FORUM
CULTURE, SPIRITUALITY AND PSYCHIATRY

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Introduction

All contemporary and modem medical disciplines are products of a non-spiritual worldview. Their claims to expertise are based on a philosophy about the reality of the outside world termed scientific objectivism and realism. It stipulates a secular credo in medicine. This evolved during a slow process that led to discarding other cultural and religious or spiritual approaches to disease. Psychiatry shares this philosophy and history with other biomedical disciplines. The sufferings and agonies of both physical and mental illnesses undermine a person's whole social and cultural standing and bring into play spiritual and religious considerations. Yet, the secular credo formulates these as falling outside the periphery of medical theory and practice. Consequently, criticisms regarding the impersonality, objectivity, and focus on disease and curing at the expense of the person and his or her well being, considered in a broad cultural framework, apply to all of medicine as for psychiatry. This general clash of values between science and secularism contra spirituality and culture, a function of modem medicine's shedding of its broader healing mandate, provides the context of the topic covered in this essay.

The unique position of psychiatry in society and general medicine

The historical path to the secular credo has involved (a) enlarging and refining local popular knowledge about the naturalistic basis of disease and (b) peeling away and setting aside cultural and spiritual (derisively termed magical-religious) encrustations that clutter conceptions as well as clinical presentations of disease considered as sickness, the personal, social aspects of disease. The secular credo is comparatively easier to sustain in general medicine because the concern is the body as a mechanical object that can be technically examined so as to leave a person's cultural and spiritual complexity aside. General physicians are free to address these correlates of disease in a compassionate but extra medical way.

If the historical itinerary and its culmination in the reigning secular credo apply equally to psychiatry as to other medical disciplines, then the topic I have agreed to write about can be reduced to that of general clashes between the practice of a secular medicine to the neglect of culture and spirituality. In contrast, I believe psychiatry has had and continues to have a far more significant tie with things cultural and spiritual. There are several chapters in this different and unique story about psychiatry (compared with general medicine) and culture and spirituality that need to be considered. I will argue that human biological evolution, cultural evolution, the social history of psychiatry, and the ontology and epistemology of psychopathology will establish a unique special link between psychopathology and culture, spirituality, and religion. It follows that psychiatry has a unique function in relation to these domains.

Human biological evolution and psychopathology

Psychopathology, my term for the problems psychiatry deals with, has a basis in human biological evolution. The laboratory production of animal models of psychiatric disorders establishes the vulnerability of the neurobiological architecture of primates to stresses and agents that cause psychopathology in humans [1-3]. The character of some of these models, the clinical pictures that can be manufactured, compel one to believe that the syndromes in question can result from stressors arising in the natural flow of events in non-human primate societies [4-6]. Many varieties

of psychopathology have a genetic basis and are assumed to have either conferred selective advantages in earlier evolutionary environments or to have emerged in modem environments because of changes in social and behavioral ecology [7-10]. Furthermore, theory in evolutionary biology and psychology suggests that the neurobehavioral mechanisms governing behavior are a product of natural selection. In relation to, developmental and environmental stress, these can be expected to break down and lead to psychopathology~ [11-14]. Some hold that the root cause of a psychiatric disorder is an adaptation that has gone awry [15].

It is not possible to fully discuss here the origins of psychopathology (6]. Its presence in hominoid communities is related to the question, of the evolution of language, cognition and culture and is involved in what has been termed the evolution of the modem mind [16-20]. The actual dating of this process is much contested between those who posit a gradual development compared with a more circumscribed emergence around 50,000 years ago [21-23]. I side with gradualists and am of the opinion that during the later phases of human biological evolution, psychopathologies emerged and manifested as concrete naturalistic behavior problems of hominid societies [6]. Early varieties of psychopathology were interpreted and handled in the context of parallel evolutionary developments involving language, culture and cognition. I assume that psychopathology has a phylogenetic basis and constitutes a human universal [24).

The origins of a sense of spirituality and a religious formulation of coping and adapting are very likely to have constituted part of the evolution of language, cognition, and culture [ZS-28]. Members of Homo sapiens are cultural animals, in whom a symbolic capacity was naturally designed. This is realized in the creation of rituals and myths and attributing emotional significance to features of the group's social ecology. Together, this system of meanings or culture makes up a symbolic niche [18,29). Along with other challenges and problems that threatened social order, then, naturally occurring psychopathologies were most likely framed or interpreted in a cosmological, existential context that was religious and spiritual. Since before its inception, the behavioral world [30) of Homo sapiens has included a cultural and spiritual dimension, and psychopathologies have been configured and played out in such a milieu. This position requires elucidation of how general disease compared to psychopathology fitted in the equation of human biological evolution; however, exploring this further is beyond the scope of this presentation [6,31].

Cultural evolution and psychopathology

In the period of time since the emergence of language and culture, modern humans have lived in increasingly complex societies. One can thus examine psychopathology and institutions for handling it as grist for the mill of the processes described as cultural evolution [32,33J. Furthermore, since societies can be arrayed on an evolutionary continuum, psychopathology and institutions for handling it are part of this evolution. Medical traditions of antiquity (e.g., Chinese, Indian, Middle American, Islamic, and European) are products of cultural evolution. They all have represented health, disease, and suffering as an amalgam of concerns that required naturalistic and spiritual formulations and forms of healing. Varieties of psychopathology are recognized entities in virtually all traditions of medicine that have been studied carefully [34-41].

ln the traditions of medicine of ancient civilizations, tensions in the conceptualization of disease and psychopathology are evident. These manifest as clashes between a naturalistic compared to a spiritual conception. In the non-western traditions of medicine, religious and spiritual emphases in the equation of sickness and especially psychopathology continue to be integrated with naturalistic, scientific conceptions [42-47]. Thus, what in the west constitutes an incompatibility between medical science and spirituality has not existed in the theory and practice of other great traditions of medicine [48,49].

With respect to psychopathology, the secular credo of international psychiatry constitutes an anomaly in the cultural practices of medicine that exist now and have existed throughout the world. lnternationalist psychiatry now endorses a purely biological emphasis, with diagnosis, neurobiology, psychopharmacology, and controlled, technical procedures of behavior management or psychotherapy constituting its distinguishing characteristics. Cultural and spiritual concerns, so basic to formulations of personhood and social reality to persons across the globe, fall outside the strict confines of (a European) international psychiatry. The secular credo has spread across natural boundaries of language, ethnicity, culture, religion, and historical context establishing colonial outposts. It is being imposed in areas where there exist traditions of medicine and healing that have not totally negated or rejected aspects of spirituality and religion.

The social history and evolution of modern western psychiatry

Two majr developments that took place during early modem European history have played determinate roles in the cultural evolution of modern psychiatry. Because these are relatively well studied, they need only be mentioned briefly. One involves what historians of medicine term the evolution of THC modern conception of disease that psychiatry has adopted [3l,SU). This means that the complex phenomena of sickness came to be explained in what I have termed the modern secular credo: disease entities, now conceived as naturalistic objects independent of persons, have an identity or being of their own, are made up of physical, chemical material, have their own distinct causes and natural histories, and are assumed to require technical, mechanical solutions.

The second factor was the emergence of the actual profession of psychiatry in Anglo-European societies [51-53]. Two subsidiary factors need to be mentioned here. The history of psychopathology in Europe has a darker side, for afflicted persons were part of a segment of society that was regarded in negative terms; in other words, as constituting a social, political, and moral problem, and were often marginalized, exploited, confined to asylums, mistreated, and stigmatized [52,54-57]. The profession of psychiatry consolidated around the mandate that its problem area, while medical, was also social and moral. In other words, from its inception, modern European psychiatry was encrusted with (inherited) an amalgam of social, cultural, moral and also spiritual problems: the existential maladies of marginalized, isolated, exploited, and rejected persons [58].

Thus, early psychiatry in Europe was engaged in two missions that, on the basis of hindsight, one can say constitute a root intellectual quandary of today. First, the profession attempted to effectively solve complex human problems that had a social, cultural, moral, and spiritual character, and secondly, it began to formulate a perspective that these problems had (i.e. could be reduced to) a medical organic substrate that admitted technical solutions by means of what evolved into the secular credo. While pursuing its social mandate, then, the discipline became committed to a credo of research and practice that was in some ways contradictory to it.

On the ontology and epistemology of psychopathology

The secular credo of internationalist psychiatric diagnosis stipulates abstract and objective (indeed, almost impersonal) criteria of thinking, feeling, and behavior [59]. It excludes essential components of human cultural psychology. The latter consists of meanings embedded in human psychology, involving such things as worldviews, models of thought, interpretation of emotions, notions of personhood, and a sense of cosmological, spiritual placement in the universe that includes religion [e.g. 42, 60-63].

Psychopathology incorporates a mental, physical, and symbolic representation of the social and behavioral environment, and its manifestations have necessarily implicated that environment in a significant way. Explaining and making sense of psychopathology has always required a consideration of the person's cultural tradition and social standing in his or her world. This is a

chapter in the story of psychiatry that cannot be gone into further here [6,48,49]. The important point is that the sphere of human cultural psychology, namely, representations of culture in the mind; constitutes an integral part of the genealogy and essence of the sickness problems that psychiatry seems destined to uphold in its theory and practice. Of course, a society's social and behavioral ecology has to be accorded a central place in explaining clinical pictures of psychiatric disorders along with features of human biology. But the important point is that so does culture and cultural psychology in the way discussed here. In short, insistence on diagnostic criteria that exclude culture and spirituality contradicts the phylogenetic basis of psychopathology discussed earlier.

Why and how cultural psychology matters in psychiatry

My account has summarized basic evolutionary, historical, and philosophical characteristics pertaining to psychopathology and the discipline of psychiatry. The question can be raised as to the bearing this has on to the position of psychiatry and its practice in relation to other medical disciplines (and the organization of medical practice) of contemporary societies. Along with disease and psychopathology, medical disciplines are culturally, historically contingent products. Disciplines that define the institution of medicine today are paradigmatic examples of this truism. What a valid, authoritative restructuring of the organization and practice of medicine of a perfect society would Iook like is difficult to be clear about, but expertise over a class of medical problems would seem to constitute a valid consideration. Medical expertise here translates into knowledge about causation, manifestations, and treatment efficacy (which brings into play the alleged natural history of disease). Thus, how the pie of human sickness and disease is academically and scientifically cut up constitutes an appropriate basis for establishing what distinguishes a medical discipline's domain of practice.

Human psychology has as legitimate a claim to be considered a pillar of a medical discipline's area of concern as do any of the other criteria that define a medical discipline or specialty, such as age group, causal agent, body location of pathology, technical means of treatment, or genes. I have already indicated that a representation of culture in human psychology plays a determinate role in configuring and enacting a picture of psychopathology, be it as a cause, organ of pathology, manifestation, aspect of natural history, or response to treatment. This implies that, given the character of psychopathology (e.g., its evolutionary basis, history, ontology), human cultural psychology should play a central role in influencing most of the criteria that constitute psychiatric expertise and that would authorize a valid system of medical psychiatric diagnosis and practice.

Indeed, my argument is that any disorder that purports to be psychiatric, that belongs within the territory and mandated sphere of influence of psychiatry, has to have a significant human cultural psychology component. This leads to the following claim: cultural meaning systems are integral components of the biological markers or criteria of psychiatric diagnosis. International psychiatry should recognize this fact.

Studies of culturally oriented psychiatrists and anthropologists have established clearly and in a convincing way that psychopathology represents a disturbance in the holistic adjustment and adaptation of the person.

The model of the world and of self (including sickness) that persons carry in their minds (i.e. their cultural psychological play a central role in the causation, perpetuation, manifestations, course and response to treatment (37,64-71]. To repeat, this `world carried in the mind' consists of ideas, world views, sense of personal identity, notions about spirituality and religion, ideas of sickness, perspectives, perceptions, and orientations about the behavioral environment considered in cultural or symbolic terms.

The emergence of language, cognition and culture during human biological evolution ensured that the symbolic dimension of adaptation, the incorporation of meaning into the equation of living, reproducing, and surviving, would of necessity play a role not only in why and how things were fitted in the economy and social ecology of experience, action, and behavior, but also in any disorders or disturbances pertaining to these realms of adaptation. Pursuing this evolutionary theme further is not appropriate here [6,48). Suffice it to say that universal parameters of adaptive behavior, for example, emotion and affects, ideas, beliefs, and thinking, notions of selfhood, alimentation and other biological functions, dissociation, and awareness and experience of the body, can break down and give rise to signs and symptoms. These would include, respectively, depression and anxiety, delusions and psychotic experience, personality function, anorexia and bulimia, possession and dissociation disorders, and somatization disorders. To complete the circle, each of these forms of psychopathology (i.e. our psychiatric disorders), when configured and played out clinically, can be shown to significantly incorporate cultural structures and models that persons carry in the mind and that make up the communication structures of their world, including spirituality and religion. In virtually any psychiatric disorder, in other words, cultural structures and models (i.e. human cultural psychology) are prominently and influentially represented.

Implications with respect to psychiatric nosology

Because adaptive human behavior has a cultural psychology character, it follows that so do maladaptive ones. All of the parameters of cultural human psychology, cognitive structures and models of a culturally constituted behavioral environment serve as the building blocks of adaptive behavior and all are implicated in psychopathology. They are vulnerable to abuse, unregulation, malfunction, aberration or dilapidation. These generalizations hold for all adaptive behavior patterns and for disorders or disturbances that are the product of perturbations of the neurobehavioral mechanisms underlying naturally designed as well as learned routines of behavior.

This implies that while psychiatric disorders have a claim to be considered universal medical categories, the disorders also have to be defined so that they bring into center stage of clinical rationale and diagnosis the reality of cultural meaning systems. In stipulating a pan cultural, universal validity about the character of psychiatric disorders, the exact outlines of which need to be developed further, it becomes necessary that the disorders also be accorded some cultural relativity [60,72]. This is the essential irony of psychopathology and psychiatry that can be concluded on the basis of an analysis of its evolution, history, philosophical underpinnings, and empirical studies in cultural psychiatry.

It seems to me that the science of psychiatric taxonomy and nosology and the rationale of a system of international diagnosis are required to take into consideration the central role that cultural psychology plays in affecting the nature and character of psychopathology [73). When one unpacks cultural psychology, one has meaning systems that include spirituality and religion among many other themes. Restoring cultural psychology to its rightful central position in the architecture and substance of psychopathology would require members of the discipline to take some account of the cultural and spiritual character not only of the life circumstances of the victim of psychopathology but of the composition of psychopathology itself. Biological criteria of psychiatric diagnosis are needed and important but so is a consideration of the central fact of variability in the way cultural psychology shapes maladaptive behavior and social and psychological suffering.

The physical territories into which world psychiatry spreads are similar to those occupied by general medicine. However, the mental territory differs substantially. General medical diseases

conform ontologically and epistemically to the strict logic of the secular credo and its directives: treatments and magic bullets can remove morbidities and lessen mortalities with relative ease and impunity. Because causes and manifestations of psychopathology are more deeply connected to culture and spirituality and are not purely mechanical distortions easily demarcated from personhood, attacking psychopathology with an impersonal agent is insufficient. Furthermore, when the agent is part of a foreign system of medicine imposed on a native tradition, this cause, a comparatively greater degree of personal and social disorganization and conflict.

To neglect the cultural character of psychopathology and handle it like general medical diseases is to make of a psychiatrist a technician intent on relieving signs of disease by prescribing illusory magic bullets. This is contrary to what an understanding of the biological and cultural evolution of psychopathology compels one to do.

Furthermore, besides setting apart the social history and mandate of modem psychiatry, this has the effect of rendering the discipline vulnerable to purely political economic influences tied to world capitalism, such as the simplistic' marketing strategies of international pharmaceutical cartels [63,67,74].

Summary and conclusions: on the seven :Ins of International psychiatry

The science and practice of contemporary internationalist psychiatry embodies and perpetuates seven cultural and spiritual sins that are in need of absolution: (1) failure to appreciate the evolutionary origins of psychopathology and the implications that this has about its symbolic character (2) advocacy of a secular, reductionistic credo of diagnosis and practice that neglects the evolved wisdom of the great traditions of medicine as well as empirical findings in cultural psychiatry pertaining to the integrated character of psychopathology; (3) reliance on a philosophy and nosology of diagnosis that negates the importance of human cultural psychology and the importance of the character of a person's social, existential reality in affecting the character of psychopathology; (4) disregard of the social, moral mandate that gave rise to the discipline and profession of psychiatry, which was to help disadvantaged, exploited, and marginalized social groups whose plight requires addressing more broadly based concerns about meaning, culture, and spirituality as well as the realities of political and economic exploitation; (5) a neglect and devaluing of the essential cultural, religious and spiritual meanings that are integral to the experience and diagnosis of psychopathology and that are in special need of reaffirmation in the contemporary world; (6) undue reliance on a system of pharmaceutical treatment, the rationale of which minimizes if not excludes the role of cultural psychology; and (7) the endorsement of forms of psychotherapy that bypass the importance of cultural, religious, and spiritual concerns in favor of objective, economistic, pre-formulated, behavioral rubrics.

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Comments

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Based on a comprehensive and scholarly analysis of relevant factors involved in shaping the secular credo of international psychiatry, Fabrega makes a case for the restitution of cultural psychology and its meaning system, including spirituality and religion, Lo a central position for the understanding, diagnosis and treatment of mental disorders. The danger of the psychiatrist becoming a technician at the service of 'pharmaceutical cartels' is spelled out, together with a poignant description of the seven sins of international psychiatry.

What follows is an attempt to underline some of the aspects of the present predicament of psychiatry in relation to spirituality and to speculate about possible future developments in this area.

A wealth of publications in recent years have dwelt upon the paradigm shift in psychiatry brought about by the expansion of knowledge in neurosciences, molecular biology, informatics and psychopharmacology, which altogether have amounted to a neurobiological revolution. Global endeavors such as the decade of the brain and the mapping of the human genome have given impetus to research and technology for the exploration of the biological basis of mental functions and mental disorders. As a result of the unilateral emphasis on the basic sciences, the clinical practice of psychiatry may have become progressively bereft of elements such as empathy, compassion, sensibility and psychological awareness. Under pressure to join the forces of biological psychiatry, more and more practitioners apparently proceed to memorize the names and alleged properties of drugs, prescribing them to correct the chemical imbalances or deficiencies supposedly responsible for mental disorders and in this process they depend heavily on the influence of the pharmaceutical industry. The problem is complicated by a drastic reduction of the

time assigned to patient's visits as a result of the managed care system and the consequent intrusive monitory exercised on the clinical practice; by third parties such as insurance companies.

Yet, despite the phenomenal scientific and technological advances in biomedicine, the customary prestige of the medical profession seems to have experienced a sharp decline. Furthermore, in consonance with the zeitgeist, public attitudes about health and lifestyles show an ever increasing interest in the magical, esoteric, the occult and all sort of myths, beliefs, practices and rituals connected with the new age and the Aquarian period. Coexisting with ready made versions of eastern mysticism, we see a heterogeneous array of therapeutic methods such as the laying on of hands, mediumistic channelings, psychic regression to previous existences, shamanic rituals, communication with angels, aroma therapy, reflexology, use of quartz crystals, aura-somatotherapy, etc. Some of them have gained acceptance by official medicine and are in the process of making the transition from alternative to complementary medicines, indicating a progressive use of such methods in combination with established medical procedures [1).

Similar interest is shown by the public and mass media in the strange phenomena grouped under the generic name of paranormal which include, among others, extrasensory perception, clairvoyance, telepathy, premonition, bilocation, telekinesis, and out of the body experiences. All of them are treated with derision by official science and usually are rejected, a priori, as subjects for serious study. States of consciousness such as ecstasy, meditation, contemplation and illumination are also handled with noticeable reluctance and the field is left open for all sorts of experts or pseudoexperts, quacks and charlatans and their often unscrupulous and irresponsible interventions. It must be remarked that an attitude of a-priori rejection of parapsychological phenomena on the part of official science seems to betray the presence of emotions that distort the necessary objectivity and equanimity that should characterize scientific thinking.

Going back to the current vogue for alternative medicine, one can speculate that factors related to its popularity may be a disenchantment with official medicine because of its impersonality, the fragmentation of the medical practice into an increasing number of subspecialties and technical procedures, and the high price of doctors' fees and medicines. Additional factors could be the persistence of culturally sanctioned traditional beliefs about health and disease, a distrust of the business-like nature of managed care, and the great amount of publicity given by mass media to alternative therapies, which generates a reciprocal reinforcement between public interest and mass media display.

As to the subject of religion, there seems to be a paradoxical development in recent years. Together with a reduction in established religion and conventional religious practices, there is a notorious increase of politically, oriented religious fundamentalism, characterized by belligerent intolerance of diversity and deep hostility towards other religions. In addition, decadence of institutionalized religion may coexist with an upsurge of esoteric cults and creeds often linked to religious (or pseudo-religious) healing practices. A case in point is that of Japan where more than 220 000 religious groups are registered at present, many of them offering spiritual cures for physical and mental problems. Recent police enquiries have revealed in some of them fraudulent practices which `have shocked Japan because of the huge scale of the deceptions' [2].

A revival of interest in religion and spirituality because of their perceived positive influence on health has become visible during recent years both among the general public and the medical profession (including both practitioners and educators). A recent publication outlines the principles of `spiritual psychotherapy' [3). Accumulated evidence shows an association of religious beliefs and practices with health benefits [4]. This has generated an animated controversy among groups purporting to maintain the separation between religion and medicine and those advocating the

beneficial power of religious beliefs, intercessory prayers and distant intentionality, as expressed in the following contrasting statements: `Even in the best studies the association between religion, spirituality and health is weak and inconsistent. We believe therefore that it is premature to promote faith and religion as adjunctive medical treatments' [5]. In response to this and referring to the effects of prayer as 'distant intentionality', a foremost practitioner of holistic medicine replies: `They neglect entirely the evidence that through their intentions people can affect distant biological systems such as human cells and sophisticated biochemical reactions, as well as the growth rates of microorganisms and plants' [6]. A recent version of the same type of controversy, enacted with great visibility and wide political implications, followed the BBC Reith Lectures 2000. As one of the lecturers, prince Charles made pronouncements such as 'Only by rediscovering the essential unity and order of the living and spiritual world-as in the case of organic agriculture or integrated medicine or in the way we build - and by bridging the destructive chasm between cynical secularism and the timelessness of traditional religion, will we avoid the disintegration of our overall environment' [7). An immediate reply, published as an open letter, by the biologist Richard Dawkins starts with this paragraph: `Your Royal Highness, your Reith lecture saddened me. I have deep sympathy for your aims, and admiration for your sincerity. But your hostility to science will not serve those aims; and your embracing of an ill-assorted jumble of mutually contradictory alternatives will lose you the respect that I think you deserve. I forget who it was who remarked: "Of course we must be open-minded, but not so open-minded that our brains drop out"' [8].

In diverse scenarios, science, religion and spirituality still seem to be playing irreconcilable roles. The dominant influence on the study of the mind comes from the neurosciences and particularly from molecular biology. Although it may seem paradoxical, brain activity and consciousness have even become subjects of increasing interest for quantum physics and it is conceivable that this discipline may provide novel directions for the development of future research on mental functions. On the other hand, the unmet spiritual needs of mankind have mobilized a relentless search for alternatives to institutionalized religion. Long ago, Aldous Huxley [9) proposed a systematic quest of the perennial philosophy: the immense repository of mental disciplines used by diverse cultures throughout history, among which appropriately conformed working groups could seek techniques to enhance desirable human potentialities. Could there ever be a synthesis between science and religion or spirituality? For those animated by syncretistic hopes, it is quite possible, as suggested by the remarkable similarities between the ideas and utterances of eastern philosophy and those of modern physicists [10).

What about the future of the neurobiological paradigm.'· Among many possibilities, those most likely to occur might be generated by historical extrapolation, amounting to a movement towards a conceptual position opposite that of the present, together with an ascending spiral of scientific knowledge. If this option actually materializes we could see a renovated and progressive interest in psychological (and parapsychological) themes and a transition of research activities from the field of molecular biology to that of subatomic and quantum physics, perhaps as an effort to cover a wider range of mental phenomena and get closer to the understanding of `the most complex material in all the universe'.

As a coda, I would like to refer to what Fabrega describes as the seven sins of international psychiatry and suggest the exploration of a possible pathway for attempting their absolution. In a summary analysis of the common characteristics observed in cures used by traditional native healers [11], several elements were detected: (1) a consensus between members of the family or social group. About the ability of the healer and her (his) disposition to help;(2) the sharing of notions about causes and treatment of the illness in question; (3) the active participation of family and social group members in the healing ceremonies; (4) acceptance of the method by the patient and confidence in its effectiveness; (5) the ceremony includes rituals of cleansing and purification;

(6) bodily contact between healer, and patient (7) induction of emotional states of excitation and relaxation along the ceremony; and occurrence, of various states of consciousness; (8) , the ceremony includes cognitive, emotional and operational elements; (9) either implicitly or explicitly the healer becomes an intermediary between the patient and .' the supernatural forces influencing the morbid condition; (10) finally, in most cases, the healer promotes cohesion of the social group and leads it into positive actions.

The rationale for cures is predicated on the belief that illness results from the loss of soul, and the therapeutic procedure opens the way for a restitution of the vital principle. Any form of treatment used by contemporary international psychiatry (even before the advent of managed care) would be hard put to march such an impressive gamut of elements, but a deliberate effort to incorporate them into current therapeutic methods may eventually contribute to bring back the soul to our profession.

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Fabrega discusses several critically important concerns in his paper. He argues convincingly that trends towards biological reductionism, and rigid diagnostic formulations based on symptom checklists, impoverish not only the field of psychiatry but our overall view of human existence. He sounds a clarion call to not only reestablish the primary of a biopsychosocial approach to understanding and intervention, but to expand it to include an understanding of evolutionary adaptation, the role of culture beyond specific immediate social context, and an increased awareness of the social and moral assumptions which underlie the profession of psychiatry. This is necessary, he argues, so that we bring the most rich and complex understanding of mental functioning to our encounters with patients.

There is little question that the evolving series of diagnostic and statistical manuals (DSM-III, IIIR, and IV) published by the American Psychiatric Association over the past 2O years have led to an increased diagnostic specificity. This has allowed for advances in treatment decision making and our ability to conduct clinical research to better understand the etiology, course, and appropriate treatment for a wide range of psychiatric illnesses. These diagnostic advances, however, have come at a price. By specifically intending the DSM series to be "atheoretical" regarding etiology of

illness, diagnostic categorization, and assumptions regarding the presence or absence of psychopathology, are based on the most superficial and concrete manifestations of symptoms. Rather than an enriched phenomenological approach, which would clearly incorporate issues of meaning of symptoms, and taking into account psychological, social, and cultural factors, we are in danger of continuing to promulgate an approach which is inappropriately and potentially harmfully reductionistic.

Nowhere in the DSM-IV, the most recent version, is there any discussion of the psychological meaning of symptoms. Nowhere is there discussion regarding the possibility that symptoms have symbolic meanings. Nowhere are the developmental antecedents of personality structure discussed. This has implications not only for the approach we take to making a psychiatric diagnosis, but also has significant implications for the approaches we take when we consider treatment options. What I am referring to, is a minimization of therapeutic interventions based on an appreciation of the cultural, social, spiritual, or psychological origins of psychiatric symptoms.

This trend also occurs at a time when economic forces and changes in healthcare delivery systems, especially in the USA but now spreading to Europe and Asia as well, have pressured psychiatrists to focus on pharmacologic interventions as a quick fix for the most superficial manifestations of psychiatric disturbance. Training programs have lost, to a substantial degree, curriculum, supervisory, and clinical experience devoted to a rich and complex biopsychosocial, cultural, spiritual approach to understanding as well as intervention. Certainly in the USA, and perhaps elsewhere, we are in danger of training a generation of psychiatrists whose perspective is restricted regarding both diagnostic understanding and treatment of psychiatric disturbances.

Of particular importance to this discussion are increasingly widespread international standards for psychiatric diagnosis and practice. While there are at present several competing diagnostic systems in widespread use (DSM, ICD, and the Chinese classification of psychiatric disorders, to name several), each shares a similar approach focused on categorizations of illness based on symptom complexes. Such a trend, as I noted earlier, impoverishes our field as it restricts our appreciation of the richness and complexity of human mental functioning.

Fabrega argues that the secular credo of modern medicine has influenced a diminution of ‘cultural and religious or spiritual approaches to disease'. While it is true that we have not yet evolved to a point at which it is possible to discuss social, psychological, and cultural influences on present psychopathology with any specificity or objectivity, I disagree that the modern approach to medicine precludes the possibility of this occurring in the future. I am reminded in this regard of discussions regarding the curative factors in psychotherapy. Some have argued that the mutative impact of psychotherapeutic interventions lies not with the specific theoretical assumptions regarding psychopathology nor the specific treatment techniques and interventions which How from those assumptions, but are based more on nonspecific factors which are aspects of the therapeutic relationship. Such a view assumes the impossibility of ever becoming more specific about these nonspecific factors. And, such an approach would suggest that our present state of knowledge is as far advanced as possible. I clearly disagree with this view, and believe that one of the important implications of Fabrega's paper is a charge to all of us to redouble our efforts to encompass this enriched and broadened view of the role of this matrix of factors in appreciating human mental development, functioning, and pathology.

Juan José López-Ibor Jr.

The main message of Fabrega's article is easy to accept: there are spiritual and cultural aspects involved in mental diseases, and by extension in all human diseases, which are as essential as the

biological ones. But, the main problem is how to integrate them, and the author gives some reasonable recommendations.

The first thing is to analyse the origin of the difficulties, which lie, as Fabrega points out in the 'clash of values between science and secularism contra spirituality and culture'. I would add that the clash is even deeper. There are two conflicting ways of confronting the meaning of nature, the sense of life, the origins and destiny of human existence. One is the spiritual, as Fabrega mentions, which accepts a nature (natura nataralis) beyond nature (natura naturata) in the form of a god (or gods) almighty and giving sense to nature to whom the human being yields. The second tries to control nature in order to prevent damage and is, represented by the gnostic philosophy, which was often considered by religion as a form of heresy to he persecuted and which led to occultism.

Modem science, which has roots in the philosopher, Descartes and Spinoza, among others, is a direct descendant from gnosticism. Even psychoanalysis, which always wanted to be a science of the mind or soul (Freud often uses the word Seele, 'soul', often translated into terms such as psychic apparatus), has strong gnostic influence as described by López Ibor Sr. in his last book (Freud y sus ocultos dioses, Freud and his Hiddlen Gods).

Psychopathology (meaning the science of abnormal mental phenomena, as physiopathology is the science of abnormal biological phenomena) is permeated by the Cartesian dualism. For instance Schneider differentiates the psychoses, which are brain diseases, from the abnormal variations of the psychological way of being which cause suffering (neuroses, abnormal personalities). Only the former are real diseases, because there is an underlying brain abnormality; the rest, defined by the presence of suffering, lead patients to consult the physician.

Psychiatric patients confront themselves with radical spiritual and cultural problems: the meaning of existence (in neuroses), of death and dying (in depression), of the world (in schizophrenia), of the need of social rules (in personality disorders), and so on. As a consequence, psychiatrists have often interpreted such phenomena as psychopathological. Religion is according to Freud a collective neurosis, built around obsessions. However, religion and obsession are not similar, they are opposite. The rituals of a religion are a way of Riving transcendence to a person's own actions and to bring together believers in a ceremony which unites them with all believers who in the past arid across the world have participated in it. Obsessions are immoral in this context, they begin and end in the same person, creating a form of ritual that has no meaning for the others.

Even in countries belonging to the same part of the world there are strong cultural differences. For instance, similar medical practices are given different names: primary practice, general practice, community practice, and family practice. In the first instance the issue is the two levels of a system (primary versus secondary and tertiary), in the second it is the issue of two approaches to disease (genera) versus specialized), in the third the issue is the setting (the community versus the hospital) and in the fourth the issue is a systemic versus an individualistic approach (the family versus the individual).

In spite of the difficulties, there is a long tradition of humanistic doctors both in the west and the east who have tried to bring the science and practice of medicine spiritual and cultural aspects..: Not all of them were psychiatrists but several of them had a strong impact on psychosomatic medicine especially in Europe (von Weizsacker, von Gebsaltel, López Ibor Sr., Rof Carballo, Marañón, Wyss, Tellenbach, and so on).

The nosological aspects referred to by Fabrega are crucial. Two contradictory perspectives can be taken, both of them acceptable. One is purely biological and relies on a strict medical model; the other is based on cultural psychology. Present classification systems, such as DSM III/IV and ICD.IU, have been able to solve the problem of communication, because they are based on observable clinical phenomena, the symptoms, which are more similar than dissimilar across the world. But they say noting about what the diseases really are. They are even unable to define what is a disease. That's why the ambiguous word disorder is used. The task of constructing a nosological system which would take into account that 'cultural meaning systems are integral components of the biological markers of criteria of psychiatric diagnosis' seems to me both attractive and colossal. If a classification is purely biological, disease can be attacked with biological weapons. But from a more complex perspective, multiple approaches can be more meaningful. A first step in this trend could be an axis on cultural issues. If psychiatry could progress along this path, it. would be able to change the rest of medicine, which shares with mental medicine, the same challenges to go beyond pure biology.

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Narendta N. Wig

I find myself in broad agreement with Fabrega's paper. As he points out, the clash of values between science and secularism versus spirituality and culture is present in whole of modern medicine, but this is more acutely felt in psychiatry, because in psychiatry, much more than in genera) medicine, the personal suffering of the individual undermines a person's whole social and cultural standing and brings into play spiritual and religious considerations.

The position is particularly difficult for psychiatrists working in non-western cultures such as India, China or Islamic countries, which have rich cultural traditions going back to thousands of years. India, for example, has been associated with spiritual traditions for a very long time, long before the rise of modern European science. It is a land where spirituality is a way of life, where even an illiterate farmer, a laborer or a housewife may surprise you with their knowledge and familiarity with philosophical issues of life [1).

Mental health professionals in non-western cultures feel this clash of secular science and spiritual culture much more acutely. They have been brought up in local cultural traditions but at the same time they have received a western education in science and medicine in which there is little scope for religion and spirituality. Most of their patients, on the other hand, are deeply immersed in local traditions. Their understanding of illness, its causation and outcome are often quite different from scientific explanations of modern medicine. This conflict between the values of western science and values of traditional cultures is a constant feature of the professional life of psychiatrists working in these countries.

Having accepted the existence of this constant conflict in the minds of working psychiatrists in non-western cultures, we must also examine the other side of the story. Modem secular medicine and psychiatry, despite the limitations as outlined above, have made tremendous progress in the past l0U years. The quality of care for the patients suffering from psychotic disorders, major affective disorders and epilepsy has dramatically improved with modern psychiatric treatment. Medical care has also become much better for conditions such as acute anxiety phobias and even obsessive-compulsive disorders. In developing countries more and more people, even from the rural areas, are coming forward to modern psychiatric services in preference to the practitioners of traditional medicine or spiritual healers. However, we still fail on two fronts. Firstly, there are large areas of psychiatric disorders, such as somatisation and conversion disorders, personality and adjustment

disorders, and common culture-bound symptoms (such as Dhat syndrome in India) for which modern psychiatry has very little to offer.

The second major failure is in the field of psychotherapy as a method of treatment. Secular psychotherapy as devised in the west, including classical psychoanalysis, has shown very little popularity in non-western cultures, except among a limited number of western-educated urban elites. Most of the successful practitioners of psychotherapy in these countries have empirically included in their practice more culturally accepted and locally popular methods, such as yoga, meditation and discussions based on well known religious texts. Even for serious mental disorders, for which people prefer modern psychiatric services, there is no complete cultural acceptance because a large number of families combine modern psychiatric treatment with regular visits to spiritual healers.

When advocating the cultural and spiritual dimension in modern psychiatry, we must also keep in mind that there is one lurking danger in this approach which we must guard against. Once we open the doors to the religious approach in medicine, all kinds of superstitions and magical rituals might creep in, especially in non-western countries. A large number of patients with serious mental disorders still suffer great harm at the hands of such traditional healers in developing countries. We will have to keep rooted in evidence-based medicine while enlarging the boundaries of psychiatry.

The real difficulty for psychiatrists in non-western cultures who want to combine cultural and spiritual aspects in modern psychiatric practice is that at present, secular medicine does not permit an integrative approach. In fact no clear model exists at present, though, as Fabrega points out, one may "address these correlates of disease in a compassionate but 'extra' medical way". Thus, there is an urgent need to enlarge the base of psychiatry to include, along with the biomedical, the psychosocial and spiritual aspects as essential parts of psychiatric training and practice. This will enhance the value of the specialty greatly, especially in the non-western cultures. It is a good sign that the WHO has already accepted the spiritual dimension as an integral part of health [1].

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Andrew Sims

Has psychiatry come of age? Has it resolved its teenage rebellion against the society elders and religious leaders of the tradition in 18th and l9th century Europe, in which it developed, realizing that faith and spirituality are more than the sterility of conforming practice? I am writing this commentary on Fabrega’s pioneering article, in order to comply with the editor's time constraints, in a country and culture completely suffused by religion, northern Pakistan. People here do not have to lower their voice and look embarrassedly over their shoulder to see who is listening when they talk about spirituality and belief psychiatrists in this part of the world know that the religious assumptions of their patients are significant for daily living. Religion is all of a piece with the rest of life.

In clinical practice psychiatrists are severely limited in their capacity to help patients unless they study their 'human cultural psychology ... world views, models of thought, interpretation of emotions, notions of personhood, and sense of cosmological spiritual placement in the universe

that includes religion'. Until recently all aspects of culture have been relatively ignored by psychiatrists in the treatment of their patients, compared with the attention given at biochemical and pharmacological aspects of mental illness and to the psychodynamics of the individual in isolation from his family or microsociety. Religion can be taken to mean that system of belief and its public expression to which the individual voluntarily or involuntarily finds him or herself. An operational definition of spiritual for psychiatrists would include (a) aims and goals-meaning in life, what is regarded as essential; (b) human solidarity-interrelatedness of all; shared beliefs; (c) wholeness of the person-spirit includes body and mind and is not separate; (d) moral aspects-good, beautiful, enjoyable as opposed to bad, ugly, hateful; (e) awareness of God-connectedness between God and man [1).

How do we incorporate sensitivity towards the religious and spiritual beliefs of our patients with our practice of psychiatry-in assessment, treatment and prognosis? For assessment, precise application of descriptive psychopathology should be used and especially the two guiding principals: the method of empathy and the distinction between form and content [2]. For religious experience this will mean understanding what belief means to the patient and how it affects the possible range of behavior, and also making the distinction between what arises from the mental illness and what from the patient's underlying religious or philosophical beliefs.

In treatment it becomes essential to know the limitations, and the possibilities, that religious belief imposes upon social and individual change. An obtuse psychiatrist in mentioning the possibility of marital separation as .a proposed solution to an emotional problem, will, in many cultures, not only antagonize the individual patient but discredit the whole profession of psychiatry. In prognosis, there is now a considerable research literature linking positive religious belief and practice to improved outcome and better response in the results of treatment; religious belief and practice generally carries an improved prognosis [3]. For these reasons, a good clinician will seek to understand a patient's religious background and its effects upon behavior, will be sensitive to how religious belief affects the demands of treatment and will take into account religious and cultural factors when giving a prognosis.

In clinical practice, enquiry about a patient's religious beliefs and spiritual convictions, and taking them into account in treatment, may not be simple or straightforward. Nor will the consequences of doing this necessarily be comfortable for patient or psychiatrist. For instance, pertinent questioning may reveal that the patient's emotional problems are intimately associated with an unacknowledged conflict between consistent behavior and a sincerely held belief system. Alternatively, his problems may appear to rise from pressures put upon him by other members of his religious group. The psychiatrist's job is not made any easier by such discoveries in assessing the aetiology of the patient's difficulties. But if honestly confronted and sensibly resolved, the potential for genuinely helping the patient is much increased by exploring the nature of the patient's beliefs.

Fabrega sounds the introit of what could be a new psychiatric practice, better adapted to the needs of patients in a post-modernist society. Cultural awareness is required to understand and incorporate the practical demands and opportunities that the patient's religious, spiritual and philosophical beliefs produce. Attunement between patient and psychiatrist is needed so that the psychiatrist can respond to specific areas of uncertainty and mistrust of the patient within the therapeutic relationship and convey the message that he, the psychiatrist, will not abuse position of power by rough-handling the patient's most intimate beliefs and assumptions. Psychiatry needs better instruments to assess and quantify the beliefs of patients and their interrelatedness with mental illness and its treatment [4]. Perhaps an uncomfortable implication of this increase in cultural awareness and greater sensitivity to the needs of patients is that psychiatrists will need to

explore their own belief systems and the consequences of these for treatments. Physicians need to know themselves to be fully effective in therapy.

Fabrega has done world psychiatry a favor by pointing out the importance of this area of our patient's experience. It is now up to practitioners to incorporate inquiry about relevant religious and spiritual factors into their assessment, and to evaluate their implications for treatment and prognosis.

Inquiry about beliefs must be made sensitively without showing hostility to what the patient holds important, nor making him feel that he must conform with the opinion of his doctor.

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The evolutionary analysis offered by Fabrega places the discussion of health and healthcare in a much broader and longer perspective than is usually the case. It recognizes the value of universality as an important consideration but challenges the validity of biological reductionism that is often attached to it. Fabrega cogently argues for the need to incorporate a measure of cultural relativism in the deliberation of health issues. Thus, his analysis is in line with a balanced approach, a creative tension heuristically relevant both to the improvement of diagnostic systems as well as to the reformulation of fundamental notion in the field of health.

The Culture Formulation in DSM-IV [I] represents an attempt to supplement the standard diagnostic formulation with a flexible statement addressing the cultural framework of personal identity, illness experience, social context (including religious affiliations) and the patient-clinician relationship. Although the meaning and impact of the whole cultural contribution to DSM-IV has been critically reviewed by the authors themselves [2], it has been independently regarded as one of the few significant innovations in DSM-IV, and efforts to enhance its use and usefulness continue [e.g. 3].

Another emerging approach to the incorporation of cultural diversity in diagnostic systems involves the development of national or regional adaptations of the International Classification of Diseases (ICD): DSM-IV could be seen, in a way, as an example of this. Another notable example is the Chinese Classification of Mental Disorders, 2nd Edition, Revised (CCMD-2-R) [4], which is an attempt to adapt ICD-10 to local reality and needs. A second Chinese attempt (CC~iD-3) to adapt ICD-10 is currently in preparation [5]. In another part of the world, the Third Cuban Glossary (GC-3) [6) has been prepared as an adaptation of ICD-10 to Cuban reality, elaborated with the participation of a vast number of psychiatrists and other mental health professionals, and it notably deals not only with the classification of mental disorders but also with its accompanying multiaxial schema. A Latin American Guide to Psychiatric Diagnosis [7) is being developed as a Latin American annotation to ICD-10.

International Guidelines for Diagnostic Assessment are being developed by the Section on Classification and Diagnostic Assessment of the World Psychiatric Association. At their core the Guidelines feature a new diagnostic model that encompasses a standard multiaxial formulation and an idiographic or personalized formulation, which pays attention to what is unique in the person and context of the patient (including cultural considerations) according to the clinician, the patient and family.

For the first time in 50 years, the definition of health enshrined in the constitution of the WHO is being revised. The changes under discussion include, first, the insertion of the term dynamic, meaning interactive, to qualify the state of physical, emotional and social well being at the heart of the concept of health and, second, the consideration of spiritual as another component of well-being.

The assessment of health status is also being broadened through a recent proposal to assess the health and healthcare of populations in different countries through the evaluation of personal and community perceptions (which are, of course, culturally informed) in addition to the more conventional life-years expectations at birth.

Also of relevance ~o the emerging incorporation of cultural considerations into key health concepts is the measurement of quality of life. Particularly promising here is the development of the WHO Quality of Life Instrument [8), which has pioneered the inclusion of high personal aspirations and spirituality within the dimensions of quality of life, at the specific request of mental health professionals from traditional societies in Asia, Africa and Latin America. More recently, a brief 10-item Quality of Life Index has been developed and validated in several languages (9]. It includes a range of internationally recognized dimensions from physical well-being to personal and spiritual fulfillment. It aIIows the subject to interpret and make self-ratings on the 10 dimensions of quality of life according to his/her cultural norms.

In conclusion, it can be argued that the concerns for culture and spirituality in psychiatry and general health elegantly presented by Fabrega are being creatively addressed, albeit perhaps only partially, through a number of recent schemas and proposals. Much remains to be done.

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Driss Moussaoui

The article by Fabrega contains some historical inaccuracies which weaken his advocacy for the importance of cultural and spiritual issues in psychiatry. One of them is when he states that `medical traditions of antiquity (e.g. Chinese, Indian, Middle-American, Islamic, and European) ... have represented health, disease, and suffering as an amalgam of concern that required naturalistic and spiritual formulations and forms of healing'. This was not the case for the Greek tradition. Hippocrates, although respectful of Greek religion, did not mix it with the diagnostic and therapeutic management of his patients. His theory on humors, with its physical and mental health components, looks very much like an ancestor to biological theories in psychiatry.

Concerning so-called Islamic medicine, which belongs to the historical period of middle ages (and not to antiquity as it was mentioned), the situation is even clearer. The prophet Mohamed used to send his friends and followers; when they suffered from an illness, to Al Harith Ibnou Kalada, who had a doctor trained in the medical school of Jondishapour in Persia. Contrary to what happened in Jesus' teaching, for example, he never tried to `cure' a patient. He, himself used many different medications in the last years of his life.

This respect paid to Hippocratic medicine by the main figure of Islam explains why this kind of medical practice flourished in the Islamic empire, where many of the doctors were Jews, Christians or Zoroastrians. One of them was Maimonides (Rabbi Moshe Ben Maimoun). He is one of the most important figures in the Jewish religion and treated his patients in a scientific way. If we take another example, the book on melancholia written in the 10th century by Ishak Ibn Omrane in Tunis, there is not one word about religion in it, except the first sentence praising God which was a traditional formula with which to start al) writings. Most of the doctors in this part of the world (e.g. Avicenna, Averroes, Avenzoar, Abentofal) were also philosophers and were well aware of the religious background of their society. However, they never mixed both domains. After the l4th century, the decadence of the Arab-Islamic civilization led many patients to adopt traditional healing as the main source of help. Magical thinking and practices took over and replaced systematized knowledge; this magical approach has in fact nothing to do with the original religion.
The other historical inaccuracy in Fabrega's article is in the following statement: 'the history of psychopathology in Europe has a darker side, for afflicted persons were ... marginalized, exploited, confined to asylums, mistreated, and stigmatized'. Historically, the first treating and caring institution for mental patients in Europe was the Maristane of Granada (whose ruins still exist), built by the Nasrids in the 13th century. Such institutions existed in all major cities in the Islamic region, and most probably since the 9th century in Cordoba. The first asylum in the Christian part of Spain was built in Valencia in 1410, by Father Gilberto Jofre, after having witnessed a mental patient being severely mistreated in the street [1]. Father Jofre visited Morocco twice (most probably Fes during Merinide times) when every major city had its maristane, and was maybe inspired by the Maristane Sidi Frej [2]. Many Spanish cities, following the example of Valencia, built asylums to protect mental patients. This was followed by the construction of such institutions in Portugal and in other parts of the Spanish empire, especially in the West Indies. Philippe Pinel [3] described the Saragossa asylum as an inspiring model for a 'moral' (humane) treatment of

patients. He insisted on the need for intelligent and caring personnel. It would be therefore excessive to say that institutions for mental patients in Europe have always been bad during the previous centuries.

One of the current trends in some teams of mental health workers in industrialized countries is to consider that psychiatry is an invention of the west imposed on the rest of the world. The historical reality is more complex; as a matter of fact, it has been a slow construction with the participation of many different cultures and civilizations. With the increasing impact of globalization, it will increasingly be the easy in future. There is no doubt that culture should be integrated as an essential part of the psychiatric daily work, and not considered as an empty theoretical shell. The cultural sensitivity of ICD-10 goes along with the tradition of the WHO that produced it. Even the DSM system will come to a better sensitivity towards cultural differences in the future, as the leadership of the 4merican Psychiatric Association is increasingly insistent on this nowadays. Religion is also an important part of culture.

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Fabrega's paper emphasizes that modern medical disciplines are products of non-spiritual worldview. Thus, what in the west constitutes an incompatibility between medicine, science and spirituality has not existed in the theory and practice of other great traditions in medicine [1]. Fabrega argues about the failure to appreciate the evolutionary origins of psychopathology and the advocacy of a secular reductionistic credo of diagnosis and practice neglecting the role of spirituality and culture.

Is it necessary to include spiritual dimensions in our attempts to define mental health? Perhaps it may not be necessary if we are satisfied to work within a limited medical model and define health as merely absence of disease, but to most of us, especially those involved in the long-term care of the mentally ill or the promotion of mental health, such limited definitions are not sufficient. Many psychiatrists regularly use religious teachings as a basis for the treatment of their patients `and also for promoting community mental health programmes in many traditional societies.

One needs to be conscious of two lurking dangers: one is that of ethnocentricity, or the belief that 'my culture is the best ; the second is the likelihood of mental health becoming a movement away from science which is at present the basis of medicine and health [2).

The spiritual dimension is an essential and important aspect of health, particularly mental health. Spiritual values are not the monopoly of any single culture; in matters of health, science alone cannot provide all the answers. Spirituality and religion are often used interchangeably. Dittes [3) argued that religion contains so many unrelated variables that it cannot be considered a

unidimensional concept of research. I argue that religion is the outward practice of a spiritual system of beliefs, values, codes of conduct and rituals [4).

The WHO defines health as not merely the absence of disease or infirmity, but a state of complete physical, mental, and social well-being. There is much pressure to add spiritual well-being for the totality of health.

Psychiatrists are less religious than their contemporaries in the general population and less religiously and spiritually minded than their parents [S-7]. Psychoanalysts, influenced by the legacy of Freud, have traditionally opposed healthy concepts of religion, viewing religion as inducing guilt and dependency. Mental health professionals have associated religion with superstitions intolerance and persecution. Kung [8] refers to this phenomenon as the repression of religion in psychiatric practice. We found that psychiatry has rarely used state-of the-art, multidimensional assessments of religion, including measures of religious beliefs, attitudes, and practices, because religion has remained on the periphery of professional interest, and psychiatrists have been unaware of the generally beneficial association religion has with mental health status [9].

In a 12-ycar review of all articles appearing in the American Journal of Psychiatry and the Archives of General Psychiatry, 72% of religious commitment variables were beneficial to mental health: participation in religious rituals, social support, prayer and a relationship with God were beneficial in 92~6 of citations [9). Similar findings were obtained from a review of the Journal! of Family Practice [10). In a British epidemiological study, churchgoing and a vital religion were found to be a protective factor from vulnerability to depression [11). Recent psychiatric literature and contemporary sociopolitical developments suggest a need to reconsider the place of religion and spirituality in psychiatry. Despite the secularizing effects of science, the presence and influence of `religiosity' remains substantial not only in traditional but also in western culture. A new diagnostic category entitled religious or spiritual problems has been included in the DSM-IV under "other conditions that may be a focus of clinical attention". Along with several other changes, this category contributes significantly to the greater cultural sensitivity incorporated into DSM-IV [12]. Failure to include faith in psychiatric thinking may lead to a distancing of the discipline from the level of everyday experience [13].

After an era in which we have been fixated with science and technology, we are now realizing that 'although they made our lives easier, they did not teach us how to live' [2]. A secular medical science without a spiritual basis slowly tends to become mechanized and dehumanized. Moreover, religion plays a major role in the symptom formation, psychopathology and management of many psychiatric patients.

Science has produced a vacuum in our spiritual life. I expect that at the turn of the century there will be a return to faith, spirituality and religions for better mental health and for more harmony between the self and the environment, to enhance virtue and altruism and to give a meaning to our lives. Faith can have its biological influences whether on physiochemistry or the immune system or the endocrine system. The comfort and peace amounting to ecstasy of believers can be hypothesised to be due to increases in endogenous opioids, sensitivity of serotonin receptors, etc. The positive relationship between mood and immune system has a direct role in fighting pain, illness, and even death. Faith can provide relief of pain, peace with the self, altruism, asceticism in worldly possession, which can be a real asset for promotion of mental health [14).

I agree with Fabrega that we should be aware of the present situation, marked by an undue reliance on a system of pharmaceutical treatment, the rationale of which minimizes if not excludes the role of cultural psychology. The endorsement of forms of psychotherapy that bypass the

importance of culture, religious, and spiritual concerns in favor of objective, economistic, preformulated; behavioral rubrics, may have a detrimental effect on mental health.

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The ago-old question of compatibility between spirituality and psychiatry can be turned into a useful debate if we introduce the cultural variable. The cultural and transcultural approach is indeed capable of removing the aura of heuristic invisibility which surrounds the spiritual dimension, turning it into 'an intellectually respectable object of study'. I therefore fully agree with the core of Fabrega's paper, upholding the thesis that it is impossible to proceed towards a comprehensive understanding of man's normal and pathologic psychic phenomena without taking into consideration one of its characterizing elements: the spiritual dimension [1,2).

Until now, the study of spirituality has been dealt with from a theological rather than a psychological perspective. The problem now seems to be how to facilitate a research procedure exploring the complex exchanges between macro systems without falling prey to the reductionistic restrictions posed in turn by the mundane and religious conception of the world?

Fabrega quite rightly underscores the existence of a `general clash of values between science and secularism contra spirituality and culture'. Unfortunately, I still think that a heuristic hiatus exists

between the dogma of the revelation of truth and scientific practice, that is difficult to solve, regardless of how honest the intentions of the participants to debate might be.

The rigorous methodology by which science identified the psychopathologies arising from the interaction between biological, cultural factors and human relationships, thus making it possible to overcome the stalemate created by the transcendental interpretation of mental disease, is certainly not an anomaly on the international horizon but the cornerstone of modem psychiatry. In this perspective, I think that we should further develop the secular credo in medicine and thereby enhance the approach proposed in Fabrega's paper: `the sphere of human cultural psychology, namely, representations of culture in the mind' as the methodology to analyze spirituality. In other words, psychiatry should focus the very same attention it placed on defining the phylogenesis and ontogenesis of psychopathology on tracing the historical phases and procedures of the development of the Erlenbins of spirituality.

How can we succeed in bridging the epistemological gap between spirituality sine substrato and psychiatry with an organic substrate? If we make it clear that spirituality is our object of study and not the extramundane subject motivating our research efforts, we can pave the way towards a boundless scope of knowledge which can effectively cast light on the interactions between culture and the construction of the self which, after all, is the implicit topic of this debate.

I am going to limit myself to quoting two statements that, although separate in time and inspiration, show the effort made in cackling this topic: 'Much more probably it was rather the conviction of being possessed which brought about a real division of the mind, whereas in the divisions observed today the relation is reversed: first there arises a genuine division of the inner life, and then the individual declares himself dual' [3] and 'By the habitual act of thinking in a particular language, or believing in the form of a particular religion, those forms of thought assume a type of physical reality in the organization of neural networks in the brain' [4]. It is statements such as these that lead me to reaffirm the need to promote surveys on the phenomenon of spirituality from the point of view of psychophysiology, genera) psychodynamics, transcultural psychiatry and neuroscience.

If, on the one hand, the compulsive use of biomedical paradigms humiliate psychiatry by reducing it to a biochemical laboratory test-bench, I don't see the grounds on which the secular credo should perform an act of contrition for having mishandled spirituality. In fact, we are witnessing an impressive effort throughout the world to rehabilitate sacred thought, which is made manifest not only by the spreading of religious fundamentalism and new religious movements, but also by trendy neospiritualisc forms that rely on pseudoscientific language and modem mass media in order to disseminate alluring promises of salvation.

Folkloric as well as paradigmatic signs such as chose collected by Seeman [5) in his description of some posters posted `on some streets in Ultra Orthodox (Hareidi) neighborhoods of Jerusalem calling on passers-by to beware of "the Danger of Psychologists" to the battle cry of `There is no subconscious there is only God' show an underlying denial of the realistic potential of the science of the unconscious in understanding the best concealed of human dynamics such as those arising from religious experience.

I am not concerned with the excess of power of psychiatric sciences that might be exerted to the detriment of culturally validated spiritual thought. Quite the contrary: from my Roman observatory I am led to believe that the forces aimed at promoting the movement of spiritual psychiatry greatly outnumber secular credo in psychiatry. The recently held 1st National Conference of the Italian Association of Catholic Psychologists and Psychiatrists, titled `Dead Gods have given rise to

Disease', launched a warning that totally belittles the modest seven sins of international psychiatry. However, I don't think-we need to shoulder the responsibility of this unsolvable mortal sin. I confide the fact that, if the international mental health organizations continue to stimulate ongoing debate, psychiatry might finally come to deserve its name: the knowledge and `iatrics' of all human psychic representations, including the puzzling beliefs in the overwhelming power of divine intervention.

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Fabrega's elaborate article contains a particularly critical review of the internationalist psychiatric diagnosis. I share his critique of the current trend of psychiatry toward one-sided biological emphases and controlled, technical procedures of behavior management without considering cultural and spiritual concerns. It is true today, as Fabrega repeatedly mentions, that psychiatrists and trainees in psychiatry are in danger of falling into a technician mindset intent on relieving signs of mental illness, like general medical disease, by prescribing drugs without taking the meaning system of the patient into consideration.

A question arises, however how can evolutionary psychopathology fill the void Ieft by the lack of religious component in the international psychiatric diagnosis? To add an extra axis of religious matters to the current multiaxial diagnostic system, or to encourage psychiatrists to catalog more culture-related syndromes, might not suffice to fill the gap. Fundamental change is required not only in the viewpoint of psychopathology but also in psychiatry and even in the viewpoint of medicine.

A comprehensive diagnostic system that comprises the whole aspect of human psychology in health and illness presupposes the complete integration of opposites: biology versus spirituality, objectivity versus subjectivity and causality versus finality in the healing approach for the suffering person as a whole. Religion and spirituality belong to the subjective value system. Therefore, their successful integration into the general psychiatric diagnostic system, that is directed by strong objectivistic and realistic principles (secular credo), might not be such an easy task. There is always the danger of displacing the secular credo with a new sacred credo or of producing a politically compromised syncretistic diagnostic system model.

Psychopathology, as the term indicates, deals with pathological psychic phenomena based on descriptions of pathological manifestations as well as verification of objective data. In this sense it has its own merits and limitations. It offers objectively verifiable facts; consequently, it inevitably

neglects in-depth comprehension of subjective experiences, including the spiritual aspect, not to mention its neglect of the concern for the normal, healthy aspects of a suffering person.

Insight oriented psychotherapists applied-long before other methods of diagnosis-a psychological or complex diagnosis to their healing practices, parallel to or aside from the official psychiatric diagnosis, in order to grasp the patient as a whole [1). There seems to be no single perfect tool in psychiatry with which one can define the whole dimension of human experience. Thus, each psychiatrist has the freedom to use ready-made tools appropriately, or to supplement them with new ones, and integrate opposing approaches in the healing practice.

To my pleasure, Fabrega advocated the great tradition of medicine. I also appreciate the holistic approach of healing in Tao as represented in traditional Chinese medicine, with its insight into the nature of illness in its cultural, emotional and ecological context. However, in practice, its metaphysical theorization lacks knowledge of brain anatomy and physiology, and requires reevaluation and reinterpretation in modern terms [2-4).

Fabrega points out very important components of culture, namely religious spiritual cultures, that have been regarded by many enlightened psychiatrists as somewhat dangerous infective agents-sometimes with justification. Psychiatrists who have been conditioned by reductionistic theories are inclined to seek only the dark side of spiritual experiences and the negative aspics of suffering without recognizing their creative healing aspects. Understandably, Fabrega mentions `representation of culture in the mind' as an integral part of the problem of sickness.

I would like to go a step further. Humans possess not only the representation of culture in their minds, but they are also spiritual beings -Homo religiosus [5). In other words, we possess in our innermost minds an ego transcending autonomous complex that we might designate as 'spirit' or `soul' (6). It is the primordial source of our spiritual experience and religious phenomena, a creator and modifier of the culture. Psychiatry is really the medicine of Cheong-Sin (`spirit' in the Chinese ideogram), and its object might be considered `human as spiritual being' [7]. From this viewpoint one sees another dimension of sickness and psychopathologic experiences, that is, `the meaning of suffering' and the goal-directed intention of life [5,8].

In the end, the question is how to see humans as a whole. In this regard, Fabrega has called our attention to one of the very essential aspects of the human mind-a forgotten dimension on the international stage.

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