

SPECIAL ARTICLE

Latin American and Spanish-speaking perspectives on the challenges of global psychiatry

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The multi-faceted phenomenon known as globalization has a particular impact on the conceptual and practical development of mental health disciplines in general, and psychiatry in particular, across different world regions. To be theoretically and functionally effective, global psychiatry requires an integration of its different components. To such objective, and after a brief review of continental European and Anglo-Saxon contributions, this article examines the history, characteristics, and contributions of Latin/Iberian American and Spanish-speaking psychiatry, in order to substantiate its role in world psychiatry. The Latin American proper (including Portuguese-speaking Brazil), Spain, and U.S.-based Hispanic components are described, revealing an identity that is based on a humanistic tradition, a value-based, culturally-determined clinical approach to patient care, and a pragmatic adaptation of different treatment resources and techniques. These may constitute supportive elements of an instrumental inter-regional bond in the present and future of our discipline.

Keywords: Latin American psychiatry; Spanish-speaking psychiatry; globalization; global mental health; Hispanic culture; identity

Introduction

Globalization is, without a doubt, one of the most frequently mentioned and debated terms in the contemporary world. The term became fashionable in the past 2 or 3 decades, driven by a variety of sociodemographic, geopolitical, economic, and techno-scientific factors. Not surprisingly, the concept has been perceived, elaborated, and utilized differently by groups positioned in favor of or against its implications. Thus, politicians and economists may see in globalization immense opportunities for growth and greater income for individuals, families, communities, and nations. Social communicators consider it a platform of total access to, and massive dissemination of information across the world.^{1,2} Yet, critics only see in globalization a sophisticated “smuggling” or misappropriation of ideas or initiatives contributing to the consolidation of already existing socioeconomic inequalities.³⁻⁵ To the emphasis on similarities and “common features” of life throughout the world – the so-called “homogeneity”, – critics of globalization respond by outlining the risks of “hegemony” by the most powerful countries or regions of the world.⁶

In the first issue of the journal *Globalization and Health*,⁷ globalization is defined as the “intensification of transnational, cultural, economic, political, social and technological interactions that lead to the establishment of transitional structures, and to the integration of ... (several) ... processes at global, supranational, national, regional, and local levels ... (implying) ... de-territorialization and multidimensionality” (p. 2). Thus, the fundamental outcome of globalization would be the disappearance of boundaries, barriers, or separations, the actual creation/establishment of “one world,” subject to processes that also tend to be global. Nevertheless, the original nature of globalization is economic⁸⁻¹⁰; it is postulated, somewhat optimistically, that globalization can be “a factor of wellbeing and can, potentially, make everybody wealthier, particularly the poorest”¹¹ (p. 504). Feachem¹¹ provides a broader perspective, which sounds, however, slightly more skeptical: “The opening to trade, to ideas, and to inversions, to people and culture ... will bring benefits today as it has been the case throughout centuries – and also will bring risks and adverse consequences, as it has done throughout centuries” (p. 505).

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The notion of a universal language, away from the failed experiment of Sanskrit, now witnesses an almost unstoppable reality of English playing precisely that role.¹² While migrations may represent the human ingredient of globalization, its material driving force is, unquestionably, technological in nature – the “wired world” of today, the ultra-rapid communication through social networks and their seemingly uncontrollable resources.^{13,14} It is not surprising that the favorite metaphorical setting for the process of globalization is the “global village.” Yet, it should not be forgotten that the metaphor entails areas of wealth and privilege coexisting with areas of poverty and exclusion.^{5,15}

These thoughts serve to introduce the present article’s central themes: the implications of globalization for mental health and psychiatry, and the need to face such implications in a comprehensive, integrated manner. After brief accounts of the main historical paths of psychiatry in modern times, the role or roles that Latin American/Spanish-speaking psychiatry might play in the global scenario are examined, and a more or less specific link, or bridging hypothetical role, is discussed. The interactions of Latin American/Spanish-speaking psychiatry with European and Anglo-Saxon psychiatry are also discussed, while the main features, structure, productivity, and contributions of European/Anglo-Saxon and rest of the world psychiatry are described. Finally, pertinent debatable areas and conclusions are proposed.

Globalization and mental health

The multidimensional nature of globalization and its product, the “global village,” have mental health implications of the highest order. In 2017, the total world population reached 7.6 billion, with 3.9 billion living in urban settings. By the year 2050, rural populations are expected to reach 3.3 billion, out of a total of 9.8 billion people.¹⁶ Ninety percent of the increase will be concentrated in Asia and Africa, even as, paradoxically, a big majority of today’s 208 million immigrants, refugees, and displaced people come from these continents. In 2015, there were 650 cities with more than one million inhabitants each, a number that will grow at least three times in the next 3 decades. By 2030, 41 mega-cities with more than 10 million inhabitants each are anticipated; currently, this number is 28.

A recent review on homicides and suicides in megacities shows the impact of economic indicators, ethnic conflicts, social inequalities, and religious and cultural differences: a disorganized process of urbanization and the marked differences between wealthy and marginalized sectors become high risk factors for a normal emotional development.¹⁷ The economic, social, emotional, and health-related consequences of these realities are particularly strong for low and middle-income countries (LMICs) in regions like Africa, Asia, and Latin America, and in countries like China, India, Nigeria, or Mexico.¹⁶

Beyond the numbers, the emotional dysregulation of increasing segments of the world population is a big and painful byproduct of globalization-induced dilemmas

experienced by the “new global citizens.”¹⁸ One of these dilemmas is the conflict-laden process of assimilation/integration vs. isolation/marginalization/alienation; another is acculturation (a rational acceptance of a host society’s norms by migrants who, however, do not renounce their own) vs. enculturation (an almost total absorption of the newcomer’s personal identity by the host society).^{19,20} Furthermore, cultural variables, such as diversity of beliefs and traditions, language and habits, and the way different societies deal with them, also have an innermost impact on the mental health of human communities. Religious clashes, leading to wars in several parts of the world, are also a response to what is perceived as the threatening hegemony of subordinating, authoritarian powers.^{21,22}

Last but not least, the so-called “quality of life” is also affected by globalization: well over 1 billion people in the world are unable to meet their minimum daily needs, one-third of children across the globe are undernourished, the average African or Haitian household consumes 20% less today than it did 25 years ago,^{23,24} migrant women live under constant fear of sexual violence, professionals of countries under dictatorships either escape, or try to increase their income by enlisting in a variety of other occupations.²⁵

Thus, the burden of social neglect, family erosion, handicaps, and disadvantages grows, fueled by deficits in nutrition, financial income, job markets, genuine affection, solidarity, or support. In the strictly clinical field, an increased prevalence of highly disabling mental disorders, comorbidities of different kinds, and the scarcity of diagnostic and therapeutic resources render the psychiatric and mental health needs of the globalized world a rather complex set of problems and uncertainties.²⁶⁻²⁹

In turn, each cultural group, although in possession of its unique value system, finds itself struggling over the survival of such values, open as they are to both dialogue and conflict. And, considering the historical and cultural perspectives, there are different ways to get ill, to express or explain symptoms, to seek help, or to respond to treatment among patients from different geographic or national origins.^{19,30,31}

This process also involves moral and ethical perspectives, since, even with the acceptance of universal precepts and norms, ethical judgment is always exercised within a particular frame of circumstances.³² Therefore, it becomes clear that the complex processes of co-existence of cultures in a globalized world demand an effort to harmonize, to seek cohesiveness and mutual strength, to build bridges of understanding, and to genuinely share knowledge, attitudes, skills, and values.³³⁻³⁵

Globalization and world psychiatry

Psychiatry has evolved differently in different parts of the world. It is clear that while its historical origins reside in Eastern civilizations and regions, the most structured and most productive source in modern times (18th century on) came from Europe, particularly its Western territories. Even within this area, continental psychiatry (with strong influence from, particularly, central European [Germany]

and Scandinavian countries)^{36,37} exhibits some differences with Anglo-Saxon psychiatry, mostly that developed in the British Islands, England in particular, and later expanded to the North American subcontinent and the Australia/New Zealand region.³⁸ Newer psychiatric groups also emerged during the 19th century in other regions – Latin or Iberian America, Asia, and Africa.

Currently, psychiatry from Western continental Europe and its Anglo-Saxon counterpart may be said to share significant features. Nevertheless, a number of differences remain in terms of basic historical precepts, recognition, and description of clinical facts, practice modalities, and public health/mental health policies and procedures. Thus, continental European psychiatry is best characterized by descriptive and phenomenological approaches (inspired by German and French pioneers, such as Jaspers, the Schneiders, Kretschmer, Ey, and many others) and particularly oriented to a solid initial diagnosis. A big platform for theoretical debates,^{37,39,40} this branch of psychiatry seems to be, however, free of rigid school- or doctrine-based rules. It advocates the active use of varied clinical resources and modalities, and an overall combination of medical approaches, empirical or scientific postulates, and humanistic principles. Continental European psychiatric practice also emphasizes diversity, with predominance of social or so-called universal coverage of mental health services.

As political and economic events moved the pendulum of colonization and led to a gradual “transference of power” from continental Europe to the British Islands, stimulating the growing influence of the English language, Anglo-Saxon psychiatry (through the work of authors like Lewis, Shepherd, Roth, Kandel, Kendler, or Spitzer) emerged, characterized by pragmatic approaches and less inclination towards conceptual and theoretical debates. Also, this emergence, in the context of growing U.S. dominance of the world scene, was accompanied by two conceptual “revolutions”: psychoanalysis and all its ramifications between the 1930s and the 1960s⁴¹⁻⁴³; and, in the last 30 or 40 years, neurobiological and neuroscientific perspectives and methods of undeniable impact.⁴⁴⁻⁴⁷ Private service delivery systems and clinical practice are still the rule in the United States (not so in the United Kingdom), but openness to “new” trends such as community-based services is also present.

Since World War II, four areas have clearly come to reflect the interaction between globalization trends and the developments in the theory and practice of psychiatry. The first relates to attempts at establishing nosological taxonomies with universalistic aspirations. The idea that mental illnesses could be uniformly formulated across the globe gained ground, thanks to epidemiological data and the “medicalization of psychiatry” movement,⁴⁸ among other reasons. The traditional mental illnesses (schizophrenia, depression, bipolar disorder, dementia, and addictions) became icons of this trend towards a “globalization of diagnosis.” To be sure, nomenclatures such as DSM-III and its successors,^{40,49-51} and the World Health Organization’s ICD (Mental Disorders, Section V)⁵² profess converging intentions; nevertheless, DSM is still considered an “American” (ergo, Anglo-Saxon) system,

whereas ICD is more “European.” Even though both systems have attempted a “conciliation” through a unifying set of diagnostic criteria, both have also been criticized for showing rigid, formalistic, and reductionist tendencies in the systematization (some would call it “simplification”) of rich sources of psychopathological, sociocultural and neurobiological knowledge,⁵³⁻⁵⁵ at the risk of confusing validity with utility or, ultimately, “alchemy” and science.

The second front is that of treatments. Biological research and its applications in pharmacotherapy, together with the expansive interest of the industrial-health complex, reflect and exemplify the “globalization of therapy.”^{56,57} At the same time, psychotherapies have been focusing more and more on the behavioral-cognitive approach, abandoning the scientifically weak psychodynamic orientation, and becoming homogenized within what many consider neat positivist thinking.⁵⁸⁻⁶⁰

The third area, planning, financing, and delivery of care, has faced more difficulties, even though it has also tended to reach global dimensions.^{61,62} Community models, socialized medicine, and charity-based approaches appeared to be expanding by the start of this century, particularly in European and American countries.⁶³⁻⁶⁶ This process led some to think that psychiatry had already become one single, solid global discipline, and that such “unity” could be recognized and practiced all over the world. The fact, however, almost two decades later, is that such approaches have neither been fully demonstrated nor generally accepted.^{67,68}

And so, other traditions have emerged, with geography, a main referent, and language, a pivotal feature in any culture, as unifying factors. These traditions encompass, of course, the two large continents of Asia and Africa; but, for the purposes of this work, the case of Latin American psychiatry (including Portuguese-speaking Brazil) and the broader Spanish-speaking psychiatry, including Spain,⁶⁹⁻⁷² will be examined. The remaining portions of the article will examine the role of this psychiatry in a world carrying the ambiguous label of globalization. We will briefly examine its three geo-demographic and sociocultural components, their history, value endowments, achievements, and contributions to a globalized world. With world psychiatry facing risks of atomization due to different, at times conflicting ways of understanding and handling the globalization process, the article’s main thrust is that the Spanish-speaking and Latin American version of our discipline may be a crucial player in efforts to preserve the best historically accrued approaches and traditions, and to convey and share such assets with other world regions.

Iberian American/Spanish-speaking psychiatry

An accepted assumption in today’s world psychiatry is that this label refers to three primary sources: Latin America (or Iberian America, if we assume that the subcontinent was conquered and colonized by the 16th century Iberian Peninsula powers, Spain and Portugal), Spain, and Hispanic psychiatry in the United States.

Latin American psychiatry

In Latin America, the colonial European countries of the Iberian Peninsula came upon vast territories and civilizations with original cultures, traditions, and philosophies, including mental health or a rudimentary “psychiatric” care. Spain conquered most of what are now Mexico and Central, Caribbean (Cuba, Puerto Rico, and Dominican Republic) and South-American countries, as well as areas from the current Southwestern and Southeastern United States. On its side, Portugal colonized the territory that formed Brazil, today the second largest country in the Americas. Therefore, all these countries may be properly called Latin or Iberian American as, beyond relatively mild language differences (between Spanish and Portuguese), they share similar geographic, historical, and cultural concerns; on a much smaller scale, England/United Kingdom did the same in what is now Jamaica, Virgin Islands, Cayman Islands, the Bahamas, Barbados, Trinidad and Tobago, Guyana, and Bermuda. France colonized Haiti, Guadeloupe, Martinique, Saint Lucia, French Guyana, and the Louisiana territory in the United States.

At the time of conquest and colonization, there were more than 300 native or aboriginal cultures and communities in what is now Latin America. Historically, the most important were the Mayas in what are now Southern Mexico and the Yucatan Peninsula, the Aztecs in Mexico, and the Incas in what are now Ecuador, Peru, Colombia, Bolivia, and northern parts of Chile and Argentina.^{73,74} These cultures linked mental illness to evil spirit possession, malevolent influence of witches or sorcerers, ill will of gods and deities, neglect of worship, individual or collective sins, offenses against holy representations, loss of the soul, or intrusion of foreign objects in the body.^{72,75,76} Likewise, they also had classification systems to diagnose and treat mental/emotional disorders or conditions. For instance, the Aztecs described “agitated syndromes” (*Tlavillocayotl*), and “non-agitated syndromes” (*Xolopiyotl*), and the Incas, *espanto* (*Bia Chebe*) and *susto* (*Jani*), in their rich original languages, *Nahuatl* and *Quechua* respectively.^{77,78}

The treatment armamentarium in those cultures included the use of shamanistic or magical approaches and religious rituals with elaborated nosological explanations and a large paraphernalia of management practices.^{72,76,79,80} These approaches collided with the design, development, and operation of mental hospitals, sponsored by religious groups (i.e., Catholic Church) throughout more than three centuries of Iberian rule. Paradoxically, during this colonialist period, an intense religious zeal also submitted many mentally ill persons by summary trials and swift executions, through the actions of the Tribunals of the Sacred Inquisition.^{75,78} Lima’s Universidad Mayor de San Marcos, the second oldest in the Americas, delineated, by the end of the 18th century, the first medical and psychological topics in its syllabi, following the Spanish model.

The trajectory of Latin American psychiatry has reflected to some extent the paths followed by psychiatry in other latitudes and regions of the world.^{63,69} Emulating (and appropriately preserving) the religious-mythical

beliefs that strongly influenced the notions of health and mental illness during the pre-Columbian phases, a “moral psychiatry” model prevailed during the colonial period and the initial decades of political independence in the new countries. In the twentieth century, contributions from the phenomenological-existential, biological, psychodynamic, social, and community camps were incorporated.⁸¹ In spite of pervasive deficits in terms of material and institutional support and human services, psychiatric ideas in Latin America followed a rich and varied sequence: from the “illustrated chronicle” or essentially narrative approach to the “functional” processing of paradigms (transference, interpretive, transformational, and productive stages), the sociodynamic, ideological view, and the inclusion of neurobiological contributions. This sequence outlines four developmental periods in the history of Latin American psychiatry (post-colonial subordination, selective import of ideas, critique and sedimentation, and synthesis), leading to the contemporary delineation of a still debatable, yet unique identity.⁶⁹

As a result of these approaches, Latin American psychiatry has been characterized by three features: *mestiza*, social, and critical.^{63,69,82} It is a *mestiza* discipline because, as the active receptacle of different trends and contributions from other parts of the world, it seems to be elaborating its own synthesis in an ongoing “syncretic” process.⁸³ This *mestizaje* gives Latin American psychiatry a peculiarly mixed tonality in clinical conceptualizations (including the so-called “cultural syndromes”),^{50,76,79,84} diagnostic practices, and therapeutic approaches, a fact that can also be considered part of a subtle but pervasively ongoing globalization process. The second characteristic, its social scope, is dictated not only by demographic and economic realities, but also by traditions that enhance sociocentrism or communalism, friendship- and family-based practices, hierarchically-inspired respect for parental as well as elderly and other types of authority, and persistence of some rural life habits.⁸⁵

The third characteristic of Latin American psychiatry is its critical stance. The contributions from other parts of the world are not necessarily passively transferred, absorbed, and/or assimilated with unconditional acceptance. Thanks to the work of leading academicians, educators, and scholars, many of the concepts coming from both Europe and the United States have been and are processed, analyzed, and critically examined before they are either taken in or, more frequently, adapted.⁸⁶ The most eminent Latin American psychiatrist of the 20th century, Peruvian Honorio Delgado^{87,88} inaugurated this tradition, pioneering throughout his career and from a critical perspective, contributions from sources as dissimilar as psychoanalysis, bio-psychopharmacology, phenomenology, existentialism, and community psychiatry.⁸⁹ A similar approach was followed by other notable figures, such as Antonio Carlos Pacheco e Silva and José Leme-Lopes (Brazil), José Ingenieros and Gregorio Bermann (Argentina), José Angel Bustamante (Cuba), Ramón de la Fuente (México), Oscar Fontecilla, Ignacio Matte-Blanco, and Juan Marconi (Chile), Carlos León and Humberto Rosselli (Colombia), Salvador Mata de Gregorio (Venezuela), Carlos A. Seguí, Humberto Rotondo, and Javier Mariátegui (Perú).

Significant contributions to phenomenology, psychopathology, clinical diagnosis, psychodynamics, medical psychology, folkloric psychiatry, clinical epidemiology, and cultural psychiatry, substantiate the trajectory of Latin American psychiatry.^{69,75,76,87,88,90-95} Mental health research in Latin America today is more consistent in Argentina, Brazil, Chile, Colombia, and México.^{96,97} It is not free of conflictive perspectives, however, as shown by the intense debate in Brazil about the ideological dominance or unconditional credibility of external research findings, in detriment of significant local contributions, particularly epidemiological ones, providing relevant guidance for mental health planning in the subcontinent.^{95,98} The Latin American Psychiatric Association (APAL) was born out of the Latin American Group of Transcultural Studies (GLADET) in the 1950s, and contributed significantly to the foundation of the World Psychiatric Association (WPA).⁹⁹ Against this historical background, and fully aware of its growing identity, Latin American psychiatry must exercise “moral prudence” while balancing a deeply-rooted humanistic philosophy, a legacy of Spanish and Portuguese forebears, and a basic cultural triad of “love, dignity and respect.”^{100,101}

The Latin American population is not a uniform, monolithic entity. Different ethnicities, languages, and subcultures persist, in some cases practically untouched by European-inspired civilization, or the actual globalization forces.^{75,78} Beyond a perceived “absence” from the front rows of the world scenario,⁸⁶ and its still urgent identity struggles, Latin American psychiatry shows encouraging features of a mature development, and growing evidence of a desire to be recognized as a full participant in world psychiatry affairs.⁷⁰

Spanish psychiatry

Attention to the mentally ill in Spain had a religion-inspired, asylum-based nature before the institutionalization of psychiatry as a medical practice. The first facility of this kind, the Manicomio of Valencia, was founded in 1409 by a group of citizens persuaded by a sermon of a celebrated orator, Catholic priest Father Jofré. Some historians maintain however, that hospital assistance to mentally-ill individuals existed earlier in Granada and Barcelona.¹⁰² These institutions, including the hospital of Zaragoza, founded in the 1700s and deserving praise from Pinel himself, were, however, mostly custodial and not strictly medical facilities. Later on, many asylums in Spain became physically or administratively associated with general hospitals, thus generating a tradition that also absorbed the significant input of religious congregations.¹⁰³

Organized didactic efforts in Spanish psychiatry started around the 18th century, but formal courses on “phrenopathology” started to be dictated in 1876, and the first specialized hospital opened in Barcelona in September 1883. Psychiatric associations and journals were created at the beginning of the 20th century. Contributions such as those of Santiago Ramón y Cajal, Medicine Nobel Prize winner in 1906, are associated with a nascent scientific tradition in neurobiological research. This was gradually

consolidated and expressed in the form of a journal called *Archivos de Neurobiología* (Archives of Neurobiology), first published in 1919 by the joint effort of a philosopher, José Ortega y Gasset, a scientist, Gonzalo Lafora, and a clinician, José Sacristán, with histologists, physiologists, psychologists, neurologists and psychiatrists in its distinguished body of collaborators.¹⁰⁴

The strong influence of German psychiatry at the beginning of the 20th century made it possible for Spanish psychiatry to absorb both phenomenological and humanistic approaches.^{105,106} There was similar acceptance of both experimental psychology and psychoanalysis. Freud’s complete works were first published in Spanish in 1922, with Luis López-Ballesteros as the leading translator.¹⁰⁷ The same enthusiastic reception of existential analysis made Spanish psychiatry an exemplary blend of works by Schneider, Jaspers, Dilthey, Heidegger, and others. The *opus* of notable figures such as Julián de Ajuriaguerra, Angel Garma, Pedro Laín Entralgo, Juan José Lopez-Ibor, Emilio Mira y López, and Ramón Sarró, among many others throughout this period, has been duly recognized.

The Spanish Civil War (1936-1939) forced into exile a good many Spanish psychiatrists from both the psychoanalytic and neurobiological fields. Most of these exiles ended up in Latin American countries, particularly Mexico, Chile, and Argentina. Dionisio Nieto’s contributions remain as an inspiring example of this historical period.^{92,108} Other schools flourished during the post-Civil War period and also later, in the 1970s, with the advent of democracy. It is clear that Spanish psychiatry embraced and expanded the contributions of continental Europe and Anglo-Saxon scholarship. The role of Spanish psychiatry in the European continent was enhanced while, at the same time (with reciprocal immigration waves beginning in the 1960s being a decisive factor), favoring an increasingly closer contact with other segments of Spanish-speaking psychiatry.^{106,109-111}

An important event during the early 1980s was the start of a profound reform in the organization and provision of psychiatric care in Spain. This process eliminated the old asylums, which were replaced with well-structured care-providing networks, closely connected with primary care practitioners. In the last three decades, advances in neurobiological and epidemiological research have produced a vast critical mass of young investigators, already competitive in the international field.

U.S. Hispanic psychiatry

The newest component of the Latin American/Spanish-speaking psychiatry, Hispanic (or Latino) psychiatry in the United States, reflects the increasing demographic significance of this population in what is still the only “superpower” of today’s world.¹¹² Beating many prognostic estimates, Hispanic population became, early in the current century, the largest minority in the United States. From initial locations in states such as California, Texas, New Mexico, Florida, Arizona, Illinois, and New York, the last two decades have seen an overwhelming expansion of Hispanics into “non-traditional” states such

as Idaho, Nebraska, North Carolina, Minnesota, or Wyoming.¹¹³

The downside of this reality, however, is that Hispanics as a group find themselves at the bottom of the economic totem pole, mostly in low-paying jobs (particularly in the agricultural area), living below poverty levels in terms of housing, income, nutrition, and other parameters.¹¹⁴ Furthermore, the significant number of “illegal” Hispanics in the United States makes their presence a unique social and political phenomenon, nourishing re-emerging racism and hatred in a number of states, supported by pronouncements at the Executive level of the current Federal Government administration. It is also important to recognize that Mexican-Americans (64%), Puerto Ricans (17%), Cubans (10%), and Central and South Americans do not constitute a monolithic group. Yet, the presence of 53 million persons in the United States – with Los Angeles, California, being the sixth largest “Hispanic” city in the world – reinforces the need for the preservation of cultural practices and values. Familism, Marianism, close family connectedness, strong Catholic practices, a mix of conservative and liberal economic philosophies, and a general sense of self-protectiveness are the main cultural characteristics of the Latino population.^{115,116}

Hispanic psychiatrists (accounting for about 5,000 of the 35,000 Hispanic physicians in the U.S.), are not exclusively dedicated to Latino patients. The work of Hispanic mental health professional organizations in the United States, such as the American Society of Hispanic Psychiatry (ASHP), founded in the late 1970s, the Latino Behavioral Health Institute, the Hispanic Caucus of the American Psychiatric Association (APA), and specialized centers in academic and clinical facilities, materializes in scientific and professional events, multidisciplinary encounters, specialized publications, and training events for young Hispanic clinicians and researchers. This makes Hispanic psychiatry a vibrant, although relatively small, presence within Spanish-speaking psychiatry. Dealing with, and working in the largest Anglo-Saxon, Caucasian-dominated society of the world, and interacting with other minorities such as African-American, Asian-American, and Native American and Pacific Islanders in the United States, through APA’s Council on Minorities, Hispanics are aware of the need to maintain constructive dialogues, strengthen their organization, and improve services, education, and research in the field. Comparative, inter-ethnic (including genetic) research projects and publications,⁹⁷ with strong inquiries on the epidemiology of subpopulations, suicidal behavior, the impact of cultural factors on quality of life, illness experiences, acculturation, and risk and protective factors dominate the contributions of Hispanic psychiatrists in the United States.¹¹⁷⁻¹²⁰

The growth of Hispanic psychiatry is also reflected in the appointment of psychiatrists from this community to department head roles in academic centers around the country, as well as in their participation in national organizations such as the APA (which has had three Hispanic presidents in the last 18 years), scientific and research agencies such as the National Institute of Mental Health (NIMH), and international entities, such as the WPA, the World Health Organization (WHO), and

the Pan-American Health Organization (PAHO). The impact of Hispanic psychiatry on the Spanish-speaking world would not be possible, however, without an ideological and conceptual consolidation of principles and values blending Hispanic cultural endowment, European/Spanish-inspired humanism and an Anglo-Saxon/U.S.-engendered pragmatism.

Discussion

In today’s world, men and women have two strong needs: freedom on the one hand, preservation of identity, on the other. It is paradoxical that, as the belief in globalization and its message of “one world,” or one way of being human, advances, a confrontational notion of national, regional, and ultimately cultural differences is also reaffirmed. The ethnic push, the arduous attention to particularities, may drown the ethical basis, made out primarily of moral universals. In the expression of dissension, there is the underlying tension between the universal (or the global that wants to be universal) and the local (the fervidly individualizing emphasis on having one’s own, unchangeable identity). It is also important to dissect the concept of globalization and note, for instance, that there are “vertebrated” globalizations that seem to encompass many aspects of life, and “cellular” globalizations, restricted to partial aspects.¹²¹ Many of the varieties of globalization that aspire to universality belong to the second type.

Furthermore, the practice of psychiatry implies a prudent balance between universal knowledge and local realities. The nature of the knowledge that we call scientific includes an aspiration to universality. However, the history of medicine and of its basic sciences has consistently taught us that such aspiration cannot always be reached, since human beings, while physiologically similar, inhabit different sociocultural scenarios. There are diverse forms of humanity, and the processes acquire different meanings in the context of each culture.^{30,100,121}

Psychiatry is, by definition, the most human and the most humanistic of medical specialties, and therefore it cannot renounce the imprint of this moral tension. Even though in some parts of the world, it may take refuge in the technicality of what is scientifically universal, its ultimate purpose is to understand human suffering, help the sick, and accompany the incurable.¹²²⁻¹²⁴ Furthermore, the “evidence” that modulates and colors each type of practice is not only scientific – it is also institutional, cultural, teleological, and ethical. That is why the dominant “evidence-based medicine,” a value-based medicine should be added, particularly in the psychiatric field.¹²⁵⁻¹²⁷

One result of the analysis conducted in these pages is the amalgam of precious characteristics and achievements of the European and Anglo-Saxon brands of psychiatry and the inner essence of the Latin American and Spanish-speaking versions of the discipline.⁸⁶ Based on a positive mix of well-rooted humanism and healthy pragmatism (born out of pervasively limited resources and, at times, testing realities) stemming from the historical and geographic ties with European and Anglo-Saxon sources,

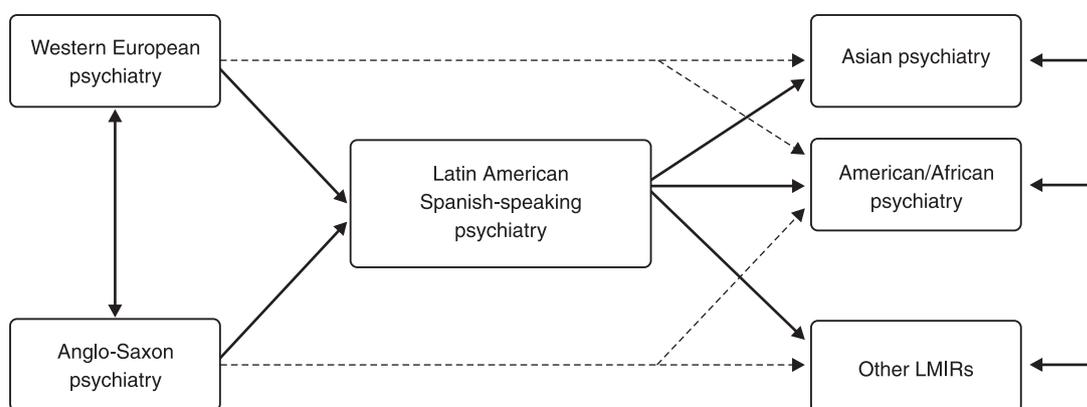


Figure 1 Latin American/Spanish-speaking psychiatry in a globalized world: links, bridges, connections, and communication. LMIR = low and middle-income regions.

and on the socioeconomic similarities with other developing, low and medium income regions such as Africa and Asia, Latin American/Spanish-speaking psychiatry provides a peculiar and unique platform to share the older and more entrenched psychiatric traditions, while participating and assisting in efforts emerging in “other sides of the world”¹²⁸ (Figure 1).

Latin or Iberian American, Spanish, and U.S. Hispanic psychiatry can join forces, strengthen their ties not to play a competitive role in the international scene, but to assist in the generation of dialogues, the creation of sources of excellence for world psychiatry, on the basis of the genuinely syncretic discipline that it is today. It can operate as a sort of mutual ontological bridge between European psychiatry, American/Anglo-Saxon psychiatry and the rest of the world (Asia and Africa, in particular), challenging the sheer use of technology as a tool of domination, preserving old values, and reaffirming new ones,¹²⁹ while learning from those different and powerful cultures as well. As said above, this role could be based on a combination of idealism and pragmatism, of acceptance and validation of what is possible vs. what is doable, on the persistence of values that nourish both clinical practice and research endeavors. The resource constraints of the so-called developing countries can forge innovative mental health care strategies (born out of both uniqueness and need), while developed countries can contribute to assess efficacy and measure outcomes.¹³⁰

Hispanic psychiatry in the United States and Iberian or Latin American psychiatry can work with Spanish psychiatry in that bridge-building role, beyond individualism (closer to the Anglo-Saxon tradition) or theoricism (mostly ascribed to continental European psychiatry), with the virtues of a practical sociocentrism, looking at each and every person in any given community.^{86,131-133} As a case in point, Brazilian psychiatry, in collaboration with American universities, is assisting countries like Mozambique with the training of mental health professionals and the scaling up of psychiatric care quality.¹³⁴ This is one of several ways to “globalize” original aspects or dimensions of Spanish-speaking psychiatry.¹³⁵ Conversely, there are reasons to conceive positive interactions and ultimate receptivity on the side of both Asian and African

psychiatric practitioners and organizations. Common cultural realities preceding colonization experiences, *mestizaje* processes, devotion to traditional descriptive, explanatory and healing practices provide flexible scenarios of historical understanding, mutual acceptance, and willingness to push cooperative efforts in clinical, teaching, and research terrains.^{136,137}

This is not an exclusivist hypothesis, an individualized – or individualistic – approach, it is not a “personalized” approach in redundant or purely rhetorical, moral, subjective, or genetic terms. On the contrary, it can be the basis of stronger coalitions, educational efforts, social responsibility, and values that entail the possibility of a non-conflicting relationship between evidence-based and reason-based psychiatric practice.^{32,69,126} These are ingredients of a true universalism. Furthermore, by virtue of common language and traditions, clinical experiences linked to environment, genetics, neuroscience, society, culture, or biology can comfortably coexist in the Latin American/Spanish-speaking psychiatric discourse and transit through these bridges toward other continents. This constitutes a broadly educated mental structure, not one trapped in the diminishing frame of reductionism.^{64,101}

There may be disagreements or even criticisms to this approach, from skepticism towards what may be called “nationalizing or ethnifying” psychiatric approaches based, however, on undeniable geographical realities and their communicational frames, to a deterministic notion of current realities being the result of purely political circumstances, i.e., colonization, exploitation, or slavery dressed up as antagonistic “psychohistoriographic” observations.¹³⁸ The main implication of the ideas put forward in this text is the need for training in multicultural competencies, along with a recognition of the “syncretic discipline” that psychiatry really is. Beyond any scientific foundation, world psychiatry constitutes a community of practices⁸³ that needs to be recognized in its historical development, its regional particularities, its sociocultural ingredients,^{6,82} and its future multidimensional perspectives. Strengthening the proposed linking functions of Latin American/Spanish-speaking psychiatry, and of its contribution to the universal knowledge base of the profession, is a true and fascinating challenge in today’s global psychiatry.

Conclusion

Latin American/Spanish-speaking psychiatry can nourish a truly integrative, comprehensive, and reciprocal process with European and Anglo-Saxon psychiatry, as cultivated in other regions across the world. It can do it by: 1) retaining the imprint and the characteristics of its people, its culture and its history (the whole notion of identity); 2) describing and comparing its problems with those of the other regions; and 3) formulating potential solutions on the basis of an authentic universal, scientific language.^{101,139} At the same time, by recognizing the positive potentials of globalization, generating and creating history, promoting lifelong learning from others,²⁹ keeping a genuine ethical dimension, rescuing humanistic values, and adopting both the concrete evidence of facts and the teleological evidence of reasoning, this multi-bridging process may become the true ontological path that many envision for the future of psychiatry across the world.

Disclosure

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