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ARTICLE

Cultural Standards, Power and Subversion in Cross-cultural Psychotherapy

Richard Rechtman
Université Paris 5

Abstract In a creolizing world, psychotherapy is challenged by the growing influence of cultural standards, systems of meaning and idioms of distress supported by new groups who play a major role in public health policies. While these elements were originally introduced in psychotherapy with ethnic minorities both to improve the patient–doctor relationship and to bring relevant material from patients' cultural background, they also became a way to empower nonwestern patients in western health care systems. When in the 1980s it became possible to readdress the issue of power in psychiatric practice, something had already changed in the social regulation that psychiatry should endorse. In this article, the author focuses on the new legitimated social and cultural values that underpin the therapeutic process. While obviously these new values should be taken into account, the aim for psychotherapy remains to find a path for a 'subversive' practice that could be something more than just following social guidelines.

Key words cross-cultural psychotherapy • empowerment • idioms of distress • power • social regulations

Nowadays, there is much evidence that power in the psychiatric setting is one of the major unsolved issues. Promoted at the end of the 1980s in clinical practice when the wave of antipsychiatry that brought it up in the 1970s had already declined, this issue has deserved much attention for two

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major reasons. First, patient empowerment was a way to improve patient participation in the therapeutic process especially in rehabilitation programs (Fitzsimons & Fuller, 2002; Hamann, Leucht, & Kissling, 2003). Second, it was a way to advocate for more sensitivity to patients' thoughts, expectations, will and civil rights when these values and needs had been systematically denied throughout the history of psychiatry (Castel, 1980; McCubbin & Cohen, 1996). While these two reasons are today undoubtedly connected, they nevertheless derive from two very different paradigms, which crossed in the middle of the 1980s mainly for socio-political reasons.

Power and Transcultural Psychiatry

The issue of power has many implications in the field of transcultural psychiatry and psychotherapy. It has of course the same consequences as in contemporary general psychiatry, but also it takes a very specific meaning with regards to cultural and ethnic clinical and political issues. As Laurence Kirmayer has pointed out in the argument for this meeting, the transcultural scene is already fundamentally a field where different structures of power interact and underpin the therapeutic alliance.

Another reason why the issue of power is so crucial in transcultural psychotherapy has to do with the growing influence of cultural standards, systems of meaning and idioms of distress in the therapeutic process. While these elements were originally introduced in psychotherapy with ethnic minorities both to improve the patient–doctor relationship and to bring relevant material from patients' cultural background, they also became a way to empower nonwestern patients in western health care systems. Based on the assumption that the struggle for minorities' rights should be extended to every area where minorities were subjected to discrimination, it became clear that psychiatry should also be targeted – not only because of the history of psychiatry and its past collusion with power and repression, but mainly because right after the 1980 revolution of DSM-III, American psychiatry had demonstrated a new capacity to support minorities' interests. After the battle for homosexuality (Bayer, 1987), and the invention of new categories such as Posttraumatic Stress Disorder (PTSD) (Young, 1995) and Multiple Personality Disorder (MPD) (Hacking, 1998; Mulhern, 1998), where feminists found a new paradigm to establish their social discrimination thanks to the new definition of trauma (Rechtman, 2002), it became clear that the transcultural clinical setting could mirror social contests and provide evidence to support minorities' rights (Rechtman, 2001). While this concern for minority rights is obviously appropriate to enhance cultural sensitivity in mental health policies, it nevertheless raises many questions when applied to psychotherapy.

For example: Should psychotherapy have for itself a major goal of helping patients cope with this issue of power and empowerment? Invented in a century when the issue of empowerment was not a key issue, psychotherapy has progressively tried to address issues of personal and collective empowerment. The question is therefore how psychotherapy can rethink its boundaries and social rules in a changing world. To answer this question, we must understand how issues of power have been addressed in modern conceptions of healing, and how they became the key to the political significance of psychotherapy.

Power and Psychiatry: A Double Genealogy

The issue of power in psychotherapy comes from two very different paradigms: (a) Changing mental health policies affecting the status of the asylum, and (b) the antipsychiatry movement. The first derives from new mental health policies which establish a strong relationship between improving patients' knowledge and improving patients' quality of life, with the assumption that better quality of life is necessarily correlated with a better social functioning and to a better capacity for social rehabilitation. Based on empirical data, this conception is the pragmatic application of new trends in mental health policies focusing on outpatient care for the severely mentally ill (Granger, 2000; Harrington, Noble, & Newman, 2004). Here I will not detail the economic and political issues that, with models of health care systems, were undoubtedly the major concerns that led to this paradigm, but instead focus on their clinical implications and their moral basis. The major clinical implication is a large focus on outpatient care and the priority given to helping patients to stay in the community and cope with social realities. As far as psychotherapy is concerned in this evolution, the therapeutic process must take into account the different levels of social reality that patients face and link them with patients' inner experience. My concern in this article is not whether the shift from the asylum to the community is right or wrong. Of course, it is better to treat patients with greater dignity and respect for their own wishes, their own cultural backgrounds and so on. Rather, I want to address another question: Who has the authority to define patients' needs?

From a historical and anthropological point of view it would be very simplistic to think that the definition of patients' real needs is based only on empirical data. At the time of the great asylums it would have been possible to collect as much data as needed to confirm that lunatics' real needs were to have shelter, some food and a place to live *far away* from the other members of society, depending on whom was asked. However, in the 19th century, no one would have thought that it could be relevant to ask this question about lunatics' needs. One was simply assumed to know what

was 'best' for lunatics. Who then had the legitimacy to speak on behalf of society for the 'good' of lunatics? Alienists, of course, were one of the major groups, not so much because they had knowledge about mental diseases, but because they belonged to, and represented, the bourgeoisie. It was the bourgeoisie and its various representatives, including physicians, the police, the judiciary and administrators that had both the power and the legitimacy to enunciate what should be the 'good' for the collectivity. While the values supported by the bourgeoisie were considered as the most advanced, the fate of lunatics belonged to this conception of the collective 'good'. I won't go further in this very well-known history. I just want to underline that the issue of needs and power for the mentally ill is in fact directly connected to the history of groups' political legitimacy.

This is the point where the second paradigm of power in psychiatry overlaps with the first. The antipsychiatry movement arose in a very specific socio-cultural context when new social groups, including homosexuals, feminists and ethnic minority groups, were beginning to gain political legitimacy (Crossley, 1998). The discipline of psychiatry was still portrayed as representing the old power of the bourgeoisie and a century of oppression against madness (Castel, 1976; Foucault, 1972). But this image did not really conform to the sociological reality for at least two reasons. First, psychiatrists had already modified their conceptions and attitudes toward the mentally ill. The revolution of psychoanalysis in the middle of the 20th century and the beginning of community mental health programs had profoundly modified the ideology of exclusion in psychiatric practice (Daumezon, 1948), even if it remained the political paradigm. Many psychiatrists no longer wanted to endorse this ideology and began to subvert this political mission (Bonnafé, 1948; Tosquelles, 1970).[1]

The second reason is probably more important, but has not received much attention. Something had already changed in the political usefulness of psychiatry, not in psychiatric institutions like asylums, but in the previously strong relationship between psychiatry and specific social regulations. Contrary to Michel Foucault's (2003) and Robert Castel's (1976) analyses, when it became possible to attack the power of psychiatry in the 1960s, it was not because psychiatry was the servile auxiliary of the power of punishment. Rather, it became possible to contest the power of psychiatry and its repressive institutions, because this power of punishment no longer needed any guarantee from psychiatry. The state had already left behind its need for a visible politic of exclusion, thanks to a century of alienisms that had achieved this process. Psychiatry in the 1970s still had a strong power of repression and exclusion, but the psychiatric establishment no longer had the legitimacy to use this power and to administrate populations in this way. Its power, social usefulness, and

social missions no longer seemed able to protect the society. This does not mean that there was no longer a need to ask psychiatry to protect society, but new social regulations, new models for managing populations were assigned to psychiatry. Psychiatry itself has been late to perceive this evolution, and this is may be one of the reasons why it was easy to transform what was already a politically irrelevant institution in the US, Great Britain, Italy, and France, at about the same time.

New groups that had gained a new visibility in defining what would be 'good' for the collectivity, supported the new legitimacies that arose in the 1970s. These groups were therefore in the right position to assign new social missions to psychiatry in order to protect society. In fact new legitimated social values became the guidelines for psychiatric practice, just as confining lunatics in asylum was a legitimated social values of the 19th century. Even if these new values are much more humanistic than the old ones, it remains that they are forms of social regulation that have to be clearly distinguished from clinical or therapeutic perspectives.

The Rise of New Social Legitimacies or Who Gets the Power Today?

What has changed in 20 years is less our conceptions about mentally ill people, than the social regulations that psychiatry still has to administrate in our modern societies. This evolution is the consequence of the encounter in the 1970s between two different interests, supported by different social actors, that suddenly matched each other: The rise of new groups' activism (patients, families, social workers, practitioners, but also women, homosexuals, ethnic groups, etc.), on the one hand, and the state's renouncing of a visible politic of exclusion, on the other. In this specific context, it became possible to concede legitimacy to these groups just as they were expressing the 'real needs' of the population they were apparently representing.

Even if patients' activism was an important factor in the development of the image of new mental health policies (Reaume, 2002), their real political power was very small compared to the power wielded by other actors (McCubbin & Cohen, 1996). In fact, the definition of patients' real needs was clearly established without patients' words (Crossley & Crossley, 2001).

As a matter of fact, one of the major goals today is to give patients what they expect, what they need, and what they are legally entitled to have as 'ordinary citizens'. This will to promote equality in citizenship is obviously an important advance over the past social condition of mentally ill patients, but, from a clinical point of view, it may leave behind elements that require specific answers. In the context of public health policies, this

position is remarkable for at least two reasons. First, it indicates that the question of power and civilian rights is now a central issue in public health policies, approved and supported by the state in the name of patients. This is an essential clue to understand how this issue of needs is now also a new regulation that governs populations rather than heals patients. Second, it indicates that behind the claim of empowerment, new activist groups wield the power and the legitimacy to express on behalf of the collective 'good' the social norms that psychiatry should support. As a result, both offer a way to transfer the former social inequalities to the field of health.

I will offer just one brief example. In France, the development of rehabilitation programs for schizophrenic patients raises the difficult question of severely mentally ill persons' aptitude to live in the community. To assure the success of these programs, which are based on the conviction that patients can achieve a better quality of life outside of the hospital, patients receive benefits including outpatient treatment, some social support, and financial aid (amounting to about US$600 a month). These were the officially approved basic needs for schizophrenic patients but, as a psychiatrist, I might think that for a chronic schizophrenic patient the real needs should be closer to US$5000 a month, because we know how much money they like to spend for nothing: An apartment with at least six rooms, where five could be used to stock all kinds of rubbish they usually keep with them, so that they could live almost decently in the last one, and two housekeepers, so one could be the bad object and the other the good one in order to be sure that at least the cleaning could be done, and so on. This might be more clinically relevant, but I assume that no one would say that they are legitimate needs. In fact, today schizophrenic patients' real 'needs' are based on the 'needs' of poor people. As we know how difficult it is for poor people to live on what is offered by the state, we can imagine how inappropriate it is for schizophrenic patients. But it still looks like a basic need. The point is that the 'real needs' are based on the social category which coincides with the socio-economic condition that is attributed to patients, in this case poverty, and not on patients' clinical condition.

Psychotherapy in a Creolizing World

I have made this long detour to show how issues of power, empowerment and 'needs' in public health policies reveal the rise of new groups' activism that not only act as health policy makers, but which also support a new therapeutic ideal. The values they claim to share with patients belong in fact to a new ideology of the value for mentally ill peoples – indeed, for all kinds of suffering people – of expressing their civil rights. These values are not based on clinical features or on psychopathological distinctions. I

think this is a major challenge for psychotherapy. While the growing influence of these new legitimacies in the construction of health policies is obviously a major advance, it may defy psychotherapy if it is applied in place of a clinical perspective.

Idioms of distress, for example, are also powerful structures of meaning that can be used as social guidelines to govern populations (Rechtman, 2000; Young, 1981, 1990). In a creolizing world where minorities face inequality and various dominating powers, groups often tend to constrict social relations in order to give the illusion that the whole group's destiny reflects the destiny of each member. For minorities' activism, this is a way to impose their leadership both upon the members of the group and outside in relation to the host society. However, the conflict between the group's social values and other values supported by the host society interacts frequently with individuals' choices. Even if this conflict is not the real reason why someone presents with psychological distress in the course of a nonapproved behaviour, the collective explanation shared by the patient and his/her group will be used as an idiom to explain the distress through this conflict.

I will call this a 'creolizing idiom of distress.' It gives a socially acceptable meaning to various psychological problems while maintaining a social coherency in spite of nonapproved behaviours. I will illustrate this issue with a brief case study.

An Impossible Question

A 25-year-old young Cambodian woman came to my office a couple of years ago. She presented with severe anxiety and major depression with suicidal ideas over the past 6 months. She was born in Cambodia just before the fall of Phnom Penh and escaped during the first weeks of the new regime to Thailand with her mother and her brothers. Her father did not come with them for unknown reasons, and he died in Cambodia while the rest of the family resettled in France after spending 2 years in refugee camps. Raised and educated in France in a traditional Cambodian family, she married a young Cambodian boy who was the son of a very close friend of the family when she was 18. She interrupted her studies 1 year before her wedding in order to work in her family's restaurant in a small town in the north of France. While this marriage was a very positive opportunity for the family, it was also her own choice regarding a boy whom she had known and loved since she was a very young girl. She had no difficulty living in France, and was very well adapted. She could easily switch from one culture to the other, and she never thought that her Asian background was in any way a problem. She wanted children and was lucky enough to give birth to four in a very short time: two boys and two girls. While it was in fact a hard task for a young mother to raise four young children, she

benefited from help from all of the family: her mother and her mother-in-law as well as her brothers.

But suddenly she fell in love with a young Vietnamese boy and decided to live with him just after their first meeting, leaving behind her four children and an inconsolable husband. The two lovers decided to move to Paris to start a new life. She knew that all the family would disapprove of this behaviour and would try to end her contact with her children. She was completely aware of her behaviour and of its terrible meaning in the Cambodian mentality, and that she would be banished from her own family. Furthermore, as the man was Vietnamese, the Cambodians' 'deadly enemy', she knew that she would not get any support from the Khmer community. She would have to spend her life living like a pariah. But she thought she had no choice. She had to do it because she was too young to spoil her life at only 25 by staying with a man whom she loved like a good friend. She wanted to choose love and life instead of a peaceful routine.

After a few months, she began to be very anxious, she could not sleep, she was afraid of dying and at the same time she wanted to commit suicide. She missed her children and she could not get news of them. Each time she called her mother she was rejected by her, and she could not even talk to her oldest son. Her mother did not want to hear from her anymore, saying that she was a bad mother, a bad daughter and a bad Cambodian girl. As an old Cambodian woman who had experienced very difficult things during her life, she could not begin to understand her daughter and just blamed herself for her daughter's poor education, accusing both the French way of life that pushes people to corrupt essential values, and the well-known 'vicious' Vietnamese mentality. Threatened by her husband and her brother, the patient was afraid of their possible punishment and became very obsessional. She could not even find support with her young lover, who became exhausted with the situation. After a while, she had to acknowledge that just as her mother had told her, he was not the kind of man she had been dreaming of.

She then thought that her family was right, and started to blame herself. She said she was the shame of her family; she was a bad mother and a lost girl. She could not live any longer with that man, but she could not go back either. Because she thought that she no longer had a place anywhere, she now wanted to die.

She decided to come to the transcultural consultation unit because she wanted a psychiatrist who was aware of Cambodian moral values. As she said at the very beginning of the first session, she had made the wrong choice and she wanted to talk with someone who could understand that point. Major anxiety and unbearable anguish were the dominant symptoms of her depression. She expressed the feeling of being lost with no other choice than death. She could neither live like a French girl and could no longer live like a good Cambodian mother. According to the Khmer mentality her problem was easily understandable. While she was obviously in a very critical situation because of her behaviour, I found this explanation

insufficient to understand her severe anguish and her paradoxically terrible fear of dying and her will to die. Furthermore it did not provide any key to engage the therapeutic process. In fact she was asking me an impossible question. Should I help her to go back to her previous life with the risk of validating that she had been a 'bad mother'? Or, should I support her wish to live with her young lover, while it would mean that she had to abandon her children? That was the question she asked me. How could she be at the same time a good Cambodian mother and a free woman, as she thought women were in France? At that point her distress could be interpreted as a consequence of the contradiction between traditional cultural values and western ones as has been widely described in the process of acculturation.

In fact, the patient's explanation of her own distress followed the template of a modern idiom of distress (a creolizing idiom of distress), which shapes the individual's experience within the expected collective moral values. But I want to emphasize that this interpretation misses the very specific meaning for this patient. Furthermore it gives an explanation that endorses moral values that the patient should express, while there is no evidence that the psychological problem of this specific patient is limited to this cross-cultural conflict. And that was the point. She did not express guilt or even regret. She was just blaming herself for not being able to follow her own choice. In the process of accusing her cultural background she started to talk about her late father. He had also made the 'wrong choice'. He decided to stay in Cambodia while all the family flew to Thailand. He abandoned her when she was just a baby and stupidly died when everybody knew he could not escape later. Her mother did not agree with the father's decision and she used to blame him for his lack of reasonableness. The patient heard this sad story many times when she was a young girl, and could not understand the reason why her father did not follow the group. Even if she later understood that perhaps her father did not decide to leave her behind, she still wanted to know how it was possible to make a 'wrong' choice. During the process of therapy she was able to link her anguish of dying with the death of her father, whose death she had never had the possibility to talk about with her mother. She could also give another meaning to her own choice. She was in fact reproducing her father's wrong choice between what she supposed was his 'life' and his family. But by choosing his own life, he died and she lost him. Now, she missed her father even if she could not remember him. In fact, she had never talked about the Khmer Rouge regime and she never knew how her father had died. It was impossible in the family to ask these questions. But her anguish as well as her extreme fear of dying and her will to commit suicide were a way to question her family history and especially her father's destiny. Twenty-four years after his death, the image of her father was returning in her symptoms.

Certainly, this case study demonstrates that this young patient was involved in a cross-cultural conflict between two different moral values. But the reason she became depressed a few months after she left her home was probably not this cross-cultural conflict, even if she expressed her distress

through this narrative. In fact this narrative of conflicting cultural values belongs to a creolizing idiom of distress that above all validates a naïve but legitimated powerful collective conception that claims that it is not possible for someone to behave against moral values, unless he/she is mentally ill. Furthermore, this kind of idiom does not give any other alternative to patients other than being rejected from their group.

The point I wish to make is that, as a psychotherapist, my task was not to decide for her (or even with her) which choice should be the best for her regarding these two opposite conceptions of the liberty of women, which are both in fact socially constructed. Rather my task was to find the inner reasons for her pathological anxiety that arose in this conflict and which was responsible for her profound distress.

Conclusion

Many individuals make choices that are not culturally sanctioned and these do not necessarily produce psychopathology or psychological distress, unless they take on a specific meaning in the personal history of a patient. While the growing power of groups' activism tends to reinforce the image of a collective destiny, creolizing idioms of distress offer a political solution to explain and to control individuals' deviations. This is a major challenge for psychotherapy.

While treating someone decently, respecting his or her own belief, understanding his or her cultural conceptions, trying to share knowledge in order to make it understandable and acceptable are essential values, they should not be confused with therapeutic goals. Respecting civil rights is probably one of the most important conditions today to practise psychotherapy, but psychotherapy needs to go beyond these aspects to produce a therapeutic act. Otherwise, psychotherapy will only be a kind of friendly technique that sometimes helps dominated people to fight against their social condition, sometimes just helps them to accept it. From a psychotherapeutic point of view, the question is not to help patients with social or political support, many other social actors could do that better than clinicians, but rather to give them psychological tools in order to take possession of their confiscated power.

Psychotherapists must be aware of the new forms of social regulation supported by the collectivity. Just as it was an ethical struggle for psychiatrists and psychotherapists to restrain the power of punishment that was involved in psychiatry, it is important today to restrain the power of the forms of social regulation supported by new groups of legitimacies that try to govern the destiny of singular individuals on behalf of the 'good' of society. In the face of these new social regulations that psychiatry has endorsed, I think psychotherapy still has to be a subversive practice. This

is the reason why we need a political anthropology of psychotherapy in a creolizing world.

Note

1. Here we can see the gap between Michel Foucault and Marcel Gauchet's perspectives. While Foucault (2003) was focusing his analysis on the famous dyad of knowledge and power that always overlies theories in psychiatry, but without paying much attention to the effective practices that occurred in asylums, at the opposite, Gauchet (1994; see also Gauchet & Swain, 1980) demonstrated the capacity of psychiatry and psychiatrists to create their own references inside this system of political values. But this is not a contradiction. Moreover, these two perspectives show the two different levels that always interact all along the history of psychiatry (Goldstein, 1997). In fact, even at that time practising psychiatry was in some way an exercise of subversion.

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Richard Rechtman, MD, a psychiatrist and anthropologist, is the Medical Director of the Institut Marcel Rivière and Editor-in-Chief of *L'Evolution psychiatrique*. He has conducted field research in transcultural psychiatry with Cambodian refugees and in the political anthropology of mental health policy at the CESAMES (Inserm, CNRS, Université Paris 5). *Address*: Institut Marcel Rivière, CHS La Verrière, 78321 Le Mesnil Saint Denis Cedex, France. [E-mail: richard.rechtman@wanadoo.fr]