (and much social constructionism) provides the basis for important critiques of Western beliefs, practices, and institutions, including those of its professional ethnomedicines. Subjects of these critiques are their systems of knowledge, that is, their classificatory systems (e.g,, the Diagnostic and Statistical Manuals of U.S. Psychiatry (American Psychiatric Association (APA) 1952, 1968, 1980, 1987) (Gaines 1992; Nuckolls 1992; Lock 1987), as well as education, organization and practice.

The constructivist approach allows for the understanding of medical knowledge as an expression of culture rather than as elite knowledge set apart and opposed to society in the form of some putative class (as in Marxist approaches) or "scientific" (as in medicine's view) ideology. While Marxisms and medicine construe medical knowledge in their own way, both agree that is an acultural ideology (Gaines and Hahn 1985).

Critical medical anthropology says, if it says anything at all about peoples' sickness experiences, that sickness is *caused* by "capitalism," "the modern world capitalist system," "social structure," "class" or "power relations," and or other hypothesized structures, processes or systems (e.g., Baer 1982, 1986; Baer, Singer and Johnson 1986; Frankenberg 1980, 1988; Navarro 1976; Scheder 1988; Scheper-Hughes 1988; Susser 1988). It is apparent to others, however, that such putatively causal entities/forces are the positivist constructs of the writers, not extant realities. "Classes," "social control," "hegemony" (Singer, Baer and Lazarus 1990:vi) are but analysts' unexamined and uncritically adopted scientistic (and Eurocentric) conceptions (Gaines 1991; Morgan 1987; Young 1982). As a consequence, while CMAs' advocates present their approaches as new and improved for the study of medical issues, they fail to note that the same conceptions have been tried and rejected in the wider domain of modern social science (not to mention those of European society and politics) (see Rabinow and Sullivan 1979; 1987). Indeed, Ortner (1984) shows how such deductive scientism remade itself in the anthropology of the '70s and '80s such that currently the differences between such positions and interpretive, i.e., cultural constructivist, social science can be quite slight. The shift to interpretive perspectives was forced by inherent weaknesses in the materialist positions, but CMAs' perspectives, presented as remedies, are analogues of models current *prior* to the shift to incorporate interpretive tenets.

Critical views implicitly reaffirm the theory of universal diseases and medicine's perception, labeling, and classification thereof. They differ with medicine only in their attribution of the *causes* of putatively empirical dis-

eases. Ignoring culture, history, meaning, and human agency, critical medical perspectives merely propose other materialist theories of disease etiology (market position, class, economy) and attribute rationalist, albeit malevolent, motives to healers as social actors. These motives are somehow induced by external, experience-distant, economic systems. Contradictorily, professional physicians are seen as autonomous and somehow personally responsible for society's medical problems (Waitzkin, Navarro, Frankenberg).

Unlike the political economy of health, constructivist research pays attention to and, indeed, focuses attention on, meaning, human frailty and suffering. Important are human agency and responsibility, and ethical considerations of theory and practice (e.g., Jenkins 1991b; Kleinman 1988b; Ots 1988; Young 1990). Human experience, and how local cultural history, context, and knowledge construct and shape it, are focal concerns. Ethnomedical research needs to remain cognizant of the cultural nature and context, for medical systems are not autonomous, isolated sociocultural strata (Elkana 1981). They represent moments of historical social and cultural processes including borrowing. Given instances are but moments of a culture-in-the-making, and as such provide one of many windows in the house of culture into which one might choose to gaze.

Critical researchers ignore the common bases of lay and professional medical ideologies which are essential to their credibility and utility for a society's people. As well, CMAs' views conceal, rather than illuminate, the very real and profound differences among the professional medicines of various countries. This concealment is accomplished by defining *a priori* the object of study as economic, acultural and universal.

The cultural constructivist rubric subsumes forms of interpretive social science in medicine that draw from different theoretical traditions and which are referred to under a variety of labels. These include: "interpretive," "hermeneutic," "cultural/symbolic studies," "Kleinman's school," "meaning-centered," "anthropology of biomedicine" and "semantic" approaches. Various of these approaches have been subsumed under the label "microlevel" and "explanatory model approach" (or "EM theorists") by critical medical anthropologists. The latter designations represent constructivist approaches as being concerned narrowly with definitions of individuals' illness only in the clinical context. It is asserted that the critical concerns are with "wider issues" i.e, putatively autonomous economic or political forces at the state or world level (e.g., Baer, Singer and Johnson 1986; Lazarus 1988; Navarro 1976; Singer 1986).

However, constructivist research has never so narrowly defined its scope of work, nor could it have. Constructivist interests are and have been medical knowledge and social action in its cultural and social context. These interests have been reflected in all such studies since the field began to attract attention and to flourish. Interpretive work continues to fruitful-

ly focus on specific issues far outside of the local clinical setting, as Low notes (1988). These include an interest in and delineation of the "local health care system," ethnomedical efficacy, help-seeking, culture- and society-wide networks of illness meaning and theories, professional medical ideology, medical status, social organization and structure (hierarchy, interactions, status, relationships), and medical history, medical education, and clinical and research practices (e.g., Comaroff 1982; Eisenberg and Kleinman 1981; Gaines and Hahn 1982; Hahn and Gaines 1985; Good, Good and Fischer 1988; Kleinman 1980, 1986; Kleinman, Eisenberg and Good 1978; Lock 1980; Lock and Gordon 1988; Latour and Wolgar 1979; Young 1988, 1990, 1991). The contributions gathered here likewise show concern for the total social context.

Failing to recognize the unique and novel perspective represented by constructivist approaches as parts of a larger interpretive social science (see Marcus and Fischer 1986; Geertz 1973, 1983, 1984; Rabinow and Sullivan 1979, 1987), critical medical anthropologists argue that their approaches are new and will provide greater insights into medical issues. However, we recognize in them the same nineteenth-century acultural, scientistic assumptions that underlie and govern normal science and biomedicine itself (Geertz 1984; Gaines 1991; Gordon 1988; Mendelsohn and Elkana 1981).

Critical approaches cannot provide new understandings of things ethnomedical because their research is based upon the same assumptions as the object of study. Their criticisms actually serve as affirmations of the Eurocentric, rationalist scientism of biomedicine itself. As well, such approaches generally do not consider actual professional medical behavior and experiences, preferring to characterize them as internally undifferentiated and homogeneous (e.g., Ingleby 1980; Frankenberg 1988). Constructivism suggests a different set of fundamental assumptions to lead us to an understanding of the cultural constructions of medicines and psychiatries.

Five central assumptions occur to me now as necessary frames for cultural constructivist medical anthropological research in complex or simple societies (see Gaines 1991, for the first outline with four assumptions.) It is clear that many of these ideas are implicitly shared with the contributors. I do not attempt here to present some of the deeper level notions underlying cultural constructivism (e.g., anti-atomism, modal realism), but rather emphasize the more operational notions which frame my own work and at least some aspects of those views I have grouped under the term.

Cultural Constructivism: Some Key Assumptions

1. ETHNOMEDICAL KNOWLEDGE IS PROBLEMATIC

The first assumption of a constructivist approach is that medical knowledge is problematic. Such a notion was doubtless axiomatic for early

researchers of popular and folk (or "primitive") medicines. However, recent research, including that contained in the present volume, clearly demonstrates the cultural bases of knowledge and practice in professional ethnomedicines, including biomedicines (note plural). Biomedicines may thus be seen as representing "many medicines," not one. Biomedicines are professional ethnomedicines and constitute "cultural systems" and are "cultural artifacts" (Gaines and Hahn 1985:4–5). The same may be said of all professional ethnomedicines whether of Asia, Africa, Europe, the Middle East, Latin and North America. As such, the cultural nature, and therefore, the problematic nature of professional medial knowledge is made clear. A fairly large body of research which demonstrates this point is now available (see, for example, Blue 1991; Bosk 1979; Comaroff 1982; Eisenberg and Kleinman 1981; Gaines 1979, 1985a, 1987a; Gaines and Hahn 1982; Gilman 1988a; Good and Good 1981; Hahn 1985, 1987; Hahn and Gaines 1985; Hahn and Kleinman 1983; Kirmayer 1988; Lock 1980, 1985; Lock and Gordon 1988; Low 1988; Maretzki 1988; Maretzki and Seidler 1985; Mendelsohn and Elkana 1981; Norbeck and Lock 1987; Ohnuki-Tierney 1984; Pliskin 1987; Townsend 1978; Weisberg and Long 1984; Young 1978, 1988).

The distinctiveness emerging from the research on these biomedical traditions emphasizes the formative influence of local culture rather than the ideological or practical "hegemony" of a single, unitary biomedicine as argued by CMA writers (e.g., Baer, Singer and Johnson 1986; Singer, Baer and Lazarus 1990; Frankenberg 1980, 1988). Thus, medical knowledge, like all cultural knowledge, is problematic and necessarily equal in epistemological standing with other ethnomedicines (Hahn and Kleinman 1983; Young 1978, 1982). Critical medical views implicitly privilege professional medical views, blunting the very bases of constructivist interpretation and the deconstruction of medical realities.

It should be noted, however, that many medical anthropologists working in international health, in ecology and epidemiology of illness, and in physical/biological medical anthropology accept U.S. biomedical knowledge as unproblematic and apply it globally (see Greenwood et al. 1988; Young 1982). One also notes that not all (socioculturally oriented) ethnomedical researchers have seen biomedicine as a culturally constructed professional ethnomedicine. Rather, they see it as a more or less unchallengeable standard by which other medical systems or medical action is judged (e.g., Foster and Anderson 1978; Hughes 1968; Prince and Tcheng-Laroche 1987; Simons and Hughes 1985).

Neither the objects of medical and psychiatric research and therapeutic gaze are things of an independent, acultural "Nature," an entity that is itself a cultural construct (see Sahlins 1976; Gordon 1988). The development of a nosological entity in biomedicine should not be seen as independent of its isolation, description, and labeling. As Devereux (1980b) pointed

out, diagnosis is a comparison of a presenting problem with known cultural *models* of pathology, not the assessment of the pathological nature of the presentation in its own terms (see Nuckolls, this volume).

Ethnomedicines, including ethnopsychiatries and ethnopsychologies, are to be seen as, to paraphrase Evans-Pritchard's postfunctionalist view of society, *moral, not natural, systems* (Evans-Pritchard 1962). They must be recognized as human creations ever in the process of recreation and alteration. The constructivist approach to psychiatric nosology for example, can make sense of and challenge not only the validity of specific nosological entities such as Post-Traumatic Stress Disorder (PTSD), (Young 1991), depression (Gaines and Farmer 1986; Kleinman 1986; Kleinman and Good 1985; Lutz 1985), or personality disorders (Nuckolls, this volume), but also the asserted acultural nature of the classificatory system itself (Gaines 1982b, 1991, 1992; Farmer 1980; Kleinman and Good 1985; Lock 1987; Marsella 1980; Nuckolls 1992).

Constructivist work reveals the nature and logic of medical practice and the marked differences among and within specialties in medicine and psychiatry (e.g., Bosk 1979; Hahn and Gaines 1985; Johnson 1985; Kleinman 1988a; Light 1980). Attempts to find and describe a homogeneous psychiatric establishment in the United States instead find a highly heterogeneous mix of ideologies and institutions that are largely autonomous but grounded in their local areas (e.g., Castel, Castel and Lovell 1982). Such highly significant internal differences are regularly effaced by deductive macrosystem or world system approaches (e.g., Baer, Singer and Johnson 1986; Frankenberg 1980; 1988; Navarro 1976; Morgan 1987). CMA approaches produce simplified pictures of reality and doubtful accounts of hegemony and power (Estroff 1988; Richters 1988; Rhodes, this volume; Morgan 1987; Sindzingre 1988).

2. ETHNOMEDICAL KNOWLEDGE IS CONSTITUTED THROUGH EMBODIED AND DISEMBODIED DISCOURSE

Ethnomedical and ethnopsychiatric realities are created, recreated and altered through social interactions and communications. Communicative forms may be embodied (speech) or disembodied (texts, telecommunications). The realities of our own studies are largely constituted in discourse about "things" such as "physician competence" (DelVecchio Good 1985) or "Christian Psychiatry" (Gaines 1982c), not by that thing itself. This is analogous to the anthropological studies of witchcraft. Anthropologists and historians interested in witchcraft actually study witch discourse, i.e., the embodied or disembodied talk about witches (confessions, accusations, expressed beliefs, divination, archives, trial records), not witches themselves (e.g., Douglas 1970; Evans-Pritchard 1937; Larner 1981). Clinical realities are defined, clarified, transformed, and maintained through

interactions (Kleinman 1980). Cultural realities germane to ethnopsychiatric transactions, particularly notions of the self, likewise are to be viewed as constructed, maintained, and transformed in and through social interaction and as incorporating aspects of the Other (Gaines 1992; Kirmayer 1989a; Kleinman and Kleinman 1990).

3. AN ETHNOMEDICAL SYSTEM IS AN UNFINISHED PRODUCT OF CULTURE HISTORY

The third central notion of cultural constructivism maintains that an ethnomedicine can not be understood without knowledge of its culture history. Medical systems are never-finished, historically derived products-under-construction. In this I suggest a processional view of medical systems in the stead of static, synchronic functionalist views. Constructivist research allows us to apprehend the central conceptual structures on which are based the productive and reproductive processes of medical knowledge/practice (Gaines 1991, Swartz, this volume; Young 1978, 1991). And, much is borrowed from other traditions and refashioned locally over time.

It is without merit to suggest that medical knowledge is grounded in some "need" of the or a world or national system. Systems cannot have neither needs nor requirements, for the systems are actually researchers' abstractions, not organic realities. Attributions of a system's "needs" simply anthropomorphize academic conceptions. As well, nothing human springs *de novo* into the world; all is historically conditioned. But political economists of health argue that medical knowledge, including nosologies, organizations, or practices, are the results of a contemporary world system's "needs" and requirements for order, control, and/or profit (Baer 1982; Frankenberg 1988; Navarro 1976; Waitzkin 1979, 1981).

4. ETHNOMEDICINES ARE CONSTITUENTS AND EXPRESSIONS OF THEIR RESPECTIVE CULTURES

The cultural constructivist position takes popular and professional ethnomedicines, including ethnopsychiatries, or any other identifiable human enterprise, as expressions of their respective cultures. Because critical approaches ignore the ideological commonalties of professional and lay groups in a society, physicians appear as acultural creatures as is biomedicine. In this view, biomedical practitioners are completely without sincerity or conviction and medical practice is merely an elite conspiracy against society (e.g., Frankenberg 1980, 1988; Ingleby 1983; Navarro 1976; Scheper-Hughes 1988; Waitzkin 1979). But, seen as products of cultural discourses, ethnopsychiatries are ever-incomplete cultural productions even when much of what is 'produced' is imposed or imported, as the selective process itself has cultural bases (Blue 1991).

Ohnuki-Tierney states this point quite clearly with respect to

Japanese biomedicine. She demonstrates that the categories of "thought operative in the medical domain are related to thought governing other domains of Japanese culture, and that these categories show historical continuity" (1984:3). While few would dispute that local culture generates and frames folk ethnopsychiatry, many deny its impact on professional biomedical and psychiatric knowledge, practice and organization. However, the impress of popular culture is clear on all studied professional medicines, whether in the U.S. (Gaines and Hahn 1982; Hahn and Gaines 1985; Lock and Gordon 1988), France (Baszanger 1985; Herzlich 1973), Germany (Maretzki 1988; Maretzki and Seidler 1985; Townsend 1978), Japan (Lock 1980; Norbeck and Lock 1987; Ohnuki-Tierney 1984), Latin America (Low 1988; Scheper-Hughes 1988), the Mediterranean (e.g., Pliskin 1987), or in Southeast Asia (Weisberg and Long 1984).

As aspects of cultures, professional ethnomedical thoughts and actions parallel, and are grounded in, lay cultural domains. Methodologically, then, the investigation of other domains can serve as a check on interpretations of the ethnomedical domains themselves. Key implicit ethnopsychological assumptions in a biomedicine would be those discernable in nonmedical domains in a culture. The assumptions of ethnomedicines must thus be seen as cultural assumptions whose form expresses and conceals popular ideas. The notion that medical and cultural ideas are separate is merely a replication of a particular Western cultural point of view.

5. ETHNOMEDICINES CONCERN HUMAN, EXPERIENCE-NEAR REALITIES

Analyses of lay and professional ethnomedical systems should see them in human experiential terms, e.g., pain, suffering, relief, frustration, loss, joy, anger, fear, sense of self, or worthiness or worthlessness, and the like. Analyses which seek explanations in experience- and culture-distant terms omit the crucial factors in health and illness, the phenomenal persons and groups wherein human experience and intersubjective (not subjective) realities are constructed (Gaines 1991; Kleinman and Kleinman 1990). (Western) scientific medicine is thought to be objective while social sciences are often said to be subjective. Cultural constructivism seeks to comprehend the intersubjective reality underlying both forms of human endeavor. Constructivist approaches seek the voices of patients, healers, and suffering. The voices of all three, in critical medical anthropologies, are obliterated, recast into structural terms (e.g., Navarro 1976; Scheper-Hughes and Lock 1986; Susser 1988), or "disembodied," as Kleinman and Good (1985) note occurs in the study of depression and dysphoric affect.

Biomedicine, on the other hand, sees itself, and has been seen by some anthropologists (e.g., Scotch 1963; Foster and Anderson 1978) as neutral and scientific and dealing in natural facts (Gordon 1988) and natural