Chapter 6

How Do Psychiatrists Heal?

There are many ways and means of practising psychotherapy. All that lead to recovery are good.

Sigmund Freud,
On Psychotherapy

What makes the majority of Indian approaches to mental health different from the dominant Western view on the subject, however, is their emphasis on the relational. *In the Indian prescriptive lists . . . one is struck by the number of ideals of mental health that prescribe the person's behavior in relation to others, especially family and community. A restoration of the lost harmony between the person and his group . . . was one of the primary aims of the healing endeavors in the local and folk traditions. .*

Sudhir Kakar,
Shamans, Mystics and Doctors

The method of the art of healing is much the same as that of rhetoric .
. . . then this is the goal of all his [the rhetorician's] effort; he tries to produce conviction in the soul.

Socrates, in Plato,
Phaedrus

During recent years much has been made of the somatic therapies employed by psychiatrists to treat mental disorders. Compared with the psychopharmacologic agents available before the 1950s, there has indeed been great progress. Drugs are now available that can control flagrantly disorganized psychotic behavior, relieve the immense distress of uncontrollable

panic, and greatly reduce the suicidal desperation of profound melancholia. Lithium can limit the profoundly disruptive swings to mania and depression in patients experiencing that bipolar diathesis. **But there** are some reasons for disquiet as well.

By and large, the types of pharmacotherapeutic agents used today have been around for several decades. Refinements have been made, but in spite of the advances in knowledge of neurophysiology and neurochemistry, no new "breakthroughs" in practical psychopharmacology have advanced the therapeutic efficacy of the clinician. Even more unsettling is our current awareness of the dire side effects of long-term treatment with the most potent of the psychopharmacologic agents. The proportions of the tragedy of tardive dyskinesia-a movement disorder of disfiguring lip smacking and grimacing caused by long-term use of antipsychotic drugs-are only now becoming fully apparent, and the extent of their medical-legal and ethical consequences is still not clear. The withdrawal hypothesis, mentioned earlier in my discussion of Warner's (19851 work, is a Drovocative thesis that the chronic use of drug therapy contributes to the chronicity of schizophrenia, it will keep researchers active for years to come and, if found even partially correct, will radically change the clinical consensus on the treatment of the most severe of the major mental disorders.'

Compared with antibiotics and other disease-specific therapeutic agents used to treat acute medical diseases, antipsychotic and antianxiety drugs are clearly not "magic bullets" that eliminate disease causes. The antidepressant drugs come the closest to this therapeutic fantasy, but they are ineffective in at least 20 percent of cases, are associated with significant relapse rates, take weeks to achieve their effect, and are equaled in efficacy by at least two types of psychotherapy (Boffey 1986; Holden 1986). Psychiatric drugs are more like palliatives and anodynes used to reduce symptoms in chronic medical disorders (e.g., asthma, psoriasis, arthritis) for which there are no complete cures. Most serious mental conditions require longterm drug use to treat repeated recrudescencé of symptoms. Patients may be impressed by the list of psychopharmacologic medications, but primary care physicians or specialists in internal medicine, who are accustomed to an enormous array of therapeutic agents, are often surprised by the relatively limited drug therapies with proven efficacy available for the treatment of psychiatric conditions. 1 do not mean to say that drugs are unimportant in psychiatry-far from it. I only wish to correct the widely popularized but, to my mind, grossly exaggerated impression one can get from the media that drugs have so revolutionized the practice of psychiatry that adequate psychiatric care is essentially the handing out of pills.

For the internist and the surgeon, what distinguishes psychiatric treatment from the rest of medicine, besides the relative weakness and limited range of its somatic therapies, is its use of "talk therapy." Primary care practitioners such as family doctors and nurse practitioners, to be sure,

not infrequently practice a **kind of rough** and ready supportive psychotherapy without explicitly calling attention to it as such-some without fully recognizing that they do so. Not all psychiatrists, of course, practice psychotherapy, and indeed most psychotherapists are not psychiatrists. Nonetheless, in the West, psychotherapy of one kind or another is practiced by most psychiatrists, and most patients go to psychiatrists with the expectation that they will participate in some kind of talk therapy. Perhaps of even greater significance, psychotherapy is closely associated in the minds of the general public with what psychiatry is all about. In North America, where there are more psychiatrists than in all the rest of the world, psychotherapy also occupies a central place in the profession of psychiatry's selfimage of how psychiatrists should provide care for their patients. Indeed, it is not at all uncommon in North America to observe an academic psychiatrist conduct laboratory research for a large part of the day, then put aside his laboratory coat and step into his office to see several hours of therapy patients. The anthropologist is struck with the cross-cultural differences in the salience of psychotherapy. In Europe and especially nonWestern societies, psychotherapy is much less central a component of psychiatric care.

Economic reward contributes to the salience of psychotherapy in psychiatric care. For Blue Cross and other third-party health insurance agencies that pay for that care in the United States, much of what they reimburse psychiatrists' outpatient billings for comes under the broad and fuzzy definition of medical psychotherapy, whereas other physicians usually do not receive reimbursement for this form of therapy. Finally, in the profession's textbooks and academic colloquia on treatment, the question of how the psychiatrist heals is most often configured as the problem of how psychotherapy heals. That is because even biologically oriented psychiatrists are sensitive to their professional audience's tendency to equate the words "therapy" and "healing" with psychotherapy.

Long dominated by psychoanalysis, psychotherapy is today a huge but fragmented field of practice. Besides the better-known psychoanalytic, behavioral, cognitive, existential, interpersonal, and counseling "schools," there are hundreds of the most different kinds of practices that go by the name psychotherapy (Herink 1980). The term "psychotherapist" stands for an equally bewildering array of persons, running from members of the allied professions of psychology and social work to pastoral counselors and a very wide assortment of laypersons-those who practice art therapy, dance therapy, music therapy, co-therapy, telephone therapy, charismatic and many other forms of religious healing, polarity therapy, dozens of kinds of meditation and relaxation therapies, EST, other group treatments, hypnosis, and much more besides. Indeed, in the United States there are about 35,000 psychiatrists, more than 60,000 fully trained psychologists,

and under 100,000 licensed social workers, but there may be as many as 1 million unregulated lay therapistsl

For purposes of defending their market share, psychiatrists bill third party payers under the code: medical psychotherapy, which in theory unites the specific medical skills of the psychiatrist with knowledge and skills in conducting psychotherapy. But there is no agreed-upon standard for defining what in practice a medical psychotherapist is supposed to do (Coleman 1986). Excluding the prescription of drugs, which in the event some psychiatrists refrain from prescribing when "doing therapy," it would be extraordinarily difficult to distinguish what a physician-psychotherapist does from the treatment provided by his nonphysician colleagues. There is no evidence, furthermore, that the type of professional degree influences the outcome of psychotherapy for patients (Smith, Glass, and Miller 1980). The remarkable findings in most studies of psychotherapy outcome are, first, that psychotherapy appears to be effective in the treatment of a wide range of conditions, and, second, that its efficacy does not seem to be greater for any particular school (Luborsky, Singer, and Luborsky 1975; Strupp, Hadley, and Comes-Schwartz 1977; Smith, Glass, and Miller 1980; American Psychiatric Association Commission on Psychotherapies 1982; Williams and Spitzer 1984). Nor does level of professional training or even extent of experience seem to significantly influence outcome (Rioch 1966; Uhlenhuth and Duncan 1968; Durlak 1979). There are also conditions that are not responsive to psychotherapy, e.g., organic brain disorders, and there are toxicities of psychotherapy, though they are less numer ous and serious than those caused by drug therapy (Bergin 1975; Hadley and Strupp 1976).

A recent multicenter clinical trial, funded by the National Institute of Mental Health to study the treatment of clinical depression, showed that cognitive psychotherapy and a mixed psychodynamic-interpersonal modality were equally as effective as antidepressant drugs (Holden 1986). Even though these talk therapies take longer to work and therefore are more costly, the findings have been interpreted by psychiatrists and other psychotherapists as a vindication of the use of psychotherapy. The development of methods to apply psychotherapy to marital relationships family ties, groups of patients, outpatients in primary care clinics, and a new array of medicalized social problems from rape to bereavement and other forms of "post-traumatic stress disorders," premenstrual syndromes, meno pause, midlife crises, and even unemployment has further intensified interest in the revitalized talk therapies. Furthermore, although more research is needed, psychotherapy appears to be cost-effective in reducing the utilization of general medical services, prescription of psychoactive medication by primary care doctors, and hospitalizations (Mumford et al. 1984; Borus et al. 1979; McGrath and Lowson 1986).

One of the more interesting controversies in the psychotherapy field is the question of whether the effects of psychotherapy are due to specific or nonspecific agents or cnange (Strupp and Hadley 1979; Karasu 1986). Each school of psychotherapy claims that unique elements in its technique of practice are responsible for specific therapeutic effects (see, for example, Wolpe 1958; Beck, Rush, et al. 1979; Klerman et al. 1984). Outcome research conducted by adherents to a particular school tends to support these claims (e.g., Rush et al. 1977). But overall the empirical evidence fails to demonstrate specific effects of specific techniques. Rather it points to nonspecific. shared aspects of psychotherapy as the most likelv chief determinants of efficacy (Frank 1974; Karasu 1986: Torrev 1986). Later in this chapter, 1 will return to this research for assistance in building a model of the therapeutic process cross-culturally.

In part because of these findings, a common criticism applied to psychotherapy by its medical critics is that it is merely a dressed-up placebo. Placebo responses are the improvement in symptoms produced by supposedly nonactive substances (e.g., sterile water or a sugar pill). They are believed to work through the activation of physiological processes owing to the patient's faith in the treatment or the healer (Shapiro 1959). Placebos occupy a strange position in medicine (Brody 19771. Though thev average a 35 percent improvement rate for medical conditions across the board, they are viewed by clinical researchers as a source of confounding effects in clinical trials of the efficacy of new treatment agents. In fact. placebo responses vary between 10 and 90 percent in such trials, and seem to be strongly influenced by the quality of the doctor-patient relationship (Moerman 1979). Rather than laud a powerful nonspecific treatment effect that all physicians should be trainers to maximize, placebos are disdained by medical researchers and teachers.

Psychotherapy may very well be a way of maximizing placebo responses, a nonspecific treatment effect, but if so, it should be applauded, rather than condemned, for exploiting a useful therapeutic process which is underutilized in general health care. The placebo effect can be reconfigured as the activation through the process of interpersonal communication of a powerful endogenous theraneutic system that is part of the psychophysiology of all individuals and the sociophysiology of relationships (Hahn and Kleinman 1983)-what Lionel Tiger (1979) has called the biology of optimism. The comparison of psychotherapy to placebos also indicates. the ambivalence with which medical science looks upon this archaic remnant of medicine's past. Psychotherapy is threatening to academics attempting to forge a psychiatric science because of its ties with folk and popular therapies and its "soft," psychosocial image. It is of great interest to the anthropologist, however, since it enables her to detect the fault lines that split the psychiatric profession into different camps.

Cross-cultural studies bring a broader perspective to the study of how

the psychiatrist heals. Whereas the systems of psychotherapy constitute culturally salient psychiatric treatment in the West, they **are not what** the vast majority of non-Western psychiatrists do. The latter are engaged in very limited contact with large numbers of patients (usually five to fifteen minutes per patient), many with the most serious of disorders and some with the psychological effects of infectious diseases (i.e., depression, anxiety, cognitive deficit, withdrawal), a situation in which somatic therapies and a more medical approach are appropriate. Nonetheless, even in the Third World, psychiatrists do engage in brief supportive talk therapies not all that dissimilar from the preferred psychosocial treatment method of primary care physicians in the West. Attraction to psychotherapy is increasing in a number of non-Western societies, especially owing to the rapidly growing educated urban middle class familiar with Western ideas and strongly influenced by the world economic order which reproduces Western cultural forms, including psychological therapies, as commodities for consumption by this new elite class.

When I began my field research in Taiwan in 1968, there was hardly any psychotherapy available and little popular understanding of its uses. In the 1970s, the works of Freud and other key figures in psychological healing were translated into Chinese and published in Taiwan for an everexpanding audience of students, professionals, and intellectuals generally. During this same period, Yang Kuo-shu (1986), an outstanding Taiwanese psychologist, demonstrated that the value orientation of college students was turning in a Western direction while maintaining many traditional values. Most notably, psychological-mindedness and individualism were on the increase. Not surprisingly, in recent years more clients have sought out psychotherapy, and it has become more prominent, though still nowhere near the North American level of popularity.

Much the same phenomenon is in a very early stage of development in China. During the last several years, the political liberalization in the mainland has witnessed the publication of scores of books on normal and abnormal psychology. Books which have printing runs of 10,000 to 30,000 copies are sometimes sold out the day they appear in the book stores. There is even a group of psychiatrists in Beijing who have introduced psychoanalytic psychotherapy, a method that was anathematized in the 1950s and attacked with great ferocity during the Cultural Revolution. Cognitive, behavioral, and supportive forms of psychotherapy are being introduced in China's major centers of psychiatric research and teaching. Psychiatrists in the developing countries have also been experimenting with the use of indigenous forms of healing which patients find more culturally acceptable. Yoga in India and qi gong in China are examples of indigenous practices widely available in psychiatric centers. The presence in those societies of active folk healing traditions-no longer enchanting to intellectuals raised with a secular vision-doubtless has contributed to the growth of

interest in psychotherapy, and has also offered a model for *indigenizing* psychotherapy (Kapur et al. 1979; Kakar 1982).

Anthropologists, for good reason, are uncomfortable with the tendency of mental health professionals to elevate the Western paradigm of psychotherapy into a comparative grid that can be used to study indigenous healing systems worldwide. Rather, for the anthropologist, psychotherapy is merely one indigenous form of symbolic healing, i.e.= a therapy based on words, myth, and ritual use of symbols (see Lévi-Strauss 1967; Turner 1967). The question of how the psychiatrist heals, then, becomes a question of comparing psychotherapy (along with the psychiatrist's other therapeutic practices) to a wide assortment of indigenous healing systems in non-Western societies, among traditionally oriented ethnic groups in Western society, and in the Western historical tradition. By demanding that psychotherapy be analyzed within this broader framework, thereby standing the ethnocentric mental health approach on its head, anthropologists seek to derive a comparative grid for studying the different forms of symbolic healing that is more scientifically valid for ascertaining cross-cultural universals in the healing process. Such a grid should also be sensitive to what is unique in each local healing system. Psychotherapy-what is it, what does it share with other healing systems, what are its effects, and how are they produced?-for the student of the world's cultures, is the question, not the solution.

In this chapter, I first compare psychotherapy (and other aspects of the psychiatrist's treatment) to healing systems in non-Western cultures and to other indigenous systems in the West, in order to demonstrate, in spite of the great diversity of "schools," that there are certain commonalities that can be discerned in cross-cultural perspective. What do these commonalities tell us about the structure of psychiatrist-patient relationships and the cultural influences on the ideology and process of psychotherapy? How does the psychotherapy practiced by psychiatrists, and indeed by all psychotherapists, produce its effects? Is there a method for translating psychotherapy into culturally relevant practice in radically different societies? What, then, is universal, what culture-specific, in the healing process?

A Comparative Cross-Cultural Grid for Assessing Psychotherapy as an Indigenous Healing System

When I review the cross-cultural literature on healing systems together with my own empirical research, juxtaposing shamans, other religious healers, doctors of traditional Chinese and Indian medicine, and the myriad of alternative practitioners and physicians of biomedicine, criteria emerge for comparing healing systems: [2]

(1) *Institutional Setting,* i.e., the specific location of the practitioners of a local healing system in a particular society's *folk, popular,* and *professional* arenas of care

(2) Characteristics of the Interpersonal Interaction

(a)Number of participants
(b)Time coordinates (i.e., episodic or continuous; length of time of interactions; etc.)
(c)Quality of the relationships (i.e., formal or informal; author itarian or egalitarian; degree of trust, warmth, support; etc.)
(d)Attitudes of the participants toward each other.

(3)Characteristics of the Practitioner

(a) Personality (charismatic, empathetic, disordered, etc.)
(b) Reasons for becoming a healer
(c) Rites of passage
(d) Training
(e) Career trajectory and clinical experience
(f) Type of practice (including special interests and skills)
(g) Status in the healing system and in community
(h) Insight into the clinical process
(i) Rewards and difficulties

(4)Idioms of Communication

(a)Mode (i.e., somatic, religious, moral, psychological, social)
(b)Code (i.e., nonverbal, verbal, special semiotic system)
(c)Explanatory models of a particular illness episode (i.e., shared, conflicting, open, tacit, etc.)
(d)Rhetorical devices for narratizing illness and negotiating treatment
(e)Work of interpretation

(5) Clinical Reality

(a)Sacred or secular
(b)Disease-oriented/illness-oriented
(c)Focus of treatment (i.e., patient, family, other)
(d)Primary/secondary/tertiary level of medical system
(e)Symbolic and/or instrumental interventions
(f)Interrogative or open-ended
(g)Patient-centered or practitioner-centered
(h)Therapeutic expectations (including clients' emotional arousal and hope and therapists' belief in or need to prove self-efficacy)
(i)Perceived locus of responsibility for care
(j)Confession and moral witnessing

(6)Therapeutic Stages and Mechanisms

(a) Process

(b) Mechanisms of change (i.e., catharsis, social learning any conditioning, persuasion, behavioral control, altered state o consciousness, sense of mastery, insight, etc.)
(c) Adherence
(d) Termination
(e)Evaluation of outcome (including toxicity and iatrogenesis'

(7)Extratherapeutic Aspects
(a) Social control
(b) Ethical codes and problems
(c) Economic costs and constraints on access
(d) Political implications

If we employ this grid to compare psychiatric care and specifically the most common form of psychotherapy practiced by psychiatrists in North America-a psychodynamically based method-with other symbolic healing systems (e.g., shamanism, other forms of religious healing, the literate Asian systems of traditional medicine, a variety of lay psychotherapies), then we quickly discover that the psychiatrist's care is unusual in a number of important ways.

To begin with, psychiatrv has a neculiar relationship to the greater health care svstem and to its parent profession. biomedicine. Most symbolic healing around the globe occurs in the popular (family and community) and folk (nonbureaucratized and nonprofessionalized) sectors of care, not in professional institutions. Other, nonbiomedical professions of healing, such as osteopathy, chiropractic, naturopathy, Ayurveda (India's indigenous profession of medicine), traditional Chinese medicine, and professionalized indigenous healing systems in Japan, Thailand, and Pakistan emphasize symbolic healing to a greater degree than does biomedicine. Unlike biomedicine, they do not possess a psychiatric or other specialty for providing svmbolic healing. That is the responsibility of each professional. In fact, there is some evidence to suggest that biomedicine as practiced in Asia and perhaps other non-Western settings is so strongly influenced by their indigenous models that it incorporates certain of these core symbols as part of the therapeutic skills of every physician; e.g., biomedical physicians in China often take the pulse in the style of Chinese medicine practitioners and inquire about aspects of diet that reflect concern for yin/yang balance (cf. Kleinman 1980; Weisberg 1984; Lock 1980). Perhaps one of psychiatry's latent functions is to legitimate a more substantial form of symbolic healing in biomedicine which makes the biomedical profession less unlike all the other healing systems by incorporating key symbolic forms of healing from the popular and folk healing sectors of the Western cultural tradition. This makes psychiatry distinctive from the rest of the profession of biomedicine, though more like other healing professions.

Psychiatric care, and biomedical care generally, as practiced in the

West, differs from other healing systems inasmuch as other systems of symbolic healing are not dyadic (they usually involve familv members and friends) or private (they occur in public in the presence of family and other patients). Nor is most healing long-term, divorced from everyday life encounters between the participants, psychologically minded, secular, or oriented to the needs and rights of the individual as against those of the family and community. Only healing systems in the West are moving toward egalitarian models of the therapeutic relationship and a concept of open practitioner-client negotiations. Virtually all others emphasize authoritarian models and tacit (if any) negotiations. Non-Western healing systems, apart perhaps from Buddhist ones, usually do not regard insight as a necessary ingredient of therapeutic change, nor are individuation or personal growth explicit treatment goals. These contrasts illumine the radical differences between egocentric Western culture and sociocentric non-Western cultures, and disclose that culture exerts a powerful effect on care.

Psychiatric care is not unusual, however, in its pragmatic integration of somatic and symbolic treatment modalities. Many indigenous healing systems employ the laying on of hands, manipulation of the body, and the use of diet, drugs, exercise, and meditative techniques side by side with practical advice and symbolic rituals. Trust, empathy, and various other components of support, furthermore, are ubiquitous in healing everywhere. There are other, nontrivial cross-cultural similarities. Both psychotherapy and indigenous non-Western therapies encourage congruence in the explanatory models of patients and practitioners regarding the cause and nature of the disorder and in therapeutic expectations about what constitutes improvement. Mutually ambivalent attitudes of healers and clients are commonplace. Healers view patients as offering an opportunity for demonstrating their therapeutic powers (with all that connotes in prestige and reward) but also see them as a potential threat of negative outcomes, including failure. Medical-legal suits may be decidedly uncommon outside the West, but healers in a number of societies are expected to pay an indemnity if their patients die. In Taiwan, if the patient dies and the family believes the physician responsible, they sometimes may place the coffin in the practitioner's office until he offers a suitable financial compensation (Kleinman 1980). For shamans in South American Indian groups, death of the patient sometimes meant that their community would take their lives. Patients and their circles often view healers as the source or conduit of great powers for good, and simultaneously as self-interested parties who can do harm. This ambivalence is most striking in those societies where healers are also feared as sorcerers who can inflict illness.

This is not the place to analyze in detail the characteristics of practitioners; yet such a comparison would demonstrate again key crosscultural similarities and differences, in the selection, training, career trajectory, clinical experience, status, and rewards and difficulties

of practitioners-similarities and differences that reflect major cultural, political, economic, and institutional constraints on healers. One crosscultural characteristic of healers is worthy of note: namely. personality. While there is little empirical evidence to confirm the hypothesis that healers are mentally ill. as an earlier veneration of anthropologists speculated (Boyer 1974; Sasaki 1969; Opler, ed., 1959), there is support for the view that the more successful indigenous healers in the non-Western world may possess charismatic personalities that radiate Dower, inspire confidence, and demonstrate empathy for the patient's exnerience (Lam bo 1974; Dean and Thong 1972; Eliade 1964; Handelman 1967; Harner, ed., 1973; Kleinman 1980; Taussig 1987; Turner 1967). Research on psychotherapists in North America repeatedly discloses the importance of the therapist's personality for therapeutic effects, and the tendency of effective therapists to have warm, supportive personalities (Truax and Carkhoff 1962; Strupp and Hadley 1979; Parloff et al. 1978; Luborsky et al., 1985). There is also an impression that successful healers may have a deeply personal need. intensified or even created by the social context. to he effective in the lives of others (Kleinman 1980, 1986). Thev need to believe in themselves and in the efficacy of their craft. A challenge to their sense of technical competence is a threat to their personal confidence. They feel inner pressure to succeed. I am not familiar with research on this subject that pertains to psychiatrists or psychotherapists generally, but it is my clinical experience that the psychiatrist's felt need to make his patients feel better is no less important an aspect of the psychiatrist's clinical success than it is of the shaman's. Perhaps this is an inner ingredient of successful practitioners of a wide range of types.

The mode of clinical communication between healer and client may be somatic, psychological, moral, religious, or social idioms of distress and care; their semiotic codes create a keyboard of nonverbal, verbal, and special signs through which these idioms are transmitted and received. For example, shamans in Taiwan use the language of gods, ghosts, or ancestors afflicting (or protecting) their clients to convey, in a culturally authorized idiom, not only practical religious concerns in the family's life but also key interpersonal tensions (Kleinman 1980). Thus, a remarkably insightful Taiwanese shaman whom I observed interpreted the acute back pain experienced by almost all the members of a family who had recently experienced the death, under highly questionable circumstances, of a young daughter-in-law as her unappeased ghost holding tightly to the backs of her intimate relatives in a display of righteous anger over the family turmoil which provoked her "suicide." The god possessing the shaman was the first to publically voice this menacing term, the expression of which, as the centerpiece of a culturally prescribed exorcism of the attacking ghost, quite literally authorized the outpouring of deeply ambivalent grief as well as something akin to penance and absolution. Usordas (1987) gives

other examples from a Brazilian religious cult of a subtle interweaving of religious, psychological, and medical rhetorics of healing. Primary care practitioners worldwide are becoming aware that physical symptoms often represent bodily metaphors of complaints for negotiating personal and social troubles that, for one reason or another. cannot be dealt with openly (katon et al. 1982). The patient complains of headaches and thereby conveys pain in the temples and a painful mental conflict to whose intensification or amelioration the medical care will contribute. It is estimated that between one-third and two-thirds of all visits to primary care practitioners may involve such negotiation of the central, if disguised, reason for care (Katon et al. 1984).

Patients, their family members, and healers differ significantly with respect to the rhetorical devices they employ to express and negotiate problems. Symptoms may be dramatically enacted in one cultural context and understated in another. Possession states (of patients and shamans) sanction powerful divine and demonic voices to demand redress or to insist on a therapeutic compromise (Lewis 1971). Individuals also differ, of course, in their talents for using culturally approved rhetorical techniques. Some are extremely effective at eliciting empathy or access to resources, others much less so. Some are spectacularly ineffective. The last include so-called chronic complainers worldwide, who in psychiatric care are labeled hysterics or hypochondriacs.

Interpretation is not by any means unique to nsvchoanalytic psychotherapy. It is a core task of healing cross-culturally. The practitioner must reconfigure the patient's illness narrative, within his therapeutic system's taxonomy, as a disease with a particular cause, understandable pathophysiology, and expectable course. Shamans as well as herbalists, faith healers as well as internists, *curanderos* (Mexican American folkhealers) and *espiritistas* (Puerto Rican spiritual healers) as well as psychotherapists must interpret somatic complaints as bodily icons of troubles in life's various domains (home, work place, school, street, interstices of the self). Nor is psychoanalysis the only healing system that elaborates an indigenous structure of exegesis for interpreting body symbols. The Ayurvedic practitioner in Bombay, the physician of traditional East Asian medicine in Kyoto, the Unani doctor in Karachi-all follow ,onhisticated native ethnotheories for understanding both *what* a particular episode of illness meant and how illnesses' meanings are to be interpreted. T he healing systems or diferent cultures and ethnic groups differ greatly, of course, with respect to use answers provided to these questions.

Healers and patients create a local ethos of expectations about clinical etiquette, action, and outcome that I have referred to as *clinical reality.* Psychotherapy's clinical reality as an aspect of psychiatric care is secular, disease- and illness-oriented, open-ended, usually more patient- than practitioner-centered, and often involves an eclectic mix of symbolic and instrumental

interventions. Expectations of successful outcome tend to be more long-term and modest than in acute medical care: the perceived locus of control is the sick person: and care frequently invokes. though psvchiatrists may not recognize it as such a kind of moral witnessing of the patient s lice with some degree of confession of difficulties usually kept from others. Generalization is difficult, because different psychotherapies vary on all these axes. Psychotherapeutic systems also diverge over whether the function of therapy is seen as improving the patient's adaptation to society or criticizing societal demands and motivating the patient toward social reform by projecting his individual problems outward onto the social structure and encouraging practical engagement in social change, or at least individual fortitude and courage to assert himself in the face of the social system. Most forms of psychotherapy tend toward the conservative (maintain the status quo) end of this spectrum, but various radical therapies encourage reform and even revolt.

Non-Western healing systems have greatly different clinical realities: often they emphasize sacred reality, illness orientation (meaning that they take the patient's account of the problem as their central concern), symbolic intervention interrogative structure. family-centered locus of control (there may even be a family or lay therapy management team which makes the crucial decisions in care-see Janzen 1978), and substantial expectstions of change, even cure. Like Western systems they differ greatly as to whether they serve conservative or reformist interests. Confession and moral witnessing are central to some non-Western systems, peripheral or even absent in others.

Most therapeutic systems world-wide appear to create emotional arousal in clients and to stimulate the feeling of hope. Even if they don't explicitly aim to remoralize clients and family members, that is often their effect. To do this, it has been argued, the healer must believe in his therapy (Torrey 1986) .

Of course, conventional biomedicine also differs from psychiatric care on a number of these axes. It to s to be oriented to disease (the pathology held to underlie the patient's complaints), instrumental interventions, interrogation, and a practitioner-centered version of clinical reality. Emotional arousal of patients, encouragement of hope and faith in the treatment, and remoralization of patients and family members are aspects of effective biomedical care too. It can be argued, however, that its intensive preoccupation with technology and with the formal logic of clinical decision making gives medical students the dangerous message that the emotional response of the patient and the practitioner's own personal investment in the treatment matter much less than the technology applied and the rationale for its use. This is a sign of the marginal status of psychiatric concerns within the profession of medicine.

All forms of healing create conditions for catharsis, though some are

much more effective than others at eliciting this important therapeutic process. Where the therapeutic ethos encourages the patient's attachment to healing symbols that are neither too remote from nor too close to the patient's emotional experience, catharsis is more likely to occur (Scheff 1983). Psychotherapies obviously differ in their cathartic efficacy, but on the whole, catharsis is much more important to psychiatric care than it is to other forms of biomedical treatment. Catharsis is a therapeutic process in most non-Western symbolic healing systems. Psychophysiological change and social persuasion are also nearly universal. So commonly do these therapeutic elements, along with the previously mentioned expectant faith in a positive outcome and shared world view of healer and patient, occur together that Frank (1974) and Pentony (1981) advance comparative models of healing cross-culturally in which social persuasion, made possible by shared-beliefs and expectations, intensifies expectant faith which in turn contributes to catharsis and psychophysioloizical change. They consideren these to be the central elements in all therapeutic effects. While emphasizing different components, Torrey (1986) and Karasu (19861 claim that it is these kinds of things that make healing effective.

Havens's (1985) important insight into the role of irony, paradox, and other rhetorical devices that can break through the conventions of mundane discourse in psychotherapy to foster therapeutic alliance may seem to some so clearly characteristics of the contemporary Western tradition that they are sure to be candidates for a unique therapeutic process in symbolic healing. But in fact this is not the case. Many indigenous healing traditions-e.g., Zen-based therapies in Japan (Reynolds 1983) and South American Indian shamans who use hallucinogens (Harner, ed., 1973)apparently make use of these tropes for some of the same reasons Havens recommends: to make contact with nonrational aspects of the self and to promote emotional change. This is not how they are conceptualized by those who apply them in the hurly-burly of clinical work, yet this is what serious students of the subject have come to believe (Leighton et al. 1968; Reynolds 1976; Kapur et al. 1979; Kakar 1982).

Ethnographic accounts of healing rituals in non-Western societiese.g., Turner's (1967) writings on Ndembu healing; Janzen's (1978) description of the Bakongo; Fabrega and Silver's (1973) discussion of shamanistic healing in Zinacantan; and Tambiah's (1977) account of Buddhist healing in Thailand-point to the universality of a tripartite process. In the first movement, an underlying casual agent is announced (e.g., the ghost clinging to the backs of bereaved family members). It is affirmed in the healing system's authorized taxonomy, and then established as a particular instance of the generalized interpretive structure that stands behind the system (e.g., the idea among traditionally oriented Taiwanese that the "hungry" ghosts of daughters-in-law who suicide because they are wronged can plague a family with illness and other misfortunes until they are ritually

propitiated). In the second phase, the svmbolic for.., that causes or materializes pathology (in this instance, the ghost) is manipulated via therapeutic rituals (sacred or secular). Finally the causal agent, on the plane of the interpretive system's core symbols, is removed (i.e., the ghost is exorcised and the shaman ceremonially pronounces its departure); the healing is affirmed, performatively, since it meets the authorized criteria, to be successful: the ritual of exorcism, if appropriately chosen and properly enacted, is said to work. A new symbolic status-cured, improved, "feelin' better," or, in our example, tree *of* ghost and protected against its return-is announced and consecrated. Psychiatric care-includinv psychodynamic psychotherapy's early (the neurotic problem is recognized as having been caused by an Oedipal conflict), middle (the conflict is worked through), and termination (the patient is helped to believe that the neurotic conflict is understood and resolved) periods-shares this processual structure with an odd assortment of bedfellows, including Northwest Coast Indian healing ceremonies (Jilek 1982), charismatic Catholic healing (Csordas 1984), traditional Chinese medicine (Kleinman 1980), the therapeutic rites of Kung Bushmen (Katz 1982), yoga (Neki 1974), Puerto Rican spiritism (Harwood 1977), and Haitian voodoo (Metraux 1959).

Psychoanalytic psychotherapy's emphatic endorsement of change in the core personality of the sick individual, isolated from kin and social circle; its preoccupation with uncovering unconscious conflicts within the deep interiority of the mind that are hidden by defenses that originate in early childhood and that, once effectively understood, can be mastered; and its identification of central conflicts almost entirely with sexual drives-all have been shown to derive from special themes in the Western cultural tradition (Rycroft 1986). There are few non-Western analogues. But we can point to phenomena like trust, empathy, moral witnessing, and the other elements of support-practical problem solving, clarification, explanation, and a variety of rhetorical devices (like nonverbal and verbal signs that the therapist believes in the patient's sense of mastery) used to remoralize and persuade-that are by no means peculiar to the Western tradition and its cultural modes of healing (Frank 1974; Leighton et al. 1968; Murphy 1964; Harwood 1977; Reynolds 1976; Csordas 1984).

Many observers of healing ritual have posited psychophysiological effects of autonomic nervous system arousal and psychoneuroimmunological and endocrinological activation (Prince, ed., 1982). But convincing evidence of the effect of therapeutic rituals on the secretion of endogenous opiates (which in theory should raise pain thresholds and damp the disabling effects of painful symptoms) and other neurohumoral agents (e.g., the brain's neurotransmitters) has not been published. Nonetheless, hardly any serious students of healing rituals doubt that significant biological effects result from catharsis, conditioning, and the other mechanisms of therapeutic change. Most psychiatrists believe that one or more of the same

processes underwrite potentially powerful biological effects in psychotherapy.

Altered states of consciousness (e.g., trance and possession), on the surface, would appear to be an interesting source of differences between psychiatry and indigenous folk healing systems. Among members of nonWestern groups and of traditionally oriented ethnic minorities and religious groups in the West with intact faith healing traditions, states of trance and possession are commonplace. They quite clearly are associated with potentially profound psychophysiological changes. Prior to the modern era of Western history, these altered states were ubiquitous in folk and popular healing traditions in the West too. But they are not widely found among middle-class Westerners in contemporary society. Nor does psychiatry or the rest of modern biomedicine seem to employ techniques for inducing possession. Yet, in fact, meditation and a wide assortment of techniques to induce relaxation (including hypnosis) are used by physicians, albeit to alter the consciousness of patients not healers. Meditation clearly brings about an alteration in state of consciousness. Technically, hypnosis, still popular in psychiatry, is controlled trance. Thus, in the disenchanted modern West, meditation, hypnosis, and other relaxation techniques appear to have replaced possession states as the major lay and professional forms for enlisting altered states of consciousness in the service *of* therapeutic change. Again a cross-cultural universal in the healing process connects psychiatry with healing traditions in other societies, with those who practice sacred folk healing in the West, and with historical traditions.

Termination is a notoriously significant issue in psychotherapy; it is less robust though still an issue in other healing systems. Adherence to prescribed treatments and proscribed activities turns out to be problematic in folk healing and self-care as well as professional therapies (cf. Chrisman n.d.), but it is "hypocognized"-not raised to the status of a self-conscious question-in virtually all other systems than biomedical care. Transference and countertransference can be shown to occur in many types of treatment, but their explicit analysis is unique to psychoanalytic psychotherapy. These two concepts may represent the most important contribution of psychotherapy to the cross-cultural comparison of healing systems.

The power of clinical reality can extend beyond the practitioner-patient relationship to the larger social arena. Movements of social change-reform, revolution, and reactionary revanchism-have not infrequently enhanced their legitimacy by invoking therapeutic metaphors. For example, the major rebellions in China in the Han dynasty, in the much more recent Qing dynasty, and in the twentieth century either grew out of healing movements or used the imagery of curing China's political sicknesses (Dull 1975). The Chinese Communist revolution played up the idea of curing the "sick man of Asia." The Nazis expropriated the metaphor of healing in their ideological defense of the need to extirpate "the rotten appendix of

the Jews" in the Aryan body. Lifton (1986) demonstrates how, in medicine's most evil hour, healing came to quite literally mean killing for the Nazi concentration camp doctors.

Social control (pace the antipsychiatrists, who would have us believe it is a creation of either psychiatry or the modern state) is an inalienable aspect of healing in every society. Indeed, if anything, the social control aspects of healing systems are greater in non-Western societies (Cawte 1974). That is to say, sickness as a social phenomenon presents the members of the social system with two challenging questions: bafflement ("Why me?") and control ("What to do?"). Sickness is a threat to the social order-in the forms of epidemic disorders, incapacitating disability, and severe mental illness, literally so. The ordering of symptoms into illness is an initial step in a process that goes on to involve various levels of controlpersonal, familial, network, institutional, community, societal. Control is exerted through the application of technical interventions and social authority. The occasion to exercise control may be an illness episode and the social tensions it either results from or exacerbates, but control can be, and often is, extended beyond healing to social relations generally.

Think of the frequently intrusive surveillance of families by child mental health authorities in North America who, through consultation in school or health clinic, have detected a significant behavioral problem. The original problem-enuresis, anorexia, hyperactivity, antisocial behavior-leads to referral of the whole family for evaluation. That evaluation, and the recommendation for family counseling that often results, may well have therapeutic significance. But it also is a form of control extended from the child to the entire family, who are told directly or by implication that they may well be the source of the difficulty. They are "followed" with assessment schedules. formal interviews. and measures of family functioning that will establish whether thev are "normal," or "deviant." or "at risk." All of this observation, counseling. and recording is conducted in a language of medical problems and their treatment. Yet the effect of focusing attention on the family, intended or unintenueu, is to alert its members that they may be at fault and should chance their ways. Whatever else it is, this is the diffusion of control into the nuclear social unit (cf. Lasch 1977; Donzelot 1980; Castel et al. 1982). Much the same happens with child and adolescent psychiatric disorders, and especially following allegations of child or spouse abuse. As interest in therapeutic and preventive family interventions intensifies, we can expect a much wider array of disorders to trigger these forays of health and mental health experts into the home.

On several occasions, psychiatric colleagues of mine from China have been surprised both by the propensity of North American health experts to enter into families to "protect" children and the willingness of courts to make rulings about what *should* happen in the home, including what is to many Chinese an astounding misuse of legal authority, the court's willingness

to remove children from the custody of their parents. They note that in their "totalitarian" society, the home is not regarded as an appropriate sphere of medical or legal intervention. Of course, China's block associations, building committees, and informal oversight over personal behavior in the work unit look to North American eyes like an even more intrusive social system.

In small-scale preliterate societies like the Kung Bushmen or Mbuti Pygmies, healing involves the entire community. There are no specialists to impose authority; rather, it emerges within the community consensus. In tribal and peasant societies, accusations of witchcraft and sorcerv as the cause of illness may lead to trials, punishment, and ostracism. In largescale, industrial societies, social control of sickness is exerted by a variety of sources-the courts, community welfare and law enforcement agencies, the healing professions, ultimately the national government. The psychiatrist, like other health professionals, may be informally expected or formally charged by the laws of the state to undertake certain forms of control. In recent decades in industrialized societies, and now in the most rapidly modernizing nonindustrialized societies as well, as I discussed in Chapters 4 and 5, social problems are medicalized, transformed from moral or legal into therapeutic questions. Psychiatry in many societies has led the way in this process, not because of the policies of the profession, but because of those of the society. We have every reason to suspect that certain of the misuses of psychiatry in the West also exist, though perhaps to a lesser extent, in the non-Western world. This is as important a question for future cross-cultural research as is its corollary: protection of the rights of psychiatric patients, including those treated in psychotherapy. There may be fewer abuses of psychiatric care in the non-Western world, but there is also less protection of patient's rights. For example, in familistic societies, patients can be hospitalized involuntarily through the connivance of their families and their psychiatrists. Most therapeutic agencies in the Third World offer no protection of confidentiality. The patient's problems are exposed in public and not always to a supportive audience. Even indigenous healing systems may coerce, threaten, and abandon patients. Charlatans and quacks are to be found in all healing systems, preying on the desperate and powerless. Finally, there is excessive use of ECT, because patients in Third World psychiatry usually have little input into professional decision making. While ethical codes of behavior for professional psychotherapists in the West have been at times self-serving, often have not been effectively enforced, and do not cover lay therapists, in much of the developing world there are no formal codes at all for holding healers accountable.

Another ethical (and legal) question that is quite central to the discussion of healing is how to assure that healers are competent, and that patients are protected from those who are not. In his race along the broadest

possible avenues of agreement among selected cross-cultural studies of healers, which aims to arrive at simple universals in the psychotherapeutic process, while trying not to lose his way in the maze of winding, narrow back streets of detail that illumine even more extensive cultural differences, Fuller Torrey (1986), a psychiatrist writing for a popular audience, offers an answer to this question. Let us establish, says Torrey, local regulations for licensing and standards for practice for all healers-psychotherapists and witchdoctors. The suggestion is as seductively simplistic as the rest of Torrey's survey. It is a solution geared to a professional sector of practice where schools, exams, licensing formalities, standards of practice, and formal ethical codes are to be found as part of the bureaucratic structure of health care. In such a system-such as professional psychotherapy in North America-such a recommendation would have a good chance to be successful. And I too would support it.

But folk healers do not practice in professional institutions. The folk healing sector of care by definition is greatly pluralistic, unlicensed, unregulated, and at its ambiguous margins quasi-legal or even illegal. Passing regulations and standards for folk healers will almost certainly accomplish several undesirable things in Benin as well as Bogota, Benares, and Boston: First, folk healers will be professionalized. Or rather those most like professional practitioners will be coopted into the professional system, usually under the control of professional practitioners. A psychiatrist from Sumatra once told me that he wanted all the folk healers in his region enumerated and licensed so that he could determine who would be allowed to practice, and those selected would then practice under his direction. "I can see at most 100 patients a day on my own." But he said, rubbing his hands in anticipation of the financial reward, "If I employed ten folk healers, I could see 1000 patientsl" One can well imagine the abuses that would result. In addition, professionalizing folk healing may attenuate or routinize just those practices that are most central to its success: empathy, sacred authority, trial-and-error innovation within tradition, minimal objectification of personal problems, and nonroutinization of practice.

Second, regulations will drive many folk healers underground, criminalizing practices that are already at the margins of legality. There is some empirical evidence from urban Africa that when folk healers are barred or severely controlled, predatory practices intensify, real criminals begin to see folk healing as a way of bilking the public, and laymen go to lengths to circumvent official obstacles in the search for care.

Torrey's temptation, as I shall call it, to bureaucratize practice and extend professional authority over the training and surveillance of practitioners is appropriate for pastoral counselors and the wide range of alternative professional or paraprofessional therapists in North America, who should be held to the same standards for psychotherapy as psychiatrists, psychologists, and social workers. But it is a prescription for creating disaster

in folk healing circles. Rather, folk healers should be brought. under closer supervision of local communities, not professional organizations, and that control should be loose enough to allow a wide variety of practitioners to flourish as long as there is no evidence of actually dangerous, unethical, or illegal practices.

Economic costs of psychotherapy and constraints on access, which in the past have contributed to the formation of a largely middle-class clientele, are significant issues for current policy debate (see McGrath and Lowson 1986; Goleman 1985b). Insofar as psychotherapy has been found costeffective in reducing so-called overutilization of primary care services and hospitalizations and in treating the common psychiatric conditions depression and anxiety as well as so-called "life problems"-e.g., marital conflicts, midlife crises, adolescent turmoil (see Mumford et al. 1984; Bloch and Lambert 1985; Borus et al. 1985)-the next-level question of cost effectiveness must turn on the findings that successful outcome does not seem to depend on the type or extent of the therapist's training. The logical argument would seem to be that if psychiatrists in the U.S. doing psychotherapy charge, say $75 to $100 per session, psychologists $50 to $75, social workers $35 to $50, and paraprofessionals even less, and all have the same outcome, why, then, what rationale can there be for governmental or third-party insurers paying for anything above the minimum? To forestall this coming query, psychiatrists, psychologists, and social workers actively lobby to protect their share of a market which, as I have noted, is increasingly dominated by a plethora of types of lay therapists, about whose cost efficacy almost nothing is known. True, few if any of these lay practitioners and alternative professionals receive third-party reimbursement. Nevertheless, if we are to take the economics of psychotherapy seriously, these practitioners must be included in the calculations. And so too must be primary health care professionals-internists, family physicians, and nurse practitioners-who treat the "hidden psychiatric morbidity," namely about 60 percent of the mentally ill (Regier et al., 1978).

This is a greatly vexed issue. On the one hand, many patients seem willing to pay a great deal more than the minimum in order to secure access to higher-status professionals. Their conviction of the competence of their therapists may well play a role in the efficacy of the care they receive. On the other hand, access to all forms of health care in the U.S. has declined for the poor (Robert Wood Johnson Foundation 1987), who in the past have not been well served by psychotherapists of any kind. While the situation is particularly deplorable in the disorganized multitiered health system in the U.S., the place of psychotherapy in the British National Health Service and in other state-run health care systems is still being fought over (McGrath and Lowson 1986).

Indigenous healing systems in the non-Western world are not immune from these problems (Bannermana et al., eds., 1983). While certain traditional

medicinal preparations, e.g., deer penis and bear claw in the pharmacopeia of Chinese medicine, and ritual practices, e.g., a nine-night Navaho sing, may be as expensive as or even more expensive than comparable biomedical treatment, it is my impression from what limited information has been published that many folk and popular health and mental health practices are affordable, if often just barely so, for rural and urban poor in developing societies. These same societies. however, provide verv limited if any financial --*port* for professional psychosocial services, and exclude most folk healing systems from reimbursement schemes. Thus, the burden of financing psychosocial care in many societies-north and south, east and west-falls squarely on the shoulders of individuals and families, perpetuating a long-standing problem of equity.

Heretofore, most research in this area has focused on macroeconomic aspects of psychotherapy and psychiatric care generally. What are now needed are microeconomic studies which tell us much more about the local determinants and consequences of lay decision making, help seeking and choice of healer in the lives of afflicted persons in need of care and their families.

Of all the extratherapeutic aspects of healing, its political implications are the most provocative. Taussig (1987) and Comaroff (1985), among others, argue that indigenous healing practices, such as shamanism among impoverished Indians in Columbia and native evangelical church healing among a Tswana group in South Africa. are forms or political resistance to colonial oppression and the ideology of the ruling class. Tausig, a physician-anthropologist, writes an entire book (1987) about shamanism in South America paying hardly any attention to what happens to the particular complaints of clients and thereby gives the astonishing impression that this indigenous form of clinical work may originate from attempts to deal with the symptoms of sick persons but really is about something altogether different:

> The power of the imagery brought to life by misfortune and its healing . . . is a power that springs into being where the life story is fitted as allegory to myths of conquest, savagery, and redemption. It should be clear by now that magic and religious faith involved in this are neither mystical nor pragmatic, and certainly not blind adherence to blinding doctrine. Instead, they constitute an imageric [sic] epistemology splicing certainty with doubt, and despair with hope, in which dreaming-in this case of poor country people-reworks the significance of imagery that ruling-class institutions such as the Church have appropriated for the task of colonizing utopian fantasies.

The radical analysis of this academic shaman-which at its most extreme would have us believe that biomedical practice among the impoverished in Colombia is worthless and even contribute, to the powerlessness

of the poor, while the shamans' hallucinogenic seances transcend the mundane mystifications of practical treatment for life-threatening infantile diarrhea aria adult infections to offer an alternative political rhetoric of the oppressed-is so excessive as to be silly and, from a public health perspective, will be seen as an example of the dangerously romantic reverse ethnocentricism of wild anthropology.

And yet the serious student of healing will realize there is a kernel of truth buried in Taussig's overgrown tangle of deconstructionist tropesone that receives far too little attention in the comparative cross-cultural literature on healing. Healing systems-professional as well as folk-can, though often they do not, offer interpretations that challenge orthodox political definitions of reality (e.g., Taiwanese shamanistic religious cults, in the past, offered one of the only permitted visible symbols of Taiwanese nationalism). They can contest the routinization of suffering and societal ideologies that seek to justify it. Folk healers as much as psychotherapists can revivify or instill personal and family hope through moral metaphors that contradict the corrosive self-images of an age that, like our own, seems obsessed with economic and biological determinist rhetorics of personal gain and narcissistic desire, and in their place reaffirm transcendence. And psychotherapists and other healers can reject cliched soap-opera solutions to personal crises, which reinforce the politically expedient and commercially profitable illusion that we live in a domesticated "natural" world of expectable order in which disorder is atypical and need not be endured. In the place of this illusion, psychotherapists and other healers can offer the hard-won critical-and therefore moral as well as political-awareness that our experiences are difficult, uncertain struggles with menace and loss in local life worlds over which we exert imperfect control, sometimes hardly any, and in which the transformation of impending chaos into transient order is, for most of us, a precarious victory to be won (or lost) every day with usually inadequate resources and within an intimate circle of interdependence on others.

When healers reaffirm, as in my experience they more commonly do, the status quo and convert social predicaments into psychological conflicts and thereby blind us to the political roots of our all too human dilemmas (as D. M. Thomas's fictional Freud does in *The White Hotel* because his psychoanalysis of a hysterical German Jewish woman in Germany in the 1930s fails to take into account the social reality of Nazism and its personal effects on her life and his)-when we healers do this, then we must be reminded of the political antecedents and consequences of healing, which should be as routine a consideration in our self-reflective understanding of what our work is about as is the libidinal component of our countertransference. If Rudolph Virchow, who pioneered the study of both cellular pathology and social pathology in medicine, could say with the conviction of a revolutionary who manned the barricades in 1848, "Politics is nothing

but medicine on a grand scale," perhaps we can reverse and appropriately moderate the saying to affirm that "healing is at times politics on a small scale."

Thus far, I have compared the psychiatrist's psychotherapy to folk healing without directly addressing the central question of comparative efficacy, or what such a comparison can tell us about how symbolic healing of any kind works. We know psychotherapy works, but what evidence do we have that folk healing is effective? Before we are entitled to use this comparison to illuminate the healing process, we surely must respond to this question. There is in fact evidence that at least some forms of folk healing are effective for certain kinds of disorders and interpersonal problems. First, it is essential to reemphasize that folk healing is not a single phenomenon, but a greatly heterogeneous set of practitioners and practices, running from legitimate, officially sanctioned healers to quasi-legal practitioners to outright charlatans and quacks (Snow 1978; Baer 1981; McGuire 1983). Substantial anecdotal evidence from ethnographers demonstrates that patients treated by folk healers generally feel better and members of the local social group generally believe them to be better. (Among hundreds of ethnographic observations of particular folk healing sessions, see Harwood 1977; Garrison 1977; Crapanzano 1973; Fabrega and Silver 1973; Lewis 1971; Turner 1967; Tambiah 1977; McGuire 1983; Nichter 1981; Kakar 1982; Eisenber$ 1985; Good et al. 1982) Such encounters usually have not involved long-term follow-up or systematic assessment, however.

Systematic evaluations of the therapeutic outcomes of various folk healing approaches also disclose that local indigenous systems of symbolic healing have rates of successful outcome similar to those found in general medical care. Kleinman and Gale (19821 for example. compared 250 matched patients treated by folk healers and internists in Taiwan and discovered that more than 70 percent of patients treated by both tunes of practitioners improved. Kleinman and Song's (19 1U) earlier study of outcome of patients treated by Taiwanese shamans showed in a small sample that all felt better except those with acute severe medical problems. Finkler's (1983 1985) study of patients treated by spiritist practitioners ,n rural Mexico documented high rates of success, especially for patients with somatized depression, anxiety, and life problems. Ness's studv (1980) of a Pentecostal healing church in Newfoundland and Dobkin de Rios's (1981) research nn a Peruvian healer came to similar conclusions. as have other studies reviewed in Csordas (1984). As a result of these and other empirical investigations, the WHO's review of indigenous healing (Bannerman et al., eds.. 1983) recommended that health professionals learn to work together with selected tvpes of folk healers in the Third World. Cross-cultural investigations have also documented definite limitations (see below) to this form of treatment as well as certain, not very common, toxicities-e.g., minor side

effects of herbal remedies, advice that, interferes with medical treatment, and feelings of guilt for not improving. But on the whole, most patients studied after visiting folk healers experience symptom relief, and a sense, usually shared by family members, that their conditions are improved.

More systematic outcome studies also indicate that many of the ecstatic claims for folk healing are grossly exaggerated, and that most success occurs in the treatment of self-limited acute conditions, in that of chronic disorders for which there is no cure, and in the management of psychosocial distress. Nonetheless, since these problems constitute the bulk of problems brought to primary care practitioners around the world, this is a significant accomplishment. Intriguingly, Kleinman and Gale (19821 discovered that both shamans and internists in Taiwan performed poorly in the treatment of natients with somatized psychiatric diseases, a finding that goes counter to the impression given by many students of this subject that folk healers are particularly effective in treating psychiatric disorders. Although these quantitative studies do indicate that folk healing can be effective, double-blind clinical trials have been impossible to conduct to determine which elements in indigenous healing practices are responsible for their efficacy. Thus, what follows is a summary of anthropological and cross-cultural psychiatric speculation on this topic.

How Psychotherapy and Other Forms of Symbolic Healing Heal?

A number of anthropologists have attempted to synthesize the leading cross-cultural theories and ethnographic data about symbolic healing into a model of how all symbolic healing works (cf. Douglas 1970; Dow 1986; Glick 1967; Horton 1967; Janzen 1978; Kleinman and Song 1979; Messing 1968; Moerman 1979; Nash 1967; Tambiah 1968; Turner 1967; Wallace 1959; and Young 1977). Their reviews provide a useful introduction for examining the process of psychotherapy from the vantage point of comparative research on how words and relationships create therapeutic effects. I shall first restate in my own terms a consensus model that emerges from the work of these and other scholars of symbolic healing; thereafter, I will draw on the materials and the ideas brought together in this model for a broader discussion of the place of psychiatric healing in contemporary health care. I hardly need to argue that psychotherapy makes a special contribution to medical care. I do wish to show that the processes underpinning how psychotherapy heals raise a troubling paradox at the heart of medicine.

Four structural processes appear to be essential to accomplish symbolic healing. Stage 1 posits the presence of a symbolic *bridge* between personal experience, social relations, and cultural meanings that I have elaborated at several

places in this book. The experiences of individuals in society (e.g., serious loss or misfortune) are signs whose meanings link up with a group's master symbols (ex.. *yin/yang,* the crucified Christ. or the bodv/selt as a broken machine). Those symbols are the deep cultural grammar governing how the person orients himself to the world around him and to his inner world. That cultural grammar is found in the central myths (e.g., the Koran or the Constitution) that authorize the values of the group and that serve as a template for the personal myths of the individual. There is a hierarchy of linked systems running from cultural symbols to social relations and on to self and bodily processes. That hierarchy is the biopsychocultural basis for healing: it underwrites the "upward" assimilation of personal experience into cultural meanings and the "downward" particularization of those meanings into bodily processes via the cognition and affect of a particular person in a particular situation.

Sebeok (1986), a leader in semiotics, suggests these systems are evolutionarily linked through the development of codes for communicating at cellular, psychological, and behavioral levels. Genetic code; the neurotransmitter code, the code of endocrine hormones, and codes communicat-.. ing meanings in social relations and cultural symbol systems-all are of very different types, but as communication systems are meaningfully interrelated (cf. Staiano 1986; Hofer 1984). That is to say, in human systems biological codes and codes of perception and behavior are made, through socialization processes, to relate, resonate, and even transact (cf. Werner and Kaplan 1967). just as illness is projected at different levels of the biopsychocultural hierarchy (see Engel 1980), so too is healing a transformation of these recursive systems. For example, a Taiwanese healing ritual may remoralize a depressed young housewife by mobilizing husband, inlaws, and parents to offer emotional and practical support and by authorizing her special status in the community and time away from onerous duties in the home, because her symptoms are interpreted as evidence the gods have chosen her as a spirit medium. The ritual itself elicits catharsis, trance, and a powerful feeling of faith and hope. These, in turn, recruit autonomic nervous system, neuroendocrine, and limbic system reactions that reverse the physiology of depression. The first stage of symbolic healing, then. is the presence of the sociosomatic linkage. When lived experience in a shared community of meaning is not its source, initiation into a particular system of healing-e.g., charismatic Catholic prayer group or psychoanalytic relationship-is.

Stage 11 commences when this symbolic connection is activated for a particular person. A patient seeks out a healer. The healer persuades the patient that the problem from which he is suffering can be redefined in terms of the authorizing system of cultural meaning (i.e., hallucinations are the work of the devil and therefore can be treated by exorcism). In small-scale preliterate societies and in many developing societies as well, healer, patient, and family are usually in agreement about those core meanings (though as McCreery 1979 shows, this is not always the case.) The pluralism of large-scale, industrialized, secular societies is certainly different, yet an analogy can be drawn. For there still are some shared authorizing meanings, in spite of social fragmentation and personal disenchantment. Moreover, the healing system itself (think of psychoanalysis or behavioral therapy or a religious cult) involves specific professional or institutional symbol systems, in which patients are socialized. The healer interprets the patient's problem in the precise terms of these codes. But clearly more than interpretation takes place. The healer uses various rhetorical devices essential for social persuasion to convince the patient that the redefinition of the problem via the authorizing meaning system is valid. This is a reciprocal movement. Healer affirms and patient accepts; healer elicits trust and belief, and patient actively participates in the therapeutic ethos and commits himself to it, often passionately. The patient's experience comes to resonate with, or is conditioned by, the symbolic meanings of the healing system. The problem *and* the patient begin to be changed by the healer's redefinition of the situation, which involves a switching of communicative codes (e.g., from bodily pain to imbalance in yin and *yang,* or from melancholy to possessing demons or a childhood-based neurotic conflict).

In *Stage 111* the healer skillfully guides therapeutic change in the patient's emotional reactions (which means bodily processes as well as self-processes) through mediating symbols that are particularized from the general meaning system. These are the svmbols manipulated in healing rituals-e.g., the Navaho singer's images of the sacred mountains, his' sand painting's figures of Navaho spirits, and the story that he sings. It is somewhat easier to see the psychotherapist's concrete clarifications and interpretations as symbols that are authorized, negotiated, and deeply felt in the psychotherapeutic sessions. It is not merely the healer's rhetorical skill at work here. The clinical reality of the healing interaction, constructed by the mutual expectations of the participants, contributes to the generalization of personal experience into therapeutic meaning systeme.g., the reinterpretation and re-experiencing of menacing amorphous demoralization as the specified anxiety of Oedipal conflict or the felt depression of blocked flow of energy-and the particularization of symbolic meaning into personal experience-e.g., from the family therapist's general idea of personal pathology representing hidden family conflicts to its concrete instantiation in an adolescent's experience of his overwhelming fear of parental divorce as the understandable and therefore treatable rage of delinquent acting out.

In Stage IV, the healer confirms the transformation of the particularized symbolic meaning-e.g., the invading spirit, now named, is subjected to specific rituals of exorcism, or the Oedipal conflict, now understood in the

details of a personal history, is worked through in the interpretation of personal events and in the experience of its transference to the analyst. This symbolic transformation activates the dialectic linking culture (symbolic code) and social relations, on the one side, and psychobiology (autonomic nervous system and neuroendocrine system) on the other, to foster a desired (hoped for, believed in) change in the patient's emotions, disordered physiology, and social ties. In anthropological terms, the healing interaction fosters this transformation as a work of culture: the making over of psychophysiological process into meaningful experience and the affirmation of success.

Meanings mediate change at different levels of the hierarchy. The parallelism between svmbolic world and body/self processes which was held to be the means by which healing restructures the person and the disorder may not be nearlv as tight ac students of ritual once claimed it to be (Q_ v.
Lévi-Strauss 1969_ Douglas 1970). The client may not be fully aware of the intricate meanings of the symbol system (Laderman 1986). Rather, it may hp his early conditioning to key cultural Bodes-sounds. smells, words, images-that are now physiologically effective even if onlv partially or wronglv understood, or his placebo-like response to more general meanings of trust in the healer's competence and a conviction that the ritual, no matter the details, will make one better-it may be these things that constitute efficacy.

Healing, as a sacred or secular ritual, achieves its efficacy through the transformation of experience. That transformation is created out of the effective enactment of culturally authorized interpretations. Demons are exorcised, and the anxious natient comes to believe that the cause of the problem has been removed; that conviction. elicited by the therapeutic ethos anti encouraged by the social circle. alters cognitive processes of hypervigilance and fearful appraisal of new situations _.- create d different emotional state: calm instead of apprehension and faith in mastery over lite problems that previously were feared to be uncontrollable, what has changed? The fife problems may or may not have been directly affected (i.e., the patient may still have to work under the same pressure imposed by his supervisor; or, on the other hand, owing to the attention a patient has received and the advice of the healer, an inattentive husband may become more supportive). How these problems are perceived, however, is no longer the same (e.g., a childhood trauma of rejection by a parent which has helped shape the patient's poor self-image and vulnerability to depression following the break-up of a close friendship, when it has been worked through in the transference and in grief work for the dead parent, is now not perceived as terrifying or responded to with intense guilt). Altered meanings exert practical efficacy in the felt experience of the patient, e.g., remoralizing the demoralized, and in the social tensions of the patient's circle, e.g., reconciling angry family members (Tambiah 1977; Kapferer 1983; Turner 1967).

Think of this change in terms of Scheff's (1979) model of catharsis The healer encourages emotional distancing and release through the experiencing of mediating symbols. That emotional change alters the patient's cognitions (e.g., the intense envy and self-grandiosity that mask a deeply hurtful but previously unexpressed self-image of inferiority emerge, become less menacing, and no longer can repress the desire for a more balanced view of self) and social relationships (e.g., the patient's children release their own ambivalence and thereafter become more supportive). Those transformed cognitions, which themselves result from and in turn amplify altered feelings, contribute to a more adaptive, or more optimistic, or simply less self-defeating self. The restructuring of social relationships, a key feature of healing rituals in non-Western societies and sometimes an intended, sometimes an unintended part of psychotherapy, intensifies this process (cf. Turner 1967). As a result, catharsis transforms inner troubles as well as one's perception and experience of the local social world. A threatened and demoralized Taiwanese patient, for example, who fundamentally questions his sense of self-efficacy, accepts a shaman's master myth of a calm, reassuring, effective spirit commanding his consciousness. During the ritual treatment he enters trance and is possessed by the guiding spirit, during which time he expresses his fears in a crescendo of cathartic release authorized in the ritual setting. That emotional outpouring overwhelms lifetime repressions that were barriers to self-insight and in so doing renders this heretofore indocile man receptive to change at the core of his character. The patient comes to demonstrate in daily life the qualities of the mythic model: i.e., his self-image becomes that of the possessing deity, Buddhalike; he no longer sees the world as threatening and frustrating and beyond his ability to control. Through this powerful therapeutic experience, the patient reverses his negative cognition's, lessens anxiety and depression, and begins to transform his personality As a member of the healing cult, moreover, his status is elevated and practical difficulties in his social life (e.g., too few clients for his woodworking business, and the absence of close friends to whom he can explain his fears of business failure and from whom he can receive affective support and practical advice) are overcome through his new social network (Kleinman 1980, pp. 333-352).

But catharsis and restructured social relationships are not the only therapeutic processes at work in this Taiwanese example or involved in symbolic healing generally. A deeply demoralized middle-class North American housewife accepts a cognitive behavioral model of her problem as a matter of the personally destructive effects of ideas of self-inefficacy which can be changed through a relationship with a therapist who applies an authorized protocol of behavioral interventions. The positive cognitions, like those of her Taiwanese counterpart, only here sanctioned by behaviorism's epistemology and experienced through the mediating symbolic meanings of the cognitive therapy, alter the patient's self-image and that

endocrine and autonomic nervous system activity experienced as decreased dysphoria, improved sleep and energy, and diminution in pain, weakness, and other symptoms (Hahn and Kleinman 1984; Tiger 1979). This is a model of social persuasion and learning; they too are at work in symbolic healing.

In the anthropological vision, the therapeutic relationship as a social exchange is important for such cognitive, affective, and physiological change to occur, which change may indeed be replicated in the patient's family setting and other intimate relationships (cf. Lewis 1971; Janzen 1978). In this model the contribution of improvement in relationships to therapeutic change is a concomitant or consequence of a more fundamental transformation in the meanings of those relationships that alters perception, expectation, communication, and commitment. Altered states of consciousness such as trance and other forms of dissociation-so ubiquitous outside the secular West-and transference, too, may facilitate these transformations. In the case of transference, the interpreted meanings are projected onto the healer, who comes to embody them; with altered states of consciousness, those resonant meanings are experienced by the patient in an aroused or highly focused ritual state which intensifies their effects and sanctions the transformation of self and social relationships.

Yet, in the cultural model of healing, these psychosomatic processes of change are not what is most essential about how symbols heal. The question is not whether catharsis or expectant faith or persuasion or restructured social relations is the single basis of healing. All are important, along with yet other processes of change-e.g., irony, paradox, modeling, insight-though none is determinative. It seems to be rather the dialectical structure of healing systems that is invariant. That structure creates a process of transformations that moves from cultural meanings to embodied experience, from the meanings of personal relationships to the relationships of personal meanings.

Psychotherapists who study healing are preoccupied with the content of narticular kinds of healing systems and with proving that a particular mechanism of chance (i.e.. personal qualities of therapist, client expectations, or social learning) is universal. They are so absorbed by the mechanics of change (e. g.. catharsis, confession, conditioning) that they tail to see that it is the structural -organization of healing on the level of svmbolic meanings that unifies all healing systems, psychotherapy included. The various mechanisms of psychophysiological and social change work within this universal symbolic structure, which, from the anthropological standpoint, is the source of cultural transformations of the body/self. Perhaps another way to put this difference in points of view is to say that psychotherapists have emphasized processes, while anthropologists have emphasized the. systems within which those nrocesses are lodged.

In summary, then, what is necessary for healing to occur is that both

parties to the therapeutic transaction are committed to the shared symbolic order. What is important is that the patient has the opportunity to tell his story, experiences the therapist's witnessing of that account, believes the therapist's interpretation of his problems, and comes to use the same sym. bolic vehicles of interpretation to make sense of his situation. Because of his own need to believe and the rhetorical skills of the therapist to make key symbols relevant to the experience of the sufferer, the sick person becomes convinced that a transformation of his experience is possible and is in fact happening. On the level of psychotherapy as symbolic performance, as Tambiah has shown (1985), positive therapeutic outcome is enunciated and supported by the completion of the ritual transformation. The ritual ends, termination is justified, the myth is reenacted, symbolic harmony is achieved, the specific techniques and theories reach a logical and necessary conclusion, and therapist and patient agree that transformation has occurred. Even if there were no specific effect on pathology, patient and healer will feel better and believe in the efficacy of the treatment. That is to say, the therapist convinces the patient he has changed for the better and perhaps to do so needs to convince himself as well. But of course such powerful psychosomatic processes do alter pathology, even serious pathology.

To analyze the structure of healing is not to invalidate the experience or to accuse the healer of false consciousness. Quite the contrary. In this anthropological schema, healing is only possible because the relationship authentically particularizes personal experience in symbols that are culturally and practically relevant. That psychotherapy, like all indigenous systems of symbolic healing, is nonspecific neither diminishes its therapeutic significance nor invalidates its appropriateness for health care.

It is appropriate to inquire if the analysis of symbolic healing holds any practical implications for the training of the psychiatrist and other psychotherapists. Psychotherapy training tends to occur in the privacy of the psychiatric resident's experiences with his clients and clinical supervisors. The latter provide the therapist with a theory to interpret the patient's story and to plan his own actions. The supervisor introduces the novice psychotherapist to a particular "school" of psychotherapy. Since most psychotherapy supervisors are still psychoanalytically oriented, a psychoanalytic paradigm is what the resident learns. In principle, exposure to supervisors representing distinctive schools and participation in a seminar whose readings cover the different therapies should provide the resident with an overview from which he can later choose those theories and interventions with which he feels most comfortable and those methods with which his personal style is most consonant. In practice, most residents learn little about even the major alternative schools of therapy, and almost nothing about what is shared in the structural process of symbolic healing. Since psychotherapy

is a lonely craft with uncertain standards, it is not surprising that young therapists feel a strong urge to affiliate with one of the schools (or, we might say, sects) in order to have colleagues who accept the same standards of "good" care.

I would suggest that a more systematic and useful means of teaching psychotherapy-to residents and also to graduate students in psychology and social work-is to begin with a seminar on symbolic healing crossculturality that reviews what is known about universal and culture-specuic asoects of *symbolic.* healing and that explores the structural model of healing described above. This should provide the resident or the student with a broader, more critical understanding of the healing process. Following this, the major schools of psychotherapy can be compared and contrasted, with the explicit purpose of understanding those skills that are shared across schools and in the expectation that the trainee will develop familiarity with at least a few of the major therapies. Practical experience in patient care could mirror the didactic training. The resident would be super vised at first with the chief aim of helping him master the major therapeutic skills common to all systems of symbolic healing. Then the resident could be supervised in the different major therapies. Residents also need to know when one psychotherapeutic method may be more suitable than others for particular patients, because of the nature of their illness or their personality organization or their educational level and cultural background. If they do not practice the appropriate type of therapy for a particular patient, they should nonetheless be skilled in making suitable referral. The overall goal would be to organize a critical rational approach to psychotherapy (cf. Manschereck and-Kleinman, eds., 1978; Manschreck and Kleinman 1981) that trains residents systematically in the most important skills (the building of rapport and trust, empathic listening, persuasion, remoralization, interpretation, etc.), that also educates residents to be critical readers of the psychotherapy literature on each of the major schools, and that otters each resident a framework for making sense of the major symbolic tasks of healing and for maximizing the symbolic effects of psychiatric care.

One desirable outcome of such a paradigm of training would be to force the profession of psychiatry to develop a more strenuous and systematic approach to psychotherapy, one that would be as independent as possible of the different therapeutic ideologies. At present, there is a tradition of important research on psychotherapy outcome, but there is no major comparative scientific study of the psychotherapies, nor for that matter any systematic empirical study of the use of a wide range of symbolic therapies by psychiatrists and other physicians. This is yet another paradox. Psychiatry is the home of psychotherapy in medicine, but, aside from promoting the important work of demonstrating that psychotherapy is useful, it has

not taken this responsibility seriously enough to create a general scientific approach to psychotherapy and symbolic healing in medicine.

My analysis of psychotherapy points to a central tension in the relationship of the psychiatrist's care to medicine and health care generally that is the reciprocal of the challenge the psychiatrist's interest in the biography of the person and the social context of illness experience presents to medicine's dominant paradigm of clinical diagnosis and pathology.

The Paradox at the Heart of Health Care and Medicine

The *Shorter Oxford English Dictionary* defines paradox as "a statement or tenet contrary to received opinion or belief . . . . A statement seemingly self-contradictory or absurd, though possibly well-founded or essentially true" (p. 1428). Psychotherapy, the major form of symbolic healing in contemporary health care and biomedicine, illumines a postmodern paradox. Healing has become increasingly marginal to the West's dominant healing system.

The psychiatrist's psychotherapy is an anomaly in the house of scientific medicine, as is the family physician's and general internist's supportive, psychosocial care. Since the time in the Enlightenment when Bichat introduced the clinicopathological conference, with its central methodology of dissection of the cadaver of the dead patient, to determine the biological pathology as "the real cause" of the patient's problem and the focus of treatment, biomedicine has given research on disease a higher priority than the care of illness (Sullivan 1986). Biomedicine, and the professional health care sector of which it is the dominant component, is organized around specific biological investigations and treatment techniques that depend on increasing reductionism. Often such reductionism has been brilliantly successful, as in the treatment and prevention of infectious disease, or in the current revolution in our understanding of the molecular genetics of many heretofore mysterious disorders, e.g., Alzheimer's disease. But too often it has also encouraged medical approaches to the care of patients that have been inhumane and also ineffective (Eisenberg and Kleinman, eds., 1981).

Talk therapy and the nonspecific (placebo) use of symbols are disdained. The psychiatrist, to the extent he is not thinking in neuroscience terms or employing somatic therapies, is an anachronism because he trades in general symbols, subjective meanings, and lived experiences.

Most of psychiatric care is not about the determination of brain pathology or the choice of a particular drug to cure the patient's disease, though these activities are not unimportant. The psychiatrist's work is chiefly about people's life stories. It is about aspirations and defeats, about pasions

and tragedies; in other words, it has to do with the deeply personal and life world (family, work, and school) problems that constitute the neuroses. And it is about assistance with the felt experience of illness in the gravest psychiatric disorders. Indeed, I would argue that this is psychiatry's signal contribution to medicine and health care generally: it has authorized the inner experience of the patient, the meanings of his illness, and his context of personal relationships as legitimate fields of inquiry and intervention for medical care.

Yet, under the pressure of culture change, psychiatry too is undergoing transformation (Eisenberg 1986). Academic psychiatry aims to become a version of high-technology internal medicine. Although the practice of psychotherapy continues to thrive in the clinic and private office because of the demands of consumers, the psychiatrist's concern with suffering and symbolic transformations is not well represented in medical schools or teaching hospitals.

The point is often made that psychiatrists, family physicians, and primary care internists should leave psychosocial inquiry and psychotherapy to other categories of health professionals-nurses, psychologists, social workers, physician assistants. This denigration of interventions that are not biological techniques (drugs, blood tests, endoscopes, surgical procedures) is reflected in the economic statuses of the psychiatrist and primary care practitioner, which are at the lowest end of the medical income scale, and in the limited curriculum time and research support provided for psychiatric teaching about symbolic interventions. One would think that every medical student should be trained to elicit the highest rates of placebo effects through mastery of nonspecific symbolic techniques. Far from it. Medical students are taught little else than that placebos confound clinical trials and may be unethical to provide without the consent of the patient. Hence the paradox. Biomedicine is the major system of healing in the West. Yet it has little to do with what is most central to most healing systems, symbolic healing. Indeed, it may not be an exaggeration to suggest that biomedicine is one of the only healing systems in which the structure of symbolic healing becomes most hedged in and routinely undercut and the training of the practitioner constrains her therapeutic use of meanings.

Whatever the doctor thinks she is doing (being scientific or providing the most up-to-date technology), she is nonetheless involved in a powerful set of psychological transactions with her patients. Her only choice is whether to recognize and maximize her "psychotherapy" or to be inattentive to it. To choose the latter is to fool herself (and her patients), and to lose some of her power to direct these psychological transactions toward conscious ends.

In this golden age of biomedical research and treatments, we are witnessing the problem of what shall become of symbolic healing. Perhaps, over the next century in North America, it will wither away in the profession

of medicine, to be practiced only in the folk and popular arenas of health care. Perhaps it will continue to hang on as a marginal but inalienable aspect of psychiatry and the primary care professions, which themselves will be transformed into the high-technology image of the rest of medicine. This question must be asked of psychiatry per se: Can it continue to legitimate psychosocial problems, humanistic interests, symbolic interventions as medical concerns? If not, will psychiatry as we know it survive? Alternatively, is there the possibility that by opening these medical concerns to the human sciences (psychology, sociology, anthropology, history, philosophy, literary studies) -by doing these things that. run against the grain, so to speak-that psychiatrists can make the meanings of illness experience and the social sources of human misery and symbolic healing an integral part of a more broadly conceived science of medicine and health care? I turn to this query as the penultimate of our anthropological questions for rethinking psychiatry.