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Special Article

The future of cultural psychiatry

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Abstract. *The early and recent history of cultural psychiatry have been reviewed by Jilek (2009, 2014) and Tseng (2001) respectively. Tseng† et al (2014) have presented how the cultural psychiatry has evolved from the scientific explorations (at the era of ethnic psychiatry), clinical applications (at the era of transcultural psychiatry), to formal establishment (at the era of cultural psychiatry), with brief suggestions for the future as discussed in the previous article in this issue. Following this premise, the main focus of this paper is to elaborate in detail the suggestions for the future as viewed by the authors.*

Keywords: Ethnic psychiatry, transcultural psychiatry, cultural psychiatry, culture-unique psychotherapy, cultural approach to religion, positive mental health and wellbeing, social psychiatry, mutual understanding and social harmony.

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OVERVIEW: General idea, emphasis, and scope for the future

There are numerous areas, direction and goals that cultural psychiatry can aim for the future. Following are some of them to be elaborated in detail in this article, namely:

(1) To focus on cultural psychiatry issues broadly for all people in their own society – beyond the matter of minorities and migrants
(2) To strengthen the training of cultural psychiatry at different level for medical students, residents and the future cultural psychiatrists
(3) To enhance clinical application – by improving culture-relevant, culture-competent psychotherapy for every patient
(4) To work on theoretical issues – to expand our knowledge and theoretical understanding for universal and culture-specific applications
(5) To consolidate and organize knowledge in the field of cultural psychiatry to establish a solid subfield of applied science
(6) To examine from the epistemological perspective about the method of study utilized in the field of cultural psychiatry
(7) To promote culture-suitable positive mental health rather concerning mental illness
(8) To pay attention to religious and philosophical aspects of human life and its implication on therapy
(9) To merge with social psychiatry to concern the whole socio-cultural environment of our society and life
(10) To help people to adjust socio-cultural change that is taking place in almost every contemporary society around the world

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(11) To minimize negative inter-ethnic, inter-racial, inter-faith and inter-cultural conflict frequently happening in the world resulting terrorism, genocidal or war
(12) To focus on culture and mental health issue around the world and for all human being, by strengthening the function of internationally-oriented cultural psychiatry organizations (such as WACP, the World Association of Cultural Psychiatry).

1. Broadening the scope of cultural psychiatry beyond minorities and immigrants

It can not be denied that the merge of transcultural psychiatry is heavily related to the care of the minorities and the emigrants because it brings about the urgent concern of the issue of culture for providing care for them: this is what has been considered the need for cultural sensitiveness and competence (Mezzich *et al*, 2009). The perspective of culture is highlighted in dealing with minorities and/or immigrants, where the clinical expertise needs to be accompanied by an anthropological approach to the personal experience as a whole (Bartocci, 2012a; Tseng, 2012; Kirmayer, 2012; Bhui, 2012; Bhui *et al*, 2012; Wintrob, 2012; Bhugra, 2012). Yet, we need to be aware that every person, no matter they are minority of majority, the immigrants or the people of the hosting society, all are impacted by cultural background and there is a need of attention of cultural dimension for any person under the care. Instead of focusing merely on minorities or migrants in societies, or studying other people in other societies (from a "transcultural psychiatry" perspective), it is more important to examine and deal with cultural issues of all people in their own society from a "cultural psychiatry" perspective (Tseng, 2006a). There are numerous subjects that are in need of persuading in each society.

Even though some societies were considered in the past to be 'monocultural' societies (such as China or Japan), there are still so many issues that need elaboration from a cultural perspective. For example, by reviewing the Congress Proceedings of the First World Congress of Cultural Psychiatry held in Beijing in 2006, concerning the scientific program that has been presented in regarding China, the study and development of indigenous personality assessment for the Chinese, (Fanny Cheung, S-I-1), a cultural prejudice in Chinese psychiatry classification (LUO Xiaonian, S-I-4), or development of (culturally competent) contemporary psychotherapy (QIAN Ming-yi, S-III-26) are some of the tasks demanding attention for the majority of the people in the Chinese society. Regarding Japan, there are mental health issues that are rapidly changing within Japanese society due to the increase of the senior population and the decrease of population of children (Kazuo Yamada, S-II-11), or the anti-stigma campaign needed to overcome people's bias against psychiatric patients (Tsuyoshi Akiyama, S-IV-33). This is true for any societies, such as America, Russia, India, at where the cultural psychiatric approach is needed for the majority of people, relating to the change of society and culture that are taking place in the contemporary time. In another word, the attention of cultural psychiatry needs to be broad beyond the concern of the minorities: what cultural psychiatry proposes is a method to study in deep the cultural factors in different cultures, especially in the Western one, which have affected or may affect mental health within their own societies.

The study of connections between Western culture and clinical psychopathology is most unpleasant because, as Murphy noted (1982), in transcultural research it is easier to judge the grass on the other side of the fence. Approaching an intra-cultural verification, we need to consider the significant changes occurred through time to the concept of multiculturalism that has long animated the hope of transcultural psychiatrists. Since '60s, multiculturalism has been an impressive attempt of managing cultural differences within national and international debate on rights, duties and models of citizenship, but has been more recently considered a mere illusion after "being stifled by its own failure toward terrorism and fundamentalism" (Kymlica & Pfostl, 2014). Therefore, the need of a "post-multicultural" approach to diversity has risen within democratic and liberal societies. Beyond local characteristics of every community, it is time for scholars in cultural psychiatry to get used to a new flexible method of investigation apt to understand, on the one hand, the immobility of cultural traits

within each society and to face, on the other hand, the cultural and social changes going on spontaneously at the same time. America, Russia, and India show clear examples of changing Zeitgeist regardless migratory factors. It is of particular interest considering the North American condition, starting from the marital system: the traditional concept of marriage has been literally shattered in piece, and a half of adult population is single, unmarried or divorced. Socio-cultural changes there involve also sedentariness, unhealthy eating habits and increasing virtuality in human relationships, resulting in more than two fifths of adult population suffering from overweight and related medical conditions. Socio-cultural factors, in this case, play clearly a role, demonstrating how cultural psychiatry should not consider just migratory status. Considering Italy, we can see how cultural elements and values coming from Vatican are constantly included in the social and political life of the Italian Republic. Clinically, we can see the pathoplastic and pathogenic effect of culture when we face the outbreak of mass murdering in North America and familial violence in Italy, the diffusion of dissociative identity in the West along with the disappearance of Acute Psychogenic Reactions (Bartocci, 2000b).

2. Training in cultural psychiatry at different levels

Associated with the increasing awareness that every person, every patient needs cultural consideration relating to medical and mental health care, there is urgent need to improve and establish formal training of culture-oriented medical care and psychiatric training for medical students and psychiatrists-in-training respectively at different levels with different foci. Although this matter has been raised and being emphasized for some time, especially in those countries in which the problem of cultural competence has been raised also for medical students, there is a need to make it happen with suggested formal training program and course for targeted medical students and also psychiatric residents (Foulks *et al*, 1998). Also, there is a need to provide advanced training for the next generations of cultural psychiatrists. Having the personal background of being abroad, being minorities or migrants, or professional experiences of providing care for clients of cultural background different from the therapist is not enough to become cultural psychiatrist as a specialist. Qualified and competent professional cultural psychiatrists need a set of specialized knowledge and experiences through advanced training (Tseng, 2003). Since it is assumed that even the non-psychiatric medical encounter involves cultural concerns (as illustrated by the example of Muslim women who may not want to be examined by male doctors), in many countries brief classes of cultural issues in medicine have been established for general practitioners or non-psychiatric specialists working in the public health system. What is still underrepresented is the Academic training in Cultural Psychiatry within the residency program in general psychiatry, which should address both the cultural relationship between doctor and patient and the cultural dynamics within psychiatric practice. Since the very beginning, WACP has proposed the urge to establish cultural training at university level, as Foulks (1998) suggested. At the 3rd World Congress of Cultural Psychiatry in London, James Boehnlein (2012) stressed this need especially for the next generations of psychiatrists, who will certainly have to deal with increasingly mixed and complex psychopathology, intertwined with cultural factors, making cultural competence the most crucial matter in the education of the psychiatrists of the future.

3. Enhancing practice application

Cultural psychiatry is characterized by not being merely an academic exercise or professional exploration, and by applying its knowledge in actual clinical practice; or vice versus, by enriching its knowledge *through* clinical experiences. In other words, it is a clinically applicable medical and behavioral science with deep roots in clinical work and experiences. Furthermore, the clinical practice usually takes the form of not a merely psychotherapy or psychiatric care, but of culture-relevant therapy and services, making it possible the investigation of micro- and macro-phenomena around the medical setting (Bartocci, 2013).

The need of culture-relevant psychotherapy for every person and client

There is a need of emphasizing culture-relevant psychotherapy for every client of each society – beyond minorities and immigrants (Tseng, 2006a; Wintrob, 2012). It is simply based on the notion that every person has his/her own cultural background therefore is subject to cultural influence for his/her thinking, behavior and psychopathology, as well as coping pattern, no matter of where he/she is, the minority or majority, the immigrant group or the hosting society. Psychotherapy can be viewed as the interaction and interchange of value system between the clients and the therapist. Thus, in order to perform competent psychotherapy, there is a need of paying more attention on the culture-rooted value system of the therapist beyond that of the client.

The need of considerations at multiple levels

In order to provide culturally meaningful and relevant therapy, there is a need to make consideration at multiple levels, including: practical adjustments, clinical considerations, theoretical modifications and expansions, as well as philosophical examinations (Tseng†, *in press*). In the past, clinicians paid more attention to practical and technical adjustments required in different cultural contexts, than to theoretical and philosophical framing needed for clinical adaptation and expansion. Psychoanalysis has been one of the first theoretical movements trying to formulate an overall framework of the evolution of human emotions. In general, overall conceptualization of mental functioning are considered mere philosophy and in conflict with biological psychiatry paradigms, usually claimed by pharmaceuticals companies (Lalli, 2008). Nevertheless, this is the area requiring improvement for the future.

The need of evidence-based research

Over the last several decades, it almost become a common sense that there is a need to carry out culturally-relevant and competent therapy for clients of diversified cultural background, but it mostly stayed in the state of professional and subject opinion as well as belief, without objective finding supporting such common sense notion or professional belief. Indigenous healing practice, for instance, had been at times idealized as very useful way to provide care for people, or devalued as a form of superstitious approach. There is a lack of systematic and meaningful research to support the notion that culture-relevant psychotherapy is certainly useful for clinical application. There are only handful evidence based research actually carried out, mostly relating to culturally unique therapies, such as Morita therapy (Kuboda & Nakamura, 2003) or Daoist Cognitive Therapy (Zhu & Young, 2013). There is a need to catch up in the future for promoting evidence-based research in this area for regular culture-competent therapy.

4. Improving theoretical elaboration and formation

It is time to pursue a more theoretical examination of cultural psychiatry

It is a fact that cannot be denied that most of the existing theories about human mind, personality, psychopathology and therapy are proposed by Western scholars based on their professional experiences with people in the Western societies. Therefore, their universal applicability has been challenged and there are several non-Western scholars, such as F.L.K. Hsu (1973) and T. Doi (1962/ 1974), who have proposed the modification and expansion of these theories and professional views derived from the West. There is a growing need to understand culture modification and expansion from a theoretical point of view (Rovera, 1994; Bartocci, 2000a; Tseng, 2001; Tseng† *et al*, 2014).

Analyzing what is universal and what is culture-specific from a theoretical perspective

It is the time for clinicians and scholars to conceive and to make statement on what is universal and what is culture-specific, trying to not overstate its suitability and applicability. For instance, the parent-child emotional conflict may be universally observed at the early childhood and even extended to the adulthood, but the Oedipus complex, as described by the early psychoanalysts by utilizing Greek mythological story for triangular parent-child conflict, is not necessary universally. There are

potentially different parental and filial figures, which can be involved in the conflict; and there are different versions of resolution for the conflict (Tseng *et al*, 2005).

The view that dependency is a sign of immaturity as seen by the Westerners is not necessary true for other cultures. It has been indicated that mutual dependency is not only accepted, but is seen as the core of the personality make up at least for the Japanese culture (Doi, 1962/1974). Likewise, also the cultural implicit prejudice toward non-monotheistic religions or beliefs should be addressed while approaching non-Western philosophies.

There is much room to examine the culture-specific personality development regarding the theme of each stage, to study the cultural variations of defense mechanisms utilized by people in different societies, to analyze the therapeutic mechanisms utilized in various forms of healing practice, and the concept of mature personality and healthy mind, which are all waiting further theoretical evaluations.

Based on a sound theoretical formation, the field of cultural psychiatry can then grow and develop as one of the applied sciences. Beyond the concern and discussion of the needed modification and adjustment of technical and clinical practices, there is a need of more theoretical examination, proposal and formation so that the field of cultural psychiatry can become more a solid field of applied science to assure future continuity.

5. Consolidating and organizing knowledge of cultural psychiatry

As mentioned elsewhere (Tseng† *et al*, 2014), in order to become a special and independent field of science, there is a need to consolidate and organize the scientific knowledge and clinical experiences that have been established in the field. In other words, there is a need of systematic and comprehensive textbooks for the field of cultural psychiatry. This has been attempted by several scholars in the past and recently. Namely:

Transcultural Psychiatry: Findings and Problems (1971) by Wolfgang Pfeiffer, which was revised and enlarged in 1994.

Handbook of Cultural Psychiatry (2001) by Wen-Shing Tseng, with the condensed and revised version of *Clinician's Guide to Cultural Psychiatry* (2003).

Textbook of Cultural Psychiatry (2007) by Dinesh Bhugra & Kamaldeep Bhui.

Apparently there is a need of continuous publications in the format of textbook with expanded scope and updated information to reflect the development and improvement of the field of cultural psychiatry.

6. Examining methodological approach utilized in cultural psychiatry

This is a subject seldom discussed and examined seriously in the past, but it is time to pay the proper attention to, and to elaborate and discuss what is the characteristic method that have been used in cultural psychiatry as a clinical scientific discipline (Littlewood, 2012).

The need of first-hand direct observations and thorough investigations of the phenomena, beyond second-hand literature reviews, elaborations, and discussions

Reviewing literature, it is surprising to learn how many so-called findings or reports were based on information obtained indirectly, or even by laymen, without a direct observation at all. Just take the example from the so-called culture bound syndrome (**Note 1**) *Windigo* psychosis: the report of this syndrome was made by a missionary who observed a woman in the pole area who wished not to see anyone outside her immediate family, because strangers looked like wild animals to her and she experienced urges to kill them in self-defense. Very soon, misunderstandings snowballed among scholars. A diagnosis and classification of human-flesh-eating psychoses (borrowed by the legendary monster of *windigo*) had been made with no observation of an actual case, based on the fragmented accounts of informants of non-professional people.

Many behavioral scientists who do not have sufficient psychiatric knowledge or even so called expert cultural psychiatrists who had no direct clinical observation of actual cases, simply relying on others' literature reports, have tried to give clinical diagnoses incorrectly (such as labeling *koro* as depersonalization disorder) or even to lump together various morbid conditions into one similar entity (for instance, *Arctic hysteria* observed among Eskimo people in Alaska, *latah* reaction observed in Malaya, and the so-called *windigo* psychosis have been categorized together as *hysteropsychoses*) or have misunderstood the culturally-accepted *latah* behavior as a mental disorder (Tseng, 2001).

This kind of approach should be stopped and replaced by first-hand direct observation, with culture-competent knowledge and experienced investigation of any individual, social, and cultural behavior.

The Japanese personality was investigated and reported during the WWII by cultural anthropologists through the method of 'study by distance' and resulted in a rather successful report, yet such study has been carefully done based on many gathered information including the interview of the captured Japanese soldiers. However, in contrast to this, there are numerous tourist-like literature reports made by psychiatrists who happened to visit a foreign country for merely a couple of weeks and to make an instant or impressionistic report of the state of psychiatry in such foreign country. The extreme case is illustrated by the famous error made by C.G. Seligman who, without any thorough epidemiological investigation, claimed in the XIX Century that the local indigenous people in New Zealand did not suffer from schizophrenia (Littlewood, 2012). And it is not uncommon that even cultural psychiatrists visiting foreign countries, based on their outsiders' brief clinical experience, claim the need of re-diagnosing certain mental disorders that have been diagnosed by the local psychiatrists for long time, perpetuating such culturally not-sensitive errors. Those are some of the examples that have happened in the past and should be avoided in the future.

World-wide multiple cultures elaboration, testing, and validation beyond bi-cultural comparison

Many investigations that have been carried out in the past without careful consideration of the selection of sample from cultural perspective used the obtained data to claim the presence or absence of cultural impact. There is a need to consider the degree and the nature of cultural difference between the subjects selected for cross-comparisons. As a typical example, in the study of cultural impact on marital relationships, it is not recommended a mere cross-comparison between Japanese and Chinese families likewise British and American families, while it would be better between Asian or Muslim or Micronesian families, seeking for potential differences that may exist. Furthermore, it would be a more proper cross-comparison if the families involved were investigated for their family and value system, addressing explicitly shared meanings and significant cultural issues. Being more clear-cut, there is a need to untangle what specific culture-related factors are, otherwise the tendency of including only socio-demographical data would prevent from taking into considerations more typical cultural elements such basic beliefs or value systems.

Also many investigations have selected merely several social units yielding ethnic or racial differences, therefore the obtained data can illustrate merely potential differences existing between the two selected samples, and will not help not us understand the aspects of universality and the culture-specific factors. For example, it has been generally postulated by scholars in the past that males have higher rate than females in terms of committed suicide (while the reverse is true for the attempted suicide rate). However, if the rate of committed suicide is examined around the world, it will be found out that such universal rule (or iron-like belief) is not necessary true at least in one case, namely: the female suicide rate is much higher than male rate in rural China, associated with the higher stress encountered by young women, who also tend to use more lethal methods (i.e., swallowing insecticide available in agricultural family), carrying out their self-destructive behavior as response to their psychological stress. Evidently, there is a need of instruments included those for valid measurement of cultural elements beyond social demographical data.

It is desirable to involve multiple cultural units, which may have wide cultural differences to explore, to test, and to validate the impact of cultural factors, in order to elucidate what is universally observed and what is culturally specific. For instance, by surveying the alcohol consumption among most of the

societies around the world, apparent differences are illustrated in the amount of alcohol consumed, from very high to almost none, verifying the fact that for alcohol problems, even though closely associated with biological factors for becoming dependent, there is a strong impact from culture, in terms of how drinking patterns are shaped by culturally associated attitudes and rules for drinking.

Continuing expanding collaborations with other scientific disciplines – including social behavioral sciences and bio-neurological sciences

As the mixed product of social and behavioral sciences and clinical psychiatry, cultural psychiatry needs to maintain its close collaboration with other disciplines including social and behavioral sciences, anthropology and cross-cultural psychology in particular, but also needs collaboration with biological neurological sciences which have demonstrated great improvement and significant impact on the mind and behavior of human being for biological and neurological aspects (Kirmayer, 2012). To develop as a solid applied science, cultural psychiatry cannot merely take position in the extreme of only concerning the cultural dimension and neglect working closely with psychological and bio-neurological field which have proven to have impact on our behavior, thinking, and even the formation of the cultural pattern. The principal interest should therefore be to those disciplines which have started more or less recently incorporating the cultural factor within the general framework of research, investigating how cultural elements are related to specific mental processes, as described by experimental psychology. Recent developments in neuroscience have included cultural elements in more appropriate and modern models, taking into consideration not only ethnicity and race (Masuda & Nisbett, 2001), but also religion and religiosity (Wu *et al*, 2010), social dominance orientation (Chiao *et al*, 2009), self-construction conceptualizations (Cheon *et al*, 2009); while research designs are now encompassing not only classical mental functioning (time organization and conceptualization, identification or contextualization of objects vs environment, etc), but also "developed" functions as empathic relationships (Cheon *et al*, 2010), theory of mind (Kobayashi *et al*, 2006), and even the epidemiology of mood and anxiety disorders (Chiao & Blizinsky, 2010). In this Journal this close connection and interest to cultural neuroscience has been expressed by the publication of a thematic special issue in June 2010 (De Luca, 2010).

7. Promoting culture-relevant positive mental health beyond mental problems

Psychiatry as a clinical applied science over-focused on negative mental health, concerning psychopathology and mental disorders, and has seldom concerned positive mental health that is desirable for every person. Cultural psychiatry had better not be constricted by such disease-oriented clinical science and should enlarge its scope more broadly, including the positive healthy mind of people to be aimed for.

In order to carry out psychotherapy, the therapist as well as the client need to have the idea of what an healthy mind means, what base the therapy has to work on, and which goal it has to aim at, in terms of healthy mind or positive mental health. Yet, it must be said that the concept of (positive) mental health is not always well defined by the professional. Most importantly, the definition of healthy mind or mature personality is subject to cultural variations. Furthermore, the concept of mental health can be approached from multiple dimensions including: ideal, practical, operational and so on, needing a comprehensive and overall assessment and understanding from cultural perspective (Tseng, *in press*). It will be one of the tasks of cultural psychiatry to define and to be aware of a culturally appropriate mental health concept to be used as the goal for psychotherapy, or for any mental health care intervention.

8. Paying attention to religions and philosophical aspects of our human life with their relevance to clinical care

It cannot be denied that, under the umbrella of "science", contemporary psychiatrists tend to despise faith, religions or beliefs as "superstitions", when they do not literally shy away. However, it cannot be ignored that faith, beliefs or religions are still very important dimensions of life for the majority of the people living in the contemporary modern society, and interest to religion cannot be escaped, requiring more attention (Favazza, 2009; Bartocci, 2012b). This is also true for philosophy which functions as the base of our way of thinking and behavior, including the style of life and the coping methods utilized to deal with problems. Religious teaching and philosophical ideas, coupled with traditional thought, deal with the core of the culture, namely the belief and value system. They always need consideration from clinicians in order to provide mental health care and psychotherapy, and even to make good use of them as a part of the healing power (Bartocci *et al*, 1998; Bartocci & Littlewood, 2004; Bartocci & Eligi, 2008).

Particular attention must be paid to propose study methods that are respectful of the religious feelings without losing the specificity of the scientific method. Therefore, the need to maintain the "psychological study of religion" (James, [1902]1997) must be emphasized, distinguishing it from the "psychology of religion", the latter based on the same value codes expressed by articles of faith. On the contrary, straightforward studies should be continued both in neuroscience (Bartocci, 2010; 2011) and in experimental psychology (Kohls & Walach, 2007; Giordano & Kohls, 2008) in order to investigate the transition from "positive" to "negative" transcendence techniques. The former can play a unifying role, uniting people around acceptable shared beliefs, while the latter lead to a progressive detachment from the world and to a loss of self (Bartocci & Dein, 2005).

Contributing to the improvement of mutual understanding, acceptance, and co-existence within people of different religious and racial groups

It is a salient fact that there still exist serious misunderstandings, strong biases and stigma, and even hostile attitudes among people of different religious groups. This often couples with the difference of ethnicity and/or race to increase the negative feeling and even aggressive behavior toward each other. It is one of the tasks for cultural psychiatry to make use of its concern for culture and its clinical experience to deal with barriers associated with culture and race in order to improve mutual understanding, acceptance and co-existence within people of different racial or religious groups. How to accept and respect the differences and to learn to live together is the challenge of our human kind, and cultural psychiatry can make some contribution in such improvement for the future, joining with other social and behavior disciplines.

9. Merging with social psychiatry to concern socio-cultural environment as a whole

Since its early stage of development, there have been academic arguments among the scholars about the distinction and boundary between social psychiatry and cultural psychiatry. As indicated by its name, social psychiatry is primarily concerned with the social aspects of psychiatry. As a scientific discipline, it is associated more closely with sociology. Its main focus is on the relation between society and mental health – how the social structure, organization, policies, and functions of a society, including its social classes, economic factors, intergroup relationships, and so on, may impact the mental illness and health. Historically, its development was directly stimulated by two social factors: the disruptions of human life by World War I; and the rapid social change that occurred after industrialization. Both factors had a significant impact on the mental health of people at all social levels. As pointed out by the pioneer of social psychiatrists (Leighton *et al*, 1957), social psychiatry focuses on several areas, including: concepts of normality and abnormality in different societies; the relation of social environment to personality development; the effects of mental illness on social environment; modes of societal reaction to mental illness; and implications of cultural diversity for

effective understanding and prevention. In stead of clinical work, it lay primary emphasis on social prevention.

In contrast to this, cultural psychiatry is primarily concerned with the cultural aspects of psychiatry. As a scientific discipline, it is associated more closely with anthropology. Historically, its development was stimulated by the academic explorations of possible differences in mental disorders among people of different cultures and later, associated with the human rights movement, turned to concern with the culture-relevant care for minorities and immigrants, while now for people of every person in every society including the majority. It is more heavily concerned with clinical application. Associated with the political and social atmosphere, "culture" has become the buzzword around the world now and, associated with such tide, the movement of cultural psychiatry is getting its momentum.

These two sub-fields of general psychiatry were separated by the scholars in the past basing on their different professional views and attitudes. But the truth is that they are not merely the different sides of the same coin but the left and right side of the same face. They both are concerned with the socio-cultural environment at large as a contrast to biology or individual psychology. From a bio-psychological-sociocultural perspective of contemporary professional orientation, both social and cultural psychiatry should work together side by side to concern themselves together with the whole living environment of the human life, rather arguing which one is more important or primary.

10. Helping people to face and find adjustment to socio-cultural changes occurring around the world

The societies around the world are facing relatively rapid and significant changes in the contemporary era. These are associated with improved communication and easy travelling, with the result of frequent cultural interactions and influence, as well as rapid improvement in technology. Not only do minorities or immigrants need to face the issue of cultural change, but also the majority living in the ever-changing society.

Paralleled with this, it must be pointed out that, by tradition, as a subfield of medicine, psychiatry tends to over-focus mental sickness or diseases, or psychological problems, and to neglect the healthy mind or positive mental health. The so-called positive mental health is perceived and viewed differently by different culture, and even in the same geographical area significant changes in conceptualizing positive mental health are constantly and dynamically occurring through the cultural contamination mechanism. How to pay attention to culture-shaped concepts and views of healthy mind and to provide mental health care, particularly as the aim of psychotherapy, is a challenge. In other words, cultural psychiatry has the responsibility to face the task of people experiencing socio-cultural changes and to consider globalization not merely in terms of expanding pharmacological interventions worldwide, but possibly reconsidering the modern challenges to mental health: reducing the stressing factors connected to these mutations and enhancing adjusting capabilities and positive opportunities given from such developmental process.

11. Promoting mutual understanding and minimizing negative feelings and aggressive actions between people of different cultural background

Facing, studying, and examining the negative views and hostile aggression existing between people of different culture, faith, race and society

In spite of our belief and the emphasis of good human nature by religion (such as Christian) or teaching of humanity (such as Confucius), in real world the human experiences are not immune to ugly and aggressive behavior. As commented by Hicks (2012), the most serious wars and atrocities that killed more than one tenth of world population at time, are rather evenly distributed over 2,500 years of history – i.e., the 20th century is not 'the worst'. The data points in later years taper downward into

smaller and smaller conflict-related deaths, as we come closer to the present time. The Dirty War Index (DWI) is a tool developed to identify rates of particularly undesirable or prohibited, i.e. "dirty," outcomes inflicted on populations during war (e.g., civilian death, child injury, or torture; Hicks, 2012). From human history, it is illustrated that there are frequent and consistent occurrences of terrorism, armed conflict, and even large scaled war and even in so-called civilized contemporary world. Many reasons underlie such hostile aggression for the sake of power, such as territory pressure or economic factors, not rarely related also to negative and even hostile attitude towards different cultures, religions, faiths, and races.

Minimizing negative feelings and aggressive actions toward people of other cultures to improve mutual co-existence in the human world

Cultural psychiatrists who are emphasizing the importance of attention to cultural dimension, and clinically experienced in providing care for intercultural marriage, cultural adjustment of immigrants, can make use of such clinical knowledge and experience to help society minimizing the problems relating to any prejudice and stigma between different religions, faiths, ethnicities and races. In another words, cultural psychiatry can be used as an avenue to promote mutual understanding among people of different cultural background and to minimize conflict as well as a form of civilian protection (Hicks, 2012).

There is no need to say that such social issue cannot be solved merely by clinicians; anyway, joining social science and facilitating social forces to promote mutual understanding and acceptance of people of different cultural background is possible. It must be considered as one of the ultimate goals of cultural psychiatry.

12. Focusing on culture and mental health at the world level

Academic reason to focus around the whole world

In the field of cultural psychiatry, more properly in the discipline of cross-cultural psychology and comparative psychiatry or epidemiology, a limited number of cultures or societies are too often sampled in academic studies for the sake of convenience. However, in order to achieve the goal of understanding the human nature at large, there is a need of worldwide multiple cultures elaboration, testing, and validation beyond bi-cultural or tri-cultural comparisons, particularly among the cultural samples that have no wide cultural differences to begin with. Broad sampling around diversified cultural samples is necessary to clarify what is universal and what is culture-specific.

Humanistic reason to concern around the world at large

In the past, being separated by high mountains or a huge ocean, people did not have the opportunity to contact regularly and have encountered experience and relationship with people living nearby. People were often not even aware of the existence of other people beyond the mountains or across the ocean. However, associated with the improvement of science and technology, there is no such geographical boundary anymore. There is frequent communication with and travel among or with people even far away and never encountered before. Thus close international, inter-regional relationships and interactions are occurring. There is a mutual influence from each other, while the process of globalization is shaping our earth affecting social and cultural perspectives. We need to learn how to care for each other and live together in our earth with a world identity beyond national, racial or cultural identity. Cultural psychiatry is one of the avenues to help people to know each other, to understand each other, and to accept the potential differences but, in the same time, to share the same goal we have as human beings. This is one of the final missions that cultural psychiatry needs to participate in.

CONCLUSIONS It has taken a slow process and long way for cultural psychiatry to emerge and develop as an independent subfield of psychiatry, and now it is time to turn our attention, to think

and to discuss what will be the direction, aim, and goal for further development and expansion in the future.

It is obvious that, as a subfield of clinical psychiatry, we need to hang on the clinical work, and through clinical work to obtain and expand our knowledge and experience concerning culture, but we also need to expand the scope more widely, including religious and philosophical aspects which have significant impact on our human life, and, at the same time from a public health perspective, to pay attention to themes concerning the whole society beyond clinical work, to engage in the public education for improving inter-ethnic, inter-racial, inter-faith relationships and to seek for mutual understanding and co-existence in the globalizing contemporary world.

Beyond the clinical work and experiences, there is a need of more solid theoretical formation, while we are requested to explore things at universal level and to examine what is culturally specific, at the same time. In regard to this, it is suggested to make good use of international, worldwide network and organizations, such as World Association of Cultural Psychiatry, to promote more international, pan-cultural exploration of theories and experiences, to expand and enrich the knowledge for further progress and for the positive mental health for the mankind.

NOTE

[1] More correctly renamed (Tseng, 2006b) as "culture-related specific psychiatric syndromes".

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