

The Relevance of Ethnography in a Psychiatric Journal

A Commentary on Diagnosis and Distress in Navajo Healing

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Our diagnostic nomenclature provides no guidance in assessing our patients' perspectives toward their psychiatric disorders. Yet we all know that their understanding of the meaning of the disorder in their lives, their views regarding their suffering, their ideas about why this occurred to them, and the effects of the disorder on their morale are all important. We need this information in deciding how best to help the patient, whether to consider hospitalization or not, and what strategies to adopt in psychotherapy.

Often we have the greatest difficulty understanding these critical dimensions of our patients when the cultural gaps between them and us are greatest. With that challenge in mind, Csordas et al. have conducted a psychiatry-oriented ethnography among 78 Dine (Navajo) people who had sought nonmedical or "folk" healing in one or more of 3 local religious traditions. These traditions included traditional Dine spiritism, Christian healing, and the Native American Church—a syncretic religion that melds aspects of Christianity and pan-Indian spiritism.

The ethnographic analyses in their report in the August issue of the Journal (Csordas et al., 2008) provide several important lessons for psychiatrists. First, Dine people employed folk modalities for a variety of nonpsychiatric medical problems that were causing them emotional distress, often in the absence of a psychiatric disorder. Second, the folk healing was sometimes useful for social problem solving, which addressed important obstacles to health and recovery. Third, one of the cases represents a "transference cure." The patient was ready to recover but required a healing event to exit the sick role (just as he required social approval to enter the role).

The case examples reveal that psychiatric diagnoses (the result of SCID interviews by experienced clinicians) could provide only a partial clue for conducting an adequate clinical assessment and care plan. SCID assessments did not include premorbid behavioral contributions to the disorder, or the roles of shame and guilt in relation to the patient's "explanatory model" of the condition. SCID data did not convey critical data on the patient's strengths and resources. Of course, SCID diagnoses do not comprise psychiatric care any more than peyote use encompasses the entire Native American Church, or laying-on-of-hands embraces all of Christian healing. To that extent, the study sets up a "straw man" argument. But the study does reveal that these folk therapies can, and often do, help people through periods of emotional distress (from any cause) via the following: (a) Supplying a venue in which family, friends, and community may express their concern and provide emotional support; (b) Providing care from peers of the same community (rather than care and support from ethnic or community outsiders), thereby reinforcing the individual's own ethnic/community identity; (c) Manifesting to the community the individual's distress (and sometimes the family's distress as well) through services that possess a public component, to increase community awareness.

Appendix I of the DSM-IV contains exactly the formula that the authors promulgate as critical information for assessment and care, but this is not cited in the article. It also may be noted that the five-axis assessment of DSM-III and III-R and the Global Assessment of Function in DSM IV require considerable information regarding bio-

psycho-socio-cultural precipitants of disorder and function. These facts are not mentioned by the authors who seem to equate SCID diagnoses with an informed psychosocial assessment and psychiatric care. This suggests that psychiatric care has indeed fallen into mechanistic fallacies, or that we have not done an adequate job of informing the public and our colleagues regarding the clinical methods of psychiatry.

A brief editorial such as this cannot address whether our profession has indeed become biologically reductionist or has succumbed to the pharmaceutical advertisements in the mass media. We can hope that the framers of DSM-V will take note and evaluate this alarming situation. In any event, the Csordas et al. study can enlighten and guide us as psychiatrists. It provides concrete examples of ways in which folk healing can supplement our own efforts in providing care. (Unintended consequences and considerable expense

may also attend folk modalities, so we should not recommend these modalities in a Pollyanna fashion).

The authors' 4 alternatives for describing relationships between professional and folk therapies (i.e., contradictory, complementary, coordinate, and coexistent) do not apply to the current study, which is a study of SCID diagnoses in comparison to folk therapy. Such a descriptive/analytical study would necessarily involve actual treatment in the health care system versus folk therapy—an approach not taken in this study. However, such a study might provide us with valuable insights regarding the prevalence, determinants, and consequences of these 4 categories (assuming they can be applied in a reliable way).

REFERENCE

- Csordas TJ, Storck MJ, Strauss M (2008) Diagnosis and distress in Navajo healing. *J Nerv Ment Dis.* 196:585–596.