Psychiatric Judgments Across Cultural Contexts: Relativist, Clinical-Ethnographic, and Universalist-Scientific Perspectives

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Abstract: Psychiatrists encounter persons from diverse cultures who profess experiences (e.g., communicating with spirits) that evoke intuitions of abnormality. This view might not be shared with the person or her/his cultural peers, raising questions concerning the justification of such intuitions. This article explores three positions relevant to the process of justification. The relativist position transfers powers of judgment to the subject's peers yet neglects individual values and operates with a discredited holistic view of culture. The clinical-ethnographic position remedies this by suspending judgment subject to understanding the individual in a sociocultural context yet finds objections with the universalist-scientific position: objective standards exist and could justify intuitions of abnormality cross-culturally. This article argues that the claim to objectivity is value-laden, reflecting instead a brand of normality and relationship to reality further upheld through epistemological utility and valued technological progress. In conclusion, it is suggested that the clinical-ethnographic position takes personal values and context seriously, both of which are crucial for responsible clinical practice.

Keywords: cultural relativity, normality, scientific epistemology, self, technology, worldview

I. Introduction

Psychiatrists impart judgments on a daily basis. To be sure, they are involved in the business of diagnosing, of deciding, which of the many categories at their disposal fits the patient's presentation. Yet, it is a more fundamental kind of judgment that precedes the clinical task of choosing a diagnosis: a judgment pertaining to the abnormality or otherwise of the experiences and beliefs professed by the patient. The situation is further complicated when a clinician encounters a prospective patient from an alien culture, one where spirits can communicate with people and dead ancestors talk to the relatives they left behind. How can a psychiatrist make sense of these phenomena, especially when her scientific clinical tradition has been largely expunged of the resources required to understand such experiences in any but abnormal terms? One possibility is to resort to the huge body of work on transcultural psychiatry to try and find an answer.

A quick perusal of transcultural psychiatric research would reveal that a central message is the universality of certain major conditions. Forms of psychopathology that are found in the psychiatric manuals have also been found in diverse cultures around the world (WHO, 1973; Singer, 1975; Jablensky *et al.*, 1992; Leff, 2004; Hopper *et al.*, 2007). Divergent cosmologies notwithstanding, schizophrenia and depression (or their semantic equivalents) cause suffering and distress in north Europe as they do in the farther reaches of India. Nuanced and subtle anthropological work has pointed out several problems with the universal aspirations of the transcultural psychiatric project: the culturally constructed nature of psychiatric categories (Barrett,

1988, 1996); the problems of applying these categories around the globe (Kleinman, 1977, 1987); the varied symptomatic expression of major conditions (Barrett, 2004; Jenkins and Barrett, 2004); and the divergent values and epistemologies that inform the assessment and understanding of psychological and behavioral deviance (Jenkins, 1988; Al-Issa, 1995).

Underlying much of this critique is a recognition that psychiatric categories encode a wide range of culturally derived norms. Fabrega (1982, 1989), for instance, has pointed out that Schneider's first-rank symptoms are violations of the limits on normal experience and belief as seen through the lens of an ideal, Western model of the self.[1] Given that psychiatric categories are constructed, they must be constructed somewhere, and it is inevitable that the norms and values of the culture of origin form the template (*cf.* Bolton, 2008, 214). This insight introduced certain wariness in applying psychiatric categories and judgments on those from cultural contexts alien to the clinician. If the categories encode the antithesis of local norms, then their imposition on those who share a different worldview is tantamount to norm imperialism. Authors of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV: APA, 1994), for example, indicate that clinicians should seek cultural consensus by consulting the patient's peers before proceeding with diagnosis.[2] This seems to be good advice; the goal of the initial clinical encounter is to choose appropriate subjects for psychiatric intervention. Such advice is predicated on a seemingly irreconcilable difference. The very fact of having to appeal to the principle of cultural consensus is proof that norms diverge to the extent that phenomenologically similar experiences can be a symptom of mental disorder in one context and a positive spiritual event in another. Thus a Pentecostal Christian from an African country may hear the voice of God and incur no judgment of abnormality, while a white Briton confessing a similar experience may certainly worry the involved clinician. Yet, a clinician is driven to consult the patient's peers only to the extent that she, intuitively, finds the patient's experience of communicating with God or a spirit unusual if not abnormal.[3] What she considers herself lacking is knowledge of the relevant norms to further assess such an experience, hence the appeal cultural consensus. We could therefore characterize the procedure advocated in the DSM-IV as an attempt to overcome our intuitive (pretheoretical) reactions to certain beliefs and experiences; the kind of reaction our hypothetical psychiatrist above might have had. Stated more precisely, there is a cross-cultural divergence in pretheoretical judgments: the divergence problem. Experiences and beliefs that certain observers may regard abnormal are not necessarily considered so in other cultural contexts. This article is an attempt to explore and critique a number of positions available to justify or oppose such intuitions and to establish their theoretical status through appeal to an overriding principle. I proceed by presenting two vignettes illustrating modes of experience that invite divergent cross-cultural judgments. Three theoretical positions relevant to justifying these judgments are raised and discussed: relativist, clinical-ethnographic, and universalist-scientific. The relativist position, in its radical form, eschews cross-cultural intuitions and relegates powers of judgment to the subject's peers. This position is undermined in view of operating with a discredited view of culture and neglecting individual's values and beliefs. The clinical-ethnographic position remedies this problem by suspending judgment subject to understanding the individual within the sociocultural context. Objections to this approach are raised through the universalist-scientific position where the claim is that extracultural, scientific standards do exist and could enable us to arbitrate the normal from abnormal cross-culturally. This position is deconstructed to reveal that the claim to objectivity is a proxy for the prioritization of a particular brand of normality and relationship to reality, further

upheld through the epistemological gains they allow and the valued technological advances such gains produce. I conclude by suggesting that the clinical-ethnographic approach remains the only coherent position and the one geared toward understanding the person and respecting her values.

II. CONTENTIOUS STATES

The Voice of the Dead

The Lakota are a Plains Indians tribe; here is a description of a specific aspect of their worldview and related modes of experience:

Any encounter with a deceased relative is construed by the Lakota as a sign of misfortune, usually a warning to prepare for one's approaching death. In addition to manifesting as the relative's voice, the warning may come in a dream, a vision, or the sight of a shadowy figure (usually of the same sex as the subject). Sometimes, however, it may consist of the sight of an owl on the top of one's residence or hearing the hoot of an owl at an unusual time. When a person hears the ancestral voice, he or she is called by name or by the appropriate kin term. In some cases, the voice says, "Come!" Medicine knows one man who responded with "No!" and he is still alive. Usually, however, the person who hears the voice prepares, together with his or her kin, for his or her death, which typically follows in two to four days (Spiro, 2001, 222).

Marriage to a Spirit₄

Marriage to a jinni (a spirit of fire) is not an uncommon phenomenon in the Dakhla Oasis. The experience of the person thus engaged is of a presence that stays by their side through parts of the day, occasionally talking to them and advising them about day-to-day problems. The spirit frequently appears by their side in bed and is known to engage in sexual intercourse at the threshold of sleep. The experience is not always pleasant, although it can be, and the person involved may want to get rid of the jinni or seek to develop the relationship further. The name given to this phenomenon is *mekhaweyya*.₅ It is not necessarily undesirable and, in fact, may be sought for the powers of clairvoyance it brings to the person.

At this point, a potential objection arises. So far the assumption has been that divergent cross-cultural intuitions apply to the same kind of experience regardless of the local semantic expression, that is, "hallucination," "spirit," "voice of God." To be able to arbitrate divergent judgments pertaining to a state, x, we need to be confident that we are seeing two instances of it that are nevertheless judged differently according to two sets of cultural standards: A and B. We need to be able to claim that "consorting with a jinni" and a "psychotic hallucination" are two instances of the same state, x, but while B considers x abnormal and may relegate it to illness, A does not. On what basis can we assume identity? One possibility is descriptive similarity: identifying both states as x is plausible since both involve a *voice in the absence of a material stimulus*. We could be accused, however, of imposing too much of our cultural baggage. The notion of material stimulus is too constraining; for culture A, the range of acceptable stimuli far exceeds the world of persons and physical objects that emit sounds. Another possibility is to seek what I call cultural mutuality. This means that a subscriber to cultural standard B on hearing the story of the jinni will most likely think along the lines of psychosis, while a subscriber to cultural standard A on hearing of a psychotic patient will think along the lines of *mekhaweyya*.₆ Mutuality in such judgments is sufficient to guarantee that regarding both states as instances of

x is an acceptable proposition. The divergence problem holds.

III. RELATIVIST POSITION

According to this position, normality is culturally defined. There are no universally applicable standards that would enable us to judge that a particular psychological state is abnormal. Thus, whether "hearing the voice of a dead relative" or "consorting with a jinni" is an abnormal experience is a matter for the culture of origin to decide. If the Lakota Indians and the people of Dakhla do not measure them with the yardstick of abnormality, then no external observer could afford to. In its radical form, this position requires two sets of commitments. The first is a commitment to the notion that in matters of judgment there is no privileged point of view. Goodman's proposed definition of relativism expresses this well:

… the doctrine that no belief, judgment, doctrine, or assumption from a given range is in objective terms more worthy of adherence than any other, or at least than any other that has met some minimal qualifications necessary to qualify it as a claim. (Goodman, 1991, 77)

This means that the Lakota Indians' judgments lie on a par with the psychiatrist's. Endorsing this commitment is, nevertheless, consistent with imparting judgments. I may recognize that there is no privileged point of view yet continue to regard the experience of "consorting with a jinni" abnormal. The radically relativist position requires the additional clause that we *cannot* (without lacking justification) make such judgments. This clause is satisfied by endorsing a second commitment expressed in the view that "holistically conceived alternative 'forms of life', 'conceptual frameworks', or 'world views' are 'incommensurable'" (Dascal, 1991, 3). Together, these two commitments set sociocultural worlds apart; not only is there no privileged point of view but also there is no justification to impart judgments of abnormality across cultural contexts.

This position has its adherents. In outlining the tenets of the ethnopsychiatry paradigm, Atwood Gaines (1992) implicitly endorses a radically relativist position. This paradigm was initially conceived by George Devereux (1969, 1980), but it was Gaines who offered a more recent systematization. The central claim of ethnopsychiatry is the incommensurability of "psychiatric systems": all are culturally constructed and mirror a culturally constructed reality. In examining such systems, the focus is "'mental derangements' as locally understood, treated, managed, and classified." Diagnosis is not the assessment of a problem on its own terms but a comparison of the presenting problem with cultural models of pathology (*cf.* Gaines, 1992, 3–22). The implications of these claims are 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" (Gaines, 1992, 5).

A similar position emerges from the writings of the anthropologist Ruth Benedict. In an early article, she questions the "modern normal-abnormal categories", asking to what extent they are culturally determined (Benedict, 1959, 263). She provides a number of examples of forms of experience and personality configurations that are considered abnormal by the standards of the modern West yet are highly valued and may form "the cornerstone of [another culture's] social structure" (1959, 268). Thus the phenomena of trance and catalepsy valued among Shamans or the existence of whole societies built upon personality traits of paranoia and megalomania force upon

us "the fact that normality is culturally defined." Normality for Benedict is a term for the "segment of human behaviour" a particular culture has "chosen" to elaborate and institutionalize. Individuals whose behavior and personality traits fall outside this socially elaborated segment of behavior are the deviants of that community, "no matter how valued their personality traits may be in a contrasted civilization" (1959, 277).

More recently, we can find shadows of the relativist position in the procedures advocated by the American Psychiatric Association as evident in the *Case Book* (Spitzer *et al.* 1994) intended to accompany the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*. Authors of the *Case Book* present a number of contentious cases an inattentive clinician might diagnose as schizophrenia or psychosis but which are understood locally in supernatural or spiritualistic frameworks. In such cases, the authors advise clinicians to relegate judgment to members of the person's culture who would then be able to tell us whether a particular case is within their boundaries of normality. The authors assume coherent systems of cultural norms to which sane members have access yet they are unavailable to the patient and outside observers.

Presented with this question: Are cross-cultural judgments of abnormality justified? Gaines, Benedict, and authors of the *Case Book* would presumably offer the unambiguous answer that they are not. Judgments of this kind depend on local standards and cannot be made irrespective of or outside culture and do not necessarily require an assessment of the individual's view of her problems.

This answer is not satisfactory and is based on a now discredited view of culture. Culture is no longer thought of as a unified, coherent, self-contained system. As James Clifford put it over two decades ago, a culture is neither a "scientific object" nor "a unified corpus of symbols and meanings that can be definitively interpreted … culture is contested, temporal, and emergent" (Clifford, 1986, 18–19). Reclaiming the place of the agent rendered culture a resource, a collection of "shared symbols and meanings that people create in the process of social interaction" (Jenkins and Barrett, 2004, 5), and a "tool kit" (Swidler, 1986) available to individuals as they deal with the contingencies of life in myriad creative ways. Psychological and behavioral changes frequently constitute a contingency not only for the individual concerned but also for the relevant social circle and sometimes the community as a whole. Cultural symbols and meanings, partially depending on whether or not they allow or encourage unusual experiences outside pathological contexts, may make it either more or less likely for the agent to be seen—and to see herself—in abnormal terms. The divergence problem is a case in point. However, it remains a matter of likelihood rather than definiteness since cultural norms and rules do not exhaust all the potential variables that occasion a judgment pertaining to the normality or otherwise of particular modes of experience. These variables include the commitments and values brought to the process of evaluation by the subject and others whereby what might appear culturally permissible is judged, in a particular instance, to lie outside the scope of normality.

By way of illustration, consider the cultural milieu in Dakhla. There, modes of experience that evoke in some observers the idea of illness or disorder are seen in the entirely different ontological and moral framework of *mekhaweyya* and sometimes even encouraged. Yet, this does not mean that every instance of this state is spared the tag of abnormality; there are particular characteristics—enumerated in the vignette above—that differentiate a genuine spirit marriage from other states. In the absence of these characteristics, the condition is not *mekhaweyya* and may actually be a spirit illness. To this extent it could still be argued that culture

alone is the measure of abnormality. There are, however, cases of genuine spirit marriage that cross the boundaries and are regarded as frank spirit illnesses requiring the input of a healer despite retaining throughout the same descriptive phenomenology. This happens, for example, when a young woman approaches the socially appropriate marriage age and desires a human partner yet is unable to do so in view of the presence of and occasional threats by the spirit involved with her. Even if the condition is considered culturally permissible, it has become, relative to social norms and the subject's goals and needs, a problem. The point where this occurs, where her experiences become problematic and disabling, is independent of the general characteristics of *mekhaweyya* and depends on the evaluation of her experiences in the context of her values, projects, and social norms. Establishing if particular modes of experience are abnormal requires attending to the individual within a sociocultural environment. This brings me to the clinical-ethnographic position.

IV. C LINICAL-ETHNOGRAPHIC POSITION

This position shares with the relativist position a commitment to the first principle stated above: there is no privileged point of view. However, although the relativists eschewed judgment rendering it a function of culture, adherents of this position *suspend* judgment until a considered understanding of the individual in context is attempted and achieved. According to the psychiatrist and anthropologist Arthur Kleinman (1988), whether or not a psychological state is abnormal depends on rules of interpretation, cultural frameworks, and individual values and beliefs. Culture is still a measure of normality but not as an entity over and above the individual, rather it's how individual experience is interpreted and understood in the context of prevalent cultural frameworks. Our judgments of normality and abnormality can only be made after giving individuals narrative space and engaging with their beliefs. Consider Kleinman and colleagues' views on the Plains Indians:

Many Plains Indians [the Lakota are a Plains Indian tribe] hear the voice of a recently deceased relative calling them from the after-world. The experience is normative and without pathological sequelae for members of these communities, and therefore by definition cannot be abnormal. On the other hand, for an adult white North American, it might well be a hallucination with serious mental health consequences. (Kleinman, 1996, 868–869)

The Plains Indians worldview includes an afterlife populated by dead ancestors, it allows for communication between them and relatives on earth, and these communications are understood as a sign of the relative's impending death. In the quote above, the authors point out that the experience is "normative" and add the important proviso "without pathological sequelae for members of these communities." Perhaps they should have added that even if it did carry pathological sequelae the individual is primary in the judgment that it has. The identification of abnormality or as Kleinman puts it "the [cross-cultural] validity of diagnostic categories" does not depend on absolute criteria and should involve

… a conceptual tacking back and forth between the psychiatrist's diagnostic system and its rules of classification, alternative taxonomies, his clinical experiences, and that of the patient, which includes the patient's interpretation. Validity is the negotiated outcome of this transforming interaction between concept and experience in a particular context. Thus, validity can be regarded as a type of ethnographic understanding of the meaning of an observation in a local cultural field.

(Kleinman, 1988, 12)

Knowledge of abnormality is emergent; it is an outcome of a process of shared interpretation and evaluation rather than preestablished rules. Questions to explore in this context include: What is the most appropriate description of the state: a voice, a hallucination, a spirit? If it is a spirit, what kind is it? Is it a Muslim, Christian, or pagan one? To what effect does the person utilize the powers and insights afforded by the spirit? Does the spirit prevent the person from performing social roles or religious duties? Is the person in liaison with the spirit a powerful and respected member of society or not? Did the person seek the spirit or did it impinge on her? Through these and similar questions the clinician would be able to probe the patient's values, the commitments of the patient's peers, and the cultural frameworks within which the experiences are understood. The question of abnormality can then be addressed. An obvious response to this position would be that it ignores universal, scientific, culture-free standards for judging the presence of abnormality. Armed with these standards, we would indeed have grounds for justifying our judgment that the modes of experience described in the vignettes above are abnormal.

V. UNIVERSALIST-SCIENTIFIC POSITION

Adherents of this position typically appeal to a principle that lies outside culture and is thought to apply to humanity in general. They would proceed to demonstrate that in the case of the conditions under consideration this principle had been violated, which justifies the judgment of abnormality. Attempts to find a naturalistic basis for mental disorder are of this variety. Not content with value-laden definitions, theorists have attempted to anchor mental disorder and by proxy the norms encoded in the various categories on to part-value, part-fact bases. These attempts at conceptual analysis have not met much success. Whether we consider Boorse's (1997) "biostatistical theory", Kendell's (1975) "biological disadvantage" criterion, or Wakefield's (1992; 1997; 1999) "harmful dysfunction" analysis of mental disorder, we find that values creep in to the proposed definitions.[7] In its conceptual analytic form, the universalist-scientific position fails the claim to cross-cultural objectivity and therefore fails to justify or render false our pretheoretical judgments regarding the abnormality of certain modes of experience. Despite this, anthropologist Melford Spiro has argued that extracultural, scientific standards do exist and can be applied to arbitrate divergent crosscultural judgments. I will consider his position in detail. In agreement with the relativists, he accepts the divergence problem:

Because in its descriptive (or emic) sense, cultural relativism is tautologically true, virtually no one would disagree that in this sense psychopathology is culturally relative. Thus, because judgments of whatever kind are based in large measure on cultural standards, and because such standards vary across social groups, it follows that for any group G, *its* judgments regarding the normality or abnormality of any psychological condition are relative to—that is, are a function of—the cultural standards of G. (Spiro 2001, 220)

However, this is where he parts way with the cultural relativists. For Spiro, the fault the relativists make is to build on descriptive relativism and endorse a normative relativism whereby the very fact of diversity in standards of abnormality precludes judgment on those very standards. Thus, the claim of normative relativists would be

There are no *pancultural* standards (standards shared by all cultures) for judging

whether some psychological condition is pathological or not [and] there are no agreed-on *extracultural* standards (standards established by a cosmopolitan science that transcends the folk standards of any and all local cultures, that are agreed on by scientific students of mental illness, whatever their culture or society of origin) for such a judgment. On both accounts it follows that there are no universal standards for arriving at judgments regarding psychopathology. Consequently, for researchers, no less than for natives, judgments regarding psychopathology are necessarily culturally relative. (Spiro, 2001, 220–221)

Yet, as he points out, a condition that threatens bodily integrity, social functioning, and acquisition of cultural ideas and norms and causes extreme emotional distress, that is, biologically, socially, culturally, and psychologically maladaptive, will most likely be panculturally *and* extraculturally assessed as pathological. The contentious states I discussed earlier, however, do not necessarily lead to biological, social, and cultural maladaptation. In fact, these states are an expression of deeply held and important cultural ideas; they may not necessarily be associated with impairment in social functioning in accordance with the norms of the culture in question, may not necessarily result in extreme psychological distress, and ultimately may not be considered abnormal. To this extent, a pancultural assessment cannot afford to claim otherwise, to claim that such states are nevertheless socially and culturally maladaptive. In such cases, however, the observer could still claim that there are extracultural standards to judge these states, especially with respect to the dimension of psychological adaptation. Thus, for Spiro, according to extracultural standards, "any psychological condition that comprises or leads to a failure in 'reality testing' is, by definition, pathological" (Spiro, 2001, 222). Consequently, even if phenomena such as trance, hallucinations, and spirit possession do not lead to failure in biological, social, or cultural functioning, they can still be judged pathological.
It is, therefore, expected to find Spiro in disagreement with Kleinman and colleagues' (1996, 868–869) contention, cited earlier, that among the Plains Indians, the experience of hearing the voice of a deceased relative calling from the afterworld is "normative and without pathological sequelae for members of these communities, and therefore by definition cannot be abnormal." Spiro (2001, 223) sees such a claim as a classic instance of the conflation of belief and experience: "Although the *belief* that deceased relatives may call from the afterworld might be culturally normative—that is, culturally constituted and, hence, socially shared—this does not necessarily imply that the *experience* of hearing a deceased relative's voice is psychologically normative—that is, psychologically normal" (*cf.* Rashed, 2010, 197, for a response to this strand of Spiro's argument). In other words, the experience itself, regardless of the cultural context and associated beliefs, involves a confusion of internal with external reality, a misidentification of "a psychological event in the mind for a physical event in the external world; and that, *by definition*, is a hallucination, whatever the cultural context" (Spiro, 2001, 223). Spiro can then make this claim:

What is at issue is not whether the Indian's experience is a hallucination, which it is, but whether the hallucination is psychologically normal or abnormal. In the view of Kleinman and others, the Indian's hallucinatory experience is normal because, unlike the white North American's, it has (as they put it) no "pathological sequelae." But given that an experience that confuses an event in the inner world with one in the outer world constitutes a failure in reality testing, in my view such an experience is itself pathological, whatever its sequelae. (Spiro, 2001, 223)

In summary, it is one thing to believe in the possibility of spirit marriage and ancestors talking from the afterworld and quite another to actually experience

a presence, communicate with a spirit, or hear your deceased relative calling on you. The former are culturally normative beliefs and part of a wider cosmology; the latter are pathological experiences subject to various explanatory theories.

The Significance of the "Reality Testing" Construct and What Spiro is Really Claiming

The notion of "reality testing" implies that our experiences should align with objective reality, with the world of objects and people out there. Our senses should ideally reflect what is going on around us, and it is obvious that it is crucial for survival that this be the case. It could be further argued that it is a matter of evolutionary design: our five senses enable us to register and react to the world as a prerequisite for further emotional and cognitive responses. This narrow vision of "reality" is also necessary for sociality: if we all became engrossed in a world of inner perceptions, we would struggle to engage in social intercourse; sociality would be threatened. This is precisely what we see in advanced forms of schizophrenia, for example.

At this point, we could ask if the issues are being exaggerated. After all, for most of their lives and for most of the time, the Plains Indians and individuals married to spirits have a healthy relationship to objective reality and are able to perceive what is out there and represent it accurately enough to go about the daily business of survival both in a practical and social sense. In fact, had this not been the case, the concerned individual will probably be considered abnormal by his own peers and the divergence problem would cease to be. It remains unclear then what motivates Spiro, as a champion of extracultural, scientific standards, to make the strong claim that "failure in reality testing" (according to a narrow definition of reality) amounts to pathology. This leads to a pertinent question: What does the commitment to the notion of "reality testing" reflect? In the remainder of this article, I attempt to deconstruct Spiro's position in order to uncover his underlying assumptions. This is the key to unravelling the universalist-scientific position and with it the objection to the clinical-ethnographic approach. Once accomplished, we would be in a better position to reassess the various theoretical justifications of intuitive psychiatric judgments.

VI. BRANDS OF NORMALITY/RELATIONSHIP TO REALITY

The epistemological stance that accompanied the rise of modern science and the foundations of the technological progress built on the scientific method are associated with particular brands of normality and specific relationships to reality, what we can call modes of engagement with the world. The philosopher Charles Taylor reminds us that it is

a feature of our civilization that we have developed a practice of scientific research and its technological application from which the symbolic and expressive dimensions have been to a great extent purged. The seventeenth-century revolution in scientific thought rejected previously dominant scientific languages in which what one can call an expressive dimension had an important part. This was the case, for instance, with the language of 'correspondences', in which elements in different domains of being could be thought to correspond to each other in virtue of embodying the same principle. (Taylor, 1982, 94)

Taylor refers to a 17th-century refutation of Galileo's discoveries, where the principle of correspondences required that the planets must be seven because the different domains of being are all aligned to this number; Galileo, the argument goes, must be wrong. If we understand the kind of argument

offered and the logic of the theory of correspondences, we would find, as Taylor argued, that pre-Galilean science had not yet rid itself of the mutuality of understanding and attunement, a mutuality whereby the order of things of which individuals would have to be a part (e.g., the correspondence between the different domains of Being) constrained the very process of evaluating evidence and challenging theories. With the modern revolution in science, the idea that the world has a meaningful order and is an object of attunement "was seen as a projection, a comforting illusion which stood in the way of scientific knowledge … science could only be carried on by a kind of ascesis, where we discipline ourselves to register the way things are without regard to the meanings they might have for us" (Taylor, 1982, 96–97).

The breaking of the connection between understanding and attunement required a rejection of the idea that the world has a meaningful order imposed on us externally, which in turn required a relocation of meaning from the various Beings and Forces that imposed it on us to the interiority of the human self. Taylor calls this "disenchantment":

The process of disenchantment is the disappearance of this world [the world of spirits, demons, moral forces which our predecessors acknowledged], and the substitution of what we live today: a world in which the only locus of thoughts, feelings, spiritual élan is what we call minds; the only minds in the cosmos are those of humans … and minds are bounded, so that these thoughts, feelings, etc., are situated "within them"… Meanings are "in the mind," in the sense that things only have the meaning they do in that they awaken a certain response in us, and this has to do with our nature as creatures who are thus capable of such responses, which means creatures with feelings, with desires, aversions, i.e., beings endowed with minds, in the broadest sense. (Taylor, 2007, 29–31)

In the premodern (enchanted) world that Taylor has in mind, and among many of the people in Dakhla with whom I have lived for several months, meanings could reside in extrahuman entities and objects, whether spirits, dead ancestors, or charged objects like amulets and the Qur'an. "Meaning exists already outside of us, prior to contact; it can take us over, we can fall into its field of force. It comes on us from the outside" (Taylor, 2007, 34). Thus, for many of the people in the community, mood changes, desires, and compulsions, in addition to more extreme behavioral and emotional changes, could be brought about exogenously through the effects of extrahuman agents like spirits and devils bent on hurting us or drawing us into their world in a variety of ways. To be affected in this way is to be taken over into a domain of meanings that exists outside the subject, prior to, and in spite of her.

Now in the enchanted world, Taylor writes:

certain boundaries which are both familiar and crucial to us seem to fade … the clear boundary between mind and world which we mark was much hazier in this earlier understanding. This follows from the fact of influence. Once meanings are not exclusively in the mind, once we can fall under the spell, enter the zone of power of exogenous meaning, then we think of this meaning as including us, or perhaps penetrating us. We are in as it were a kind of space defined by this influence. The meaning can no longer be placed simply within; but nor can it be located exclusively without. Rather it is in a kind of interspace which straddles what for us is a clear boundary. Or the boundary is, in an image I want to use here, porous. (Taylor, 2007, 35)

Contrast this with the modern "buffered" self, no longer subject to impingement by extrahuman agents and capable of "disengaging from everything outside the mind" (Taylor, 2007, 38). Thus, my moods are not to be explained with reference to extrahuman agents that draw me in to an *independent*

world of meanings but by a consideration of the circumstances of my life, my thwarted hopes, my failures, and my purposes, all the way to the possibility of altered neurochemistry.

The modern, or as some authors call it the "Western," self is a product of a process of disenchantment that leads to relocation of meanings from exogenous, extrahuman domains to the interiority of the mind. In his *Sources of the Self*, Taylor (1989) calls this "inwardness" and traces its intellectual sources to Plato, Descartes, Augustine, and Locke. Yet, Taylor's characterization of the modern self was arrived at by other scholars, notably anthropologists, without the need to peruse the history of ideas or the heritage of the Western tradition's great minds. Seen in the mirror of other culture's notions of selfhood, qualities of the modern self have been expressed in a number of metaphors. Buffered as discussed above and also detached, independent, autonomous (Marsella, 1985), and bounded, a "unique, more or less integrated motivational and cognitive universe" (Geertz 1984, 126). Fabrega takes the ideal self to be

autonomous, separate, sharply bounded and wilful. It originates or is the source of its own activity, and outside influences cannot control it. Properties of the self include thoughts (as well as actions and feelings), which are like language statements that are a part of the mind, and the self owns and controls them. They are secret and private things no one except the self can know about. (Fabrega, 1989, 53)

From this brief overview, we could draw a distinctive relationship to reality that seems to have accompanied the rise of modern science. I am not making any causal claims here, but simply pointing out that the epistemological stance required by modern science, a stance that involved a breakdown of the connection between understanding and attunement, was associated with a reordering of humans' relationship to the world and the very conception of the person. The world was largely expunged of extrahuman forces, meanings are located within and among agents, objects in the world are related to each other and to ourselves in non-mysterious ways, and while the specific relations may sometimes elude us, they are ultimately subject to potentially discoverable rational laws. This, together with the conceptualization of the person as a bounded, individuated, wilful entity resulted in a distinctive brand of normality codified in behavioral, emotional, and experiential norms. A quick perusal of our forms of psychopathology suffices to show that the range of relations and communications with extrahuman agents is understood as "psychosis," the wielding of intangible powers onto others is a "delusion of thought control," and the substitution of extrahuman for personal agency with regards to the production of moods, compulsions, and thoughts is a manifestation of "schizophrenia".

VII. "FAILURE IN REALITY TESTING" AS PROXY FOR "THE PRIMACY OF TECHNOLOGICAL PROGRESS"

With the previous section's insight at our disposal, how can we understand Spiro's contention that the experience of hearing the voice of a dead relative constitutes a failure in "reality testing" and is therefore pathological? What does the commitment to the notion of "reality testing" reflect? One way of understanding the issue here is the idea of epistemological priority. The notion of reality as Spiro intends it includes a clear distinction between the inner (the psychological) and the outer (the physical). Muddling up the two, or mistaking the former for the latter, threatens the priority of the proper forms of experience that constitute legitimate sources of knowledge about the world. A voice in the absence of a material stimulus is pathological because it does not yield empirical knowledge.

For the Plains Indians, however, the voice of a deceased relative constitutes knowledge of an invisible world, a world that will be their future abode and where their loved ones reside. The realities that Spiro (as a representative of extracultural scientific standards) and the Plains Indians subscribe to are different in many respects, crucially the presence of an afterlife and supernatural world in the latter. Spiro's claim that their experiences constitute a failure in reality testing and are therefore pathological is a proxy for saying that he does not agree with their *vision* of reality. Although he claims that the belief in ancestors calling from the afterworld is culturally normative but the actual experience of hearing a voice is pathological, it turns out that his primary problem is with a worldview whereby having such an experience is not considered pathological, a fact that indicates deeper problems with their beliefs.

At this point, the argument has shifted from the level of assessing experience to that of assessing worldviews, and it is my contention that this is Spiro's implicit concern. Enacting such an argument would require of us to assess the Plains Indians' worldview and the scientific/secular worldview to which Spiro subscribes in relation to their respective claims to knowledge: Which has a more legitimate claim to knowledge? The answer implicit in Spiro's argument and expressed in his notion of "reality testing" would be that the latter is superior and provides a universal basis on which to assess other visions of reality. At this point, we enter the debate on cognitive relativism, and without venturing too deep into it, allow me to consider an influential argument in support of the priority of scientific/secular worldviews over others.

The argument here is Ernest Gellner's. In his attempt to establish a Single World, a Unique Truth, he proposed two converging arguments, an epistemological and a sociological. He wrote

The epistemological … Initially anything may be true. We ask: how can we pick out the correct option of belief, seeing that we have no prior indication of what it may be? The answer is contained in the epistemological tradition which has accompanied the rise of modern science … The answer is, in rough outline: eliminate all selfmaintaining circular belief systems. As the main device of self-maintaining systems is the package-deal principle, which brings about the self-maintaining circle of ideas, break up information into as many parts as possible, and scrutinize each item separately. This breaks up the circle and destroys self-maintenance. At the same time, assume nevertheless the regularity of nature, the systematic nature of the world, not because it is demonstrable, but because anything which eludes such a principle also eludes real knowledge. (Gellner, 1987, 90)

He then goes on to argue that although the world consists of many diverse communities, a few of them possess enormous "cognitive wealth," the implementation of which has led to a "very powerful technology." These communities apply the kind of epistemology quoted above: "Powerful technology is based on a science which in turn seems to observe the rules of an information-atomizing inquiry, and of symmetrical and orderly theory construction" (Gellner, 1987, 91).

It is perhaps no longer required to provide justification for the claim that "a great discontinuity has occurred in the life of mankind, the view that a form of knowledge exists which surpasses all others, both in its cognitive power and in its social iciness" (Gellner, 1992, 50). Evidence for this statement can be seen in the implementation of this cognitive power and its truth presupposed every time I click on the keys of my laptop and every time a Qur'anic Healer from Dakhla takes his child for a vaccination. The significant technological advance brought about by adopting the scientific method *and* the appeal of the results to the diverse cultures of the world, according to this argument, suffice to prove the superiority of the scientific worldview in terms of claims to knowledge. The sociologist/philosopher Steven Lukes

summarizes it thus:

No one *really* doubts that science yields objective knowledge that enables us to predict and control our environment and that there has been massive scientific and technological progress, and no one really supposes that judgements of the cognitive superiority of later over earlier phases of scientific or of scientific over prescientific modes of thought are merely prejudices relative to 'our' local conceptual or explanatory scheme. People across the world live many-layered lives that can combine magic, religion and science in countless ways, but no longer in ways that preclude acceptance of the cumulating cognitive power of science. When people are ill, they can believe in miracles, prayer and surgery. Creationists and religious fundamentalists take flu vaccines whose development presupposes the truth of Darwinism, fly in aeroplanes, and surf the Web on computers. Members of tribes who consult witch doctors seek cures in local hospitals when they can; and although countless people in modern societies hold innumerable weird and apparently irrational beliefs, they do so against the massive background of science-compatible common sense. Those who most loudly proclaim their anti-modernism never reject the whole package. Antimodernism is a modernist stance; there is no route back from modernity. (Lukes, 2008, 13–14)

According to the epistemological and sociological arguments, the Plains Indian's worldview and the spirit-dominated worldview in Dakhla will emerge inferior. Epistemologically, adherents of both worldviews celebrate and refuse to doubt received knowledge. Knowledge pertaining to the world of spirits and departed ancestors is unfalsifiable, and evidence for its truth is spontaneously confirmed in people's experiences, the most radical example of which is the normativity of consorting with spirits and receiving communications from dead ancestors. This shields received knowledge from doubt and renders unlikely the elimination of self-maintaining circular belief systems. Contrast this, for example, with the scientific view of similar experiences. Not only they are epistemologically dubious but also they are considered pathological, and those who profess such experiences risk falling under the psychiatric gaze. Sociologically, neither community contributes to the "very powerful technology" produced by the kind of epistemology quoted above. The fact that these forms of experience are not considered pathological is therefore an indication of a much deeper epistemological problem, a problem that will not allow such communities to contribute to the cognitive wealth and the consequent valued technological progress that characterizes the age in which we live.

It seems that we have turned Spiro's argument on its head. The initial claim that the experiences of hearing the voice of a dead relative or consorting with a spirit constitute a failure in "reality testing" and are therefore pathological turns out to be fundamentally motivated by a prioritization of a specific relationship to reality and a distinctive brand of normality, while both are upheld through the epistemological gains they allow and the valued technological progress such gains ultimately produce.

VIII. Conclusions

The hypothetical psychiatrist I referred to in the first paragraph of this article encountered a person who professed that he is married to a spirit. The spirit communicates with him on a frequent basis. Her intuitive judgment will most likely be that these experiences are abnormal. This is a situation real psychiatrists are familiar with and a judgment many would be inclined to make. Yet, the fact that such experiences are not considered abnormal in the patient's own cultural context poses a dilemma. Are our psychiatric judgments justified, are they false, do we have grounds to make them? The relativist position might have been a powerful means of shifting the grounds

for making such judgments by relegating all powers to the culture. Yet, the deficient view of culture required by this position and the fact that the individual remains out of sight made it unviable. The clinical-ethnographic position allows one to suspend judgment further to understanding the individual in context. Whether the person's experiences are abnormal is an emergent and not a fixed judgment. Spiro, as a representative of the universalist-scientific position, attempted to fix this judgment by appealing to extracultural, scientific standards whereby any experience that constitutes a failure in "reality testing" is pathological. In the last two sections, I demonstrated that Spiro employs the language of "pathology" as a proxy for the undeclared but implicit prioritization of the scientific worldview, the cognitive wealth amassed through its adoption, and the technological advances that resulted. The dilemma is thus not so much solved, but shifted to more fundamental levels of analysis. We could, for example, question Gellner and Luke's contention that the conjoined facts of powerful technology and its appeal to diverse cultures place the scientific worldview in a position superior to all others. In addition, if we succeed in showing otherwise, we could then argue that the relationship to reality and the distinctive brand of normality presupposed by other worldviews cannot be labeled "abnormal" or "pathological". To attend to these questions and possibilities exceeds the scope of this article, but let me point out that I believe the question here is ultimately one of values. Even if the scientific worldview is superior in terms of cognitive wealth and the powerful technology this has resulted in, there will always be a moral dimension to such claims. There will always be a conflict of values that cannot be reduced either to the fact of technology or the fact that diverse cultures have embraced it. This is because of the simple fact that technology may seep in to homes in London, Zanzibar, and Dakhla, but values do not always, or necessarily, tag along; this is one of the peculiar characteristics of the movement of culture.

The universalist-scientific position is not value or culture free. The language of "pathology" and "reality testing" masquerades as objective and scientific yet is ultimately value-laden. If we deconstruct these terms and the arguments that employ them, we find that they are used, by proxy, to impose value judgments toward distinctive and diverse worldviews. Once we realize this, we can continue upholding such judgments, only becoming aware that we are ultimately arbitrating which value system is superior. Such judgments will fall back on the kind of life we want to live and the kind of things we want to surround ourselves within vicious cycles of valued values, which stop the moment we consider a certain value absolute, a value that falls back on our idea of what a good life is.

From a clinical perspective, both the relativist and the universalist-scientific positions represent an abandonment of responsibility toward those who find themselves with psychiatry. The relativist position abandons the person by giving absolute powers to her cultural group to decide whether she is ill or not. The universalist-scientific position abandons the person by implicitly imposing a set of values to the neglect of her own. Through suspending judgment of abnormality and the adoption of an exploratory approach, the clinical-ethnographic position seems to be the one geared toward understanding the person and respecting her values. This is not only a requisite for a potentially productive clinical alliance but also the means of establishing who needs clinical help and support and who does not.

Notes

1. Commenting on the cultural basis of Schneider's first-rank symptoms Fabrega (1982) wrote: "These [first-rank] symptoms imply to a large extent persons are independent beings whose bodies and minds are separated from each other and function autonomously. In particular, they imply that under

ordinary conditions external influences do not operate on and influence an individual: that thoughts are recurring inner happenings that the self "has"; that thoughts, feelings, and actions are separable sorts of things that together account for self-identity; that thoughts and feelings are silent and exquisitely private; that one's body is independent of what one feels or thinks; and finally that one's body, feelings and impulses have a purely naturalistic basis and cannot be modified by outside "supernatural" agents … and it is based on this psychology (i.e., a Western cultural perspective) that schizophrenic symptoms have been articulated" (56–57).

2. This is evident in the following warnings: religious beliefs are not delusions if "ordinarily accepted by other members of the person's culture or subculture (i.e., it is not an article of religious faith)" (APA, 1994, xxiv); "hallucinations may … be a normal part of religious experience in certain cultural contexts" (APA, 1994, 275).

3. Abnormality, in the sense used here, refers to conditions, behaviors, experiences, and personality traits that are undesirable irrespective of the explanatory frameworks brought to bear upon them. An intuitive or pretheoretical judgment that a particular condition or state is abnormal may be followed by a further impetus to impart a diagnosis or conceptualize an explanation. Whether it is couched in supernatural or biological terms and whether or not it is made in the form of a diagnosis, an explanation—if understood with regard to its ultimate manifestation—is a rhetorical move with the purpose of negotiating individual agency and responsibility in subtle or crude ways, to allow some action to be taken toward managing the problem.

4. This vignette is distilled from several months of fieldwork in the Dakhla Oasis, Western desert, Egypt (May 2009 to April 2010).

5. The term is derived from the root for "brother," and it refers to a state of close (though not necessarily sexual) involvement between two individuals. In the context of spirits, *mekhaweyya* refers to a state of intimacy between a human being and a jinni of the opposite sex.

6. My personal experience throughout fieldwork in the Dakhla Oasis confirms this claim; the persons I interviewed, expert and otherwise, when presented with a typical description of psychosis thought of *mekhaweyya*.

7. For a recent discussion on why these attempts do not work consult Derek Bolton's *What is Mental Disorder* (2008, 111–162). In summary, Bolton argues that attempts to define disorder in naturalistic terms have been found wanting. There are two influential accounts in support of a naturalistic definition of mental disorder. Both break down disorder into a harm component (socially defined) and a dysfunction component (objectively defined), to then proceed and delineate the nature of the dysfunction. In the first account, dysfunction is a matter of deviation from a statistical norm, a distinction that runs into problems partly since it begs the question why lying on an extreme end of a bell-curve in the absence of harm would constitute a dysfunction, which suggests that the presence of harm—and therefore social norms and values—seems to be the point at which judgments of dysfunction are made. In the second account, dysfunction is a matter of a mechanism not performing the function it was designed to do through the process of evolution, a theoretically plausible distinction that nevertheless has limited clinical and practical utility since it hypothesizes the existence of complex evolved mechanisms in the absence of ready-to-hand models that could enable a clinician to judge whether the patient he is seeing has this sort of dysfunction or not. Further, this definition rests on the "now doubtful assumption that there is a clear (enough) division between psychological functioning that is natural (evolved and innate), as opposed to social (cultivated)" (Bolton, 2008, 124).

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