In This Issue

Psychiatry and Philosophy

Anna Yusim, M.D.
New York University School of Medicine

*Everybody inclined to disregard philosophy will be overwhelmed
by philosophy in an unperceived way. —Karl Jaspers*

Both psychiatry and philosophy are academic disciplines devoted to understanding the mysteries of the mind and the basic tenets of human nature: perception, reality, thought, affect, free will, determinism, and personal identity, to name a few. This issue includes an interview with one of the leading thinkers about the interface of philosophy and psychiatry, Dr. Kenneth Kendler, who discusses how an understanding of basic philosophy can inform our understanding of psychiatry. Then, Dr. Ricardo Cáceda explains the ancient philosophical question of the "rational" vs. "intuitive" dichotomy and its implications in our field. Dr. Nomi Levy-Carrick has contributed an article on the difference between ethics and professionalism in medicine, in both theory and in practice. Finally, Gladys Reyes and Dr. Helena Hansen focus on yet another philosophical issue inherent within our current psychiatric nosology: establishing culturally appropriate tools for diagnosing and treating mental illnesses worldwide. We hope that this issue will influence residents to consider ways in which the fields of psychiatry and philosophy have the potential to inform and enhance one another.

Interview With Dr. Kenneth S. Kendler

Anna Yusim, M.D.
New York University School of Medicine

The following is an interview with Kenneth S. Kendler, M.D., on "philosophy and psychiatry," conducted by Anna Yusim, M.D. Dr. Kendler is the Rachel Brown Banks Distinguished Professor of Psychiatry and Eminent Scholar at the Medical College of Virginia/Virginia Commonwealth University, where he serves as Director of the Virginia Institute for Psychiatric and Behavioral Genetics. He is a thought leader on the intersection of philosophy and psychiatry and author of Philosophical Issues in Psychiatry: Explanation, Phenomenology, and Nosology *(Johns Hopkins University Press, 2008). Dr. Yusim is a fourth-year Psychiatry Resident at New York University and the Editor for this issue.*

Dr. Yusim: Although your primary research is in the area of psychiatric genetics, you have done a great deal of writing and thinking about issues at the interface of psychiatry and philosophy. What motivated your interest in this subject?

Dr. Kendler: I didn't study philosophy in college. Around 1998, I listened to some tapes by the American philosopher John Searle and was quite transfixed by the mind-body problem—or the question of how exactly the mind relates to the body. At the time, I had been struggling with problems of how you interrelate reductionist molecular models of psychiatric illness with more mentalistic psychological models and constructs. So coming upon this literature was revelatory because here were people who had thought about this issue seriously. For several years thereafter, I was reading everything I could get my hands on in the mind-body area. Then one day Nancy Andreasen, the Editor-in-Chief of *The American Journal of Psychiatry* at the time, invited me to write a review of the mind-body problem, which I did with some trepidation since I was not an expert in this area. It was ultimately a very rewarding experience, and Nancy was pleased with the results. Going into print in an area that you are not deeply expert in is not so easy, and this has been an increasing theme. Now when I give talks to philosophy departments, I virtually always begin by saying, "You know, I'm not *really* a philosopher."

Dr. Yusim: How do you think an understanding of philosophy can inform and enhance our understanding of psychiatry?

Dr. Kendler: We are still in a phase of American psychiatry that is a reaction formation against psychoanalysis. That has led to an aversion of more conceptual philosophical approaches. Were you to look at major psychiatric journals from the 1980s and 1990s, you would see that there really wasn't a consideration of these deeper conceptual issues. I think this is to our detriment. One of the deepest of these issues is the problem of reductionism versus emergence, the concept of pluralistic explanations. When your patients ask you what is causing their depression, what do you tell them? Do you give them the molecular neurobiological answer or the soft psychological answer? Thinking about the many discussions I have had with Eric Kandel over the years, I think if you really pushed him, he would likely accept temporarily the concept of these softer psychological explanations, but ultimately he would take a more reductionist approach and argue for a molecular neurobiological explanation. I don't know if I completely agree. Betting against the progress of science is always somewhat dangerous, but I believe there is something incredibly important about the concept of meaning as an emergent property. I am pretty deeply committed to explanatory pluralism, as articulated very well by Sandra Mitchell in her recent book *Biological Complexity and Integrative Pluralism,* in which she carves out a middle ground between "anything goes" pluralism and reductionism in biology. In my research, I deal with psychological constructs, social constructs, cultural factors, issues of free will, you name it. How do these factors interrelate to explain the phenomena we observe in our patients? I believe that thinking seriously about conceptual philosophical questions such as this can inform our practice as psychiatrists.

Dr. Yusim: One important philosophical issue about which you write is the way in which we as psychiatrists create the nosological constructs that define our field. Our present psychiatric nosology is based on the biopsychosocial model of mental illness. What do you see as the problem(s) with such a model?

Dr. Kendler: I'm not a large fan of this model because it's so uncritical. To put it simplistically, it's right-hearted and wrong-headed. Yes, we need to be roughly pluralistic, but the way it gets translated in psychiatry is that "everything's important, let's all sit down together." It's kind of a feel-good approach, which is not what the discipline needs. Each approach needs to be rigorously and empirically embedded, and the answers about what is important with respect to explanation and causality are not going to be the same for all diseases. For example, in schizophrenia large-scale societal factors are probably not very critical with respect to etiology. For eating disorders, on the other hand, they are probably vital. Yes, there are many potential factors and levels that impact psychiatric illness, but for each particular disorder they need to be rigorously embedded. In the biopsychosocial model, by saying that the biological, psychological, and social factors are equally important, we actually say very little.

Dr. Yusim: Psychiatry residents have little exposure to the subject of philosophy in the psychiatric curriculum. Should more philosophy be integrated into the residency curriculum, and, if so, what should this entail?

Dr. Kendler: You're not asking easy questions. Yes, I believe so. It's a real challenge to train psychiatrists in the amount that they ought to know in areas like anthropology, sociology, and history. I would at least feel that the history of early psychiatric thought is very important. If you talk to even very well-trained psychiatry residents in the United States today about Kraeplin, Bleuler, Jaspers, Schneider, they might know the names, but only one in 10 would have ever picked up a book or could ever tell you anything about them. I would also think that it would be important to have a basic lecture series on the key conceptual and philosophical issues in psychiatry. These include the mind-body problem; the problem of levels of explanation; scientific pluralism, reductionism, and emergentism; certainly something about categories and characterization; and probably something around the free will versus determinism question, particularly as it pertains to topics like addiction. This would be a good start.

Integration of Reason and Intuition: Is It Relevant to Everyday Life?

Ricardo Cáceda, M.D., Ph.D.
Emory University School of Medicine

There is a long-standing tradition of conflict regarding our so-called rational and intuitive minds that dates back to ancient Greece, with the Apollonian and Dionysian dichotomy. This dichotomy has been alive for centuries, with each of the two camps defended by illustrious philosophers such as Plato, Descartes, Kant, Smith, Nietzsche, Jung, and others (1). In this century, the debate has continued and been enriched by cognitive psychology and neuroscience. During the last decade, significant progress has been made toward our understanding of the neural substrates of higher cognition. A variety of experimental paradigms have applied brain imaging to explore social emotions/attitudes such as empathy (2), cooperation (3), altruism (4), disgust (5), punishment (6), and moral dilemmas (7). These sentiments have been collectively associated with a consistent core of brain regions—dorsolateral prefrontal cortex, medial prefrontal cortex, orbitofrontal cortex, anterior cingulate cortex, posterior cingulate cortex, precuneus, anterior temporal cortex, superior temporal sulcus, ventral striatum, insula, and amygdala—involved in both cognitive as well as emotional information processing.

In the field of moral psychology, a clear neurobiological differentiation between justice and care ethics has been described (8). To differentiate these two concepts in philosophical terms, justice ethics is associated primarily with human rights and the application of moral rules, whereas care ethics is related to human needs and a situational approach involving social emotions. Connectivity analysis, a technique whereby functional magnetic resonance imaging is used to identify which regions of the brain or neural networks are activated together during a specific task, was used to identify a functional neural network involving the frontal pole, anterior cingulate cortex, superior temporal sulcus, and posterior cingulate cortex in a moral sensitivity task in which subjects were presented with vignettes pertaining to care, justice, strategic, tactical, or neutral content (9). The cognitive response (e.g., whether subjects felt they were faced with justice versus care ethics issues) appeared to depend on the pattern of activity within this network. This finding suggests that human ethics reflects the integration of opposing cognitive rule-based and social emotional-based responses (10, 11) that compete for limited neural resources. It seems that rather than having either a rational or an intuitive mind, we are biased toward a given cognitive outcome that is driven by the interactions within neural networks at a particular moment.

Traditionally, moral forms of cognition have been considered separate, and even antagonistic, entities from nonmoral forms of cognition. An example of nonmoral cognition is strategic/tactical thinking, which is the canonical paradigm of executive thinking and planning. Strategic/tactical thinking is frequently associated with business, economic, or military settings and refers to the organization and management of resources in order to attain certain goals within determined time frames. In a recent study (12), we revisited the long-standing assumption that moral cognitions are separate and distinct from nonmoral cognitions, namely strategic/tactical thinking, and found stunning similarities between them. Specifically, a very similar pattern of brain activity organization during justice moral cognition tasks and strategic (nonmoral) cognition tasks was seen for the following three distinct factors: executive (frontal pole, dorsolateral and dorsal medial prefrontal cortex, and anterior cingulate cortex), emotional (anterior and posterior insula and inferior parietal gyrus), and self (superior temporal sulcus and posterior cingulate cortex). Moreover, individuals with moral devel-

opment and strategic aptitude displayed increased neural activation in the insula (involved in emotion and proprioception) and lower activity in the prefrontal cortex (associated with executive function and planning), suggesting that they performed both types of cognition tasks in a more automatic "gut feeling" way, with less need to engage limited cognitive resources. It is possible that incorporating the calculation of moral issues could allow for better accounting of the "human factor," leading to more efficient strategic planning. The overlap between moral (justice) and nonmoral (strategy) cognitions is consistent with the notion of integration of competing rule- and social emotional-based forces.

Like moral psychology, other fields of study of normative judgment have undergone similar rationality versus emotion/intuition polarization. Moral philosophy has historically been divided between two camps: the "rational" utilitarians and the more "intuitive" deontologists. Utilitarians, epitomized by John Stuart Mill, defend the pursuit of "the greater good" and, as adherents to consequentialism, judge the moral worth of an action by its results in effecting the greatest amount of good for the greatest number of people. In contrast, deontologists, such as Immanuel Kant, propose universal moral principles that should be observed despite the greater good and determine the moral worth of an action by examining its inherent value (1). Study of normative judgments in the law has shown that juries' decisions are not entirely dispassionate and rationally based but can be strongly influenced by emotion (13). In economics, emotion has also been found to interfere with the rational motivation of obtaining maximal profit predicted by neoclassical economics and game theory (14). In all of these fields, human behav-

ior does not follow rigidly one of two extremes but usually transits along a middle fluctuating path between reason and emotion/intuition.

It is tempting to hypothesize that integration of opposing forces, reason, and emotion/intuition might be a common strategy found in human cognitive experience. The human mind is more complex than a simple dichotomy. In everyday life, we transit the continuum from pure intuition to exact cold hard reason. Mental health likely requires flexibility to do so. However, once we get trapped in either of the extremes, it is likely that we will march into the territory of psychopathology. Aspiring to have our patients to be completely rational all the time would be an unrealistic and undesirable goal. Common clinical examples of this are alexithymia and the excessive or inappropriate use of psychological defenses such as intellectualization and rationalization. The core of this idea is not new, nor exclusive to modern neuroscience, as illustrated by Freud's topographical model (15) and most recently by dialectical behavioral therapy and its construct of the "wise mind" as a product of the rational and emotional minds (16).

Dr. Cáceda is a fourth-year psychiatry resident at Emory University School of Medicine.

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Writing for the "Blue Journal":
The Residents And Fellows Edition of *The American Journal of Psychiatry*

Date: **Monday, May 24, 2010**

Time: **9:00 AM to 10:30 AM**

Location: **RM 346/347 in the Morial Convention Center**

Ethics and Professionalism in Medicine

Nomi Levy-Carrick, M.D., M.Phil.
New York University School of Medicine

Ethics and professionalism have both generated significant consideration by the individual physician regarding the duties and responsibilities to his or her patients and to society at large. In the context of recent healthcare reform, there has been a call for public support of the medical profession "to preserve professionalism among physicians" (1). What does this mean? And what does it mean for psychiatry? With the passage of mental health parity, psychiatry will be under increasing scrutiny at all levels, and a review of the basic principles of ethics and professionalism may be a useful starting point for discussion among practitioners.

Ethics and professionalism share the goal of treating human beings in a way that recognizes and preserves dignity and respect. As dynamic concepts, they have served as readily applicable guides to action and as frameworks for setting standards of behavior within a profession.

Ethics

Ethics is a branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions and to the good and bad of the motives and ends of such actions. The major principles of medical ethics are fourfold: respect for autonomy (the basis for informed consent), nonmaleficence, beneficence, and justice.

In medical practice, ethics committees in hospitals have been primarily concerned with a circumscribed set of clinical issues, including end-of-life care and withdrawal of life sustaining measures. Hospitals often charge their ethics committees with a limited mandate: to provide consultation on individual patient cases with ethical questions in order to help clarify (and at times coordinate) a reasoned and fair outcome based on the four major principles.

Professionalism

Professionalism in medicine has become an umbrella term that refers to a set of ideas and criteria variably defined and understood by those who are both engaged in and affected by its implications. In its most concise description regarding clinical interactions, professionalism refers to the goal of the physician to be competent, use his or her knowledge and skills first and foremost for the benefit of patients, and recognize that medicine as a profession relies on the public's trust (2). Professionalism has come under significant scrutiny over the past two decades, particularly as corporate sector involvement (including managed care) has eroded the public's trust that physicians make decisions based solely on the best interest of the patient.

The scope of professionalism has since been elaborated. One thoughtfully described set of criteria includes competence, engagement, reliability, dignity, agency, dual focus on illness and disease, and concern for quality (3). Others have added altruism, compassion, capacity for self-reflection, and service to this list (4–6).

In residency training, professionalism has a more modest scope, defined by the Accreditation Council for Graduate Medical Education (ACGME [7]), indicating "a commitment to carrying out professional responsibilities and an adherence to ethical principles." Residents are expected to demonstrate the following attributes (7):

- "compassion, integrity, and respect for others;
- responsiveness to patient needs that supersedes self-interest;
- respect for patient privacy and autonomy;
- accountability to patients, society, and the profession; and
- sensitivity and responsiveness to a diverse patient population, including but not limited to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation."

Interestingly, in the ACGME model, patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, and systems-based practice are additional core competencies that do not fall under the professionalism rubric. Note also that ethical principles are recognized as implicit to professionalism and therefore do not require delineation.

From Theory to Clinical Practice

In exploring the points of intersection of ethics and professionalism, it is reasonable to posit that ethical behavior is a necessary, but not sufficient, criterion for professional behavior. By definition, one cannot be professional without also being ethical. The converse, however, is not necessarily true. One can be ethical without being completely professional, given the broad scope of guidelines that this has come to encompass. There are a variety of ways to display professional conduct, and these include variations among general and specialty practice (8).

Although there certainly is not always consensus about what constitutes ethical behavior in different contexts, the process of evaluation is arguably better delineated than that of professionalism. While the field of ethics has several well-described methodologies to bring clarity to a particular situation, professionalism does not. Institutions have ethics committees to review concerns about ethical issues with regard to patient care. In contrast, the many components of professionalism are managed through multiple channels, such as departmental committees, hospital committees, risk management, and human resources departments. This fragmentation in agency and process is a function of many aspects of medicine. In addition, specialization is usually reinforced through autonomous admin-

istrative hierarchies, which is overlaid by bureaucracies internal to the profession.

Shared Endeavor Between Individuals and Institutions

Reciprocity in the social contract between physicians and patients has received significant attention over the years, but this tenet has been less explored between physicians and their institutions. In practice, professional (i.e., "appropriate") behavior for the individual physician is often defined in its breech; specifically, committees are established to deal with the impaired physician, conflicts of interest, boundary violations, etc. Often overlooked, however, is the degree to which the culture of an institution implicitly affects the behavior of individual physicians. Indeed, as one Veteran's Affairs team asserted:

The capacity of staff to adhere to ethical norms and standards is powerfully shaped by factors extrinsic to the individual, most notably, the organizational environment... so profound is the effect of the organization on the individual that the cause of gaps between how staff ought to act and how staff act should first be sought within the organization's systems and processes, and not in the individuals who work within the system. (9)

If an institution establishes a policy to limit its physicians' contact and receipt of gifts from the pharmaceutical industry, for example, then limiting the access of those pharmaceutical representatives to physicians on the medical center campus would be the institution's reciprocal responsibility.

A compelling, albeit challenging, mandate would be proactively to identify guidelines to help an institution foster and recognize professional action. This may be limited to clarifying existing institutional guidelines and policies in a manner that elucidates their relationship to the institution's mission, allowing for greater coherence and transparency. This may also provide a setting in which the principles that focus on fairness of application of rules (procedural justice) and of distribution of resources (distributive justice) can be both identified and invoked.

Conclusion

Why does this matter? This model of reciprocity is important in maintaining a sense of coherence, fairness, and justice in an institutional system like an academic center. Public trust is central to our understanding of medicine as a profession and of our duties and responsibilities as physicians, particularly in psychiatry. Professional behavior is likely to be better maintained if it is understood as the byproduct of right and respectful action rather than limited to adherence to a prescribed set of mandated and prohibited behaviors.

Dr. Levy-Carrick is a fourth-year resident at New York University. Dr. Levy-Carrick

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The Philosophy of Nosology: Global Mental Health and Lessons from Cross-Cultural Psychiatry

Gladys Reyes
Gallatin School of Individualized Study at New York University
Helena Hansen, M.D., Ph.D.
New York University School of Medicine; Columbia University Medical Center

In a special series published in *The Lancet*, the Global Mental Health Group called for closure of the gap between the need for mental health services internationally and the current availability of care (1). In this series, it was proposed that the "overall volume of services provided to treat people with mental disorders needs to be substantially increased in every country—but especially so in low-income and middle-income countries—so that the available care is proportionate to the magnitude of need." This call for closure was addressed primarily toward European and North American societies, which espouse a largely biomedical nosology regarding psychiatric illness. Can European and American practitioners bring their biomedical model to other countries in a way that accounts for cultural difference? For clues on how this may be accomplished, both clinical and public psychiatrists can look to research emerging from medical anthropology and cross-cultural psychiatry.

The growing body of research in cross-cultural psychiatry supports the following four premises of medical anthropology: 1) because behavior is socially normative, behaviors can only be identified as symptoms of mental disorders in relation to their cultural context; 2) even disordered behaviors identified as nonnormative in their cultural context may have specific social meaning and aims; 3) a (self) awareness of the culturally specific nature of biomedical psychiatry on the part of European and American practitioners is crucial to successful diagnosis and treatment of disorders in non-European cultural contexts; and 4) given the "socio-centric" nature of less individualistic non-European cultural groups, effective interventions often employ a social-systems approach, utilizing local resources.

In biomedical psychiatry, the diagnosis of mental illness is based on categorization of symptoms and other empirically observed characteristics. Although the DSM attempts to capture universal processes, its system of categorization and validation is the product of a culturally specific European post-Enlightenment paradigm. Symptom-based categorization leading to a specific treatment based on a theory of differential causation is an approach rooted in positivist European science. Anthropologist Atwood Gaines (2) expressed this problem as follows: "DSMs are moments of a (re)creative, constitutive, cultural historical process through which certain ethnic Western selves say something to and about themselves and others." Because the DSM is a product of the culture from which it emerged, caution must be applied in order to avoid assuming that behaviors are pathological outside of that culture without understanding the context of what is "normal" within the cultural group at hand. Psychiatrist-anthropologist Arthur Kleinman (3) wrote, "The experience of illness (or distress) is always a culturally shaped phenomenon."

A related problem involves the expanding reach of biomedical categorization to include everyday phenomena. Kleinman also made the following observation: "Adjustment disorder is important today because it straddles the border between normality and abnormality at a time in which diagnostic inflation has recast many normal reactions to the dangers of everyday life…as pathologies" (4). Medicalization raises the possibility that what is normal in a particular culture can be re-classified as pathological according to Western standards.

In a pioneering review of culture-bound syndromes, Ivan Karp (5) defined such syndromes as "forms found in other societies and at other times [that] are often associated with exotic and flamboyant forms of action which are spectacular even by the standards of the societies in which they are found." Such behaviors are easily classified as pathological. However, many anthropologists would argue that culture-bound syndromes have social significance beyond merely being "odd" behaviors. Culture-bound syndromes serve as a way for individuals to express something that is against the social norm, perhaps serving as a form of social resistance. This was the case in Aihwa Ong's (6) ethnography about spirit possession, in which female factory workers in Malaysia developed inexplicable mass hysteria in response to economic exploitation. In instances like this, clinicians must look into the context of behaviors to understand the etiology. In this way, idioms of distress serve as powerful ways to achieve some form of compromise between the needs of the individual and of his or her society, especially within sociocentric societies, where one's conception of self is largely defined by one's family and community.

Given the social nature of idioms of distress, group interventions are a promising strategy for closing the aforementioned treatment gap. One such intervention is sociotherapy, a form of group therapy designed to help individuals in a variety of cultural contexts identify local idioms of distress and address social problems. The group therapy approach reduces stigma by reframing the nature of therapy, which can be perceived as a mechanism of social control in sociocentric environments. In the context of mass trauma, sociotherapy demonstrates to the individual that he or she is not the only one suffering. In Rwanda, a community-based sociotherapy program helped rebuild the social structure and established powerful

systems of community support (7). This not only ameliorated individual suffering but also helped to prevent additional damage to social relations caused by ongoing behavioral disturbances. Although the sociotherapy approach targets a large number of people at once, its effect noticeably reaches communities at the individual level.

Another way of closing the treatment gap is by training community health workers, which addresses the lack of health professionals in developing countries. A program in Mexico involving *promotoras*, who serve as trained, nonprofessional community health workers, has increased the services available in underserved communities. Since *promotoras* come from similar backgrounds as the patients, they can view patients' distress through a sympathetic sociocultural lens and subsequently cultivate trust among the patients they serve. In this way, *promotoras* have assisted people in navigating and obtaining crucial services necessary for the empowerment of patients and communities (8).

Although interest in international mental health has increased in the past several years, more effort is needed to improve the services provided to developing countries. Incorporating an anthropological perspective can help psychiatrists to develop culturally appropriate tools for diagnosing and treating mental illnesses in the developing world. As shown in past studies, sociotherapy and the training of community health workers can be effective in closing the treatment gap, decreasing stigma associated with mental illness, and increasing the likelihood of successful treatment around the world.

Gladys Reyes is a Junior at the Gallatin School of Individualized Study at New York University. Dr. Hansen is a fifth-year resident and Robert Wood Johnson Health and Society Scholar at Columbia University Medical Center as well as an Addiction Psychiatry Fellow at New York University.

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