Outline for an externalist psychiatry (2):

an anthropological detour

Abstract:

Philosophical speculation about how psychiatric externalism might work in practice has yet to consider the multitude of actual externalist psychiatric systems that exist outside of modern psychiatry. On the conviction that anthropological insights can inform philosophical debate on the matter, the paper illustrates one such case. The discussion is based on 19 months of first-hand ethnographic fieldwork among Akha, a group of swidden farmers living in highland Laos and neighbouring borderlands. Firstly, the paper describes the Akha set of medicinal, ritual, and shamanic practices, analysing issues of stigma and medical pluralism within it. Secondly, it makes the case that the Akha realise a functioning biopsychosocial system which comes with a well-developed set of resources for treating the social dimension of illness. Externalism among the Akha reframes psychiatric illness as a 'problem in living', which becomes manageable as such. The paper claims that, in so doing, the Akha system succeeds in many of the areas where modern internalist psychiatry falls short, and that it does so because Akha society is structured in such a way so that its practitioners can shift the social environment around the patient. As a take-away for philosophers, it suggests that the development of an externalist psychiatry must begin from questioning the accepted ontology of the social causes of psychiatric illness.

Keywords:

Introduction

'Externalist psychiatry' grows from the thesis that the mind is not brain-bound but extends into the world. The sick mind, it follows, can also be constituted by relevant aspects of the social environment, to the point that acting on the social environment can constitute psychiatric treatment. If fully developed, an externalist psychiatry would make up for what I argued is the biggest failing of the biopsychosocial model, namely, the lack of resources for dealing with the social dimension of psychiatric illness. It would also pre-empt many crippling issues linked to internalist approaches – e.g., stigma, self-blame, symptom-exacerbating 'looping effects' – while opening up therapeutic possibilities. I noted, nevertheless, that philosophical discussion on this possibility seems to have reached a standstill. For as long as philosophers have been toying with the idea, psychiatric externalism has remained inchoate because it is hard to imagine what it would actually mean in practice.

This paper seeks to move the discussion forward by summoning anthropological knowledge. Over the past century, anthropologists have brought to light a wide variety of living examples of externalist psychiatries, which cast both causes and treatment of psychiatric illness onto the social environment under the assumption that the mind indeed extends beyond the skull. There are many reasons to believe this wealth of evidence can provide insights into current debates, in line with the premises of cross-cultural philosophy (Thompson, 2014). Possibly, this has not been done yet due to rigid disciplinary boundaries, or to the feeling that non-Western traditions are irrelevant because unfamiliar with the naturalism of modern science. For the present purposes, let me offer the suggestion – widely shared within anthropology – that the anthropological record should not be treated as a collection of social realities incommensurable to our own, or, worse still, belonging to an earlier stage of history, but a possibility-space of human forms that can potentially surface in various guises at any point in time, and that might be relevant to present concerns for precisely this reason (see

Graeber & Wengrow, 2021 for a powerful argument in support of this view). If recent intellectual history is anything to go by, it is safe to assume that most current views in philosophy of mind or psychiatry will be largely passé in 30 years, let alone 100 or 200 years. They won't be only insofar as they capture something fundamental to the human condition that keeps above the transience of intellectual trends. To that end, delving into the vast pool of anthropological evidence seems important because it equips us with a refined sense of the limits and potentials of therapeutic systems. Commanding a broad view of the landscape of possible psychiatries will also allow us to have a better say on what direction modern psychiatry might take in the future.

It is in this spirit that I will be illustrating one such example of an externalist psychiatry – that of the Akha people of highland Laos, among whom I conducted long-term ethnographic fieldwork. Until recently, the Akha lived outside the orbit of biomedicine and have dealt with illness in ways that are substantially different to those most Western psychiatrists are familiar with. In the first part of the paper, I describe the Akha medical system in its broad outlines. I look at their medicinal, ritual, and shamanic set of techniques, and consider the nature of stigma and medical pluralism within these domains. In the second part, I bring this ethnographic material to bear on the discussion begun in the previous essay, firstly by looking at the Akha's as a biopsychosocial system, then by analysing what makes part of it an externalist one. I will also highlight some fundamental differences between psychotherapy and shamanism. The central argument of the paper is that the Akha successfully realise a biopsychosocial model of illness, and that this is so because Akha society is structured in such a way so that its practitioners have the power to shift the social environment around the patient.

I should point out that my intention in presenting this ethnographic account is not to 'import' the Akha model into modern psychiatry. As we will see, this would entail the impractical task of importing pigs, rice fields, and bamboo altars, because little in this model

makes sense outside its own ecological setting. My purpose is to analyse its organising principles, to take it as an ethnographic case that is 'good to think with'. The existence of a system that realize the BPS model effectively, I believe, should invite philosophers to consider the conditions that make it so.

The Akha medical system

The Akha are a group of village-based, livestock-raising, rice-cultivating people of highland Southeast Asia who are well-known for having consciously remained, historically, beyond the control of lowland states (Scott, 2009; Tooker, 2012). In the process, they have developed a cultural system that is many ways antithetical to that of lowland groups. While lowlanders cultivate wet paddy rice, have states and a writing system, the Akha practice swidden cultivation, are politically egalitarian and mostly non-literate. Also, while the lowlanders are predominantly Buddhists, the Akha are animists. They practice a mix of ancestor worship and rice fertility rites and see their social environment as populated by spirits, which meddle in many domains of social life including illness and healing. Akha customs and rituals are extensive and identity-defining: an Akha person can feel part of the same imagined community through shared genealogical links, networks of support, kinship rules and spiritual practices that have been recorded in similar form across large swathes of mountainous territory spanning five nation-states (i.e., Akha should not be considered a 'small-scale society').

Between 2015 and 2017, I spent 19 months in a remote Akha community in northwestern Laos to study their medical tradition (Ongaro, 2019). I carried out standard ethnographic fieldwork, settling into the village, learning the language, and documenting people's life through participant observation. I concentrated on their medical system and particularly on efficacy: on how healing practices work and on how people think that they work.

Akha make a distinction between three sets of treatments, distinguished by the type of condition that they are meant to cure. There are herbal remedies and pharmaceuticals (at least recently) for natural ailments. There are rituals for disorders of the soul. And there are rituals for spirit affliction. When falling ill, Akha might try a combination of all three sets of treatments, either because the cause of illness is unknown or because the illness is likely to have a combination of natural, soul-related, and spirit-related causes. This pragmatism is underpinned by a coherent causal theory about how these three sets of causes and treatments interact. Let me explore each in turn.

Medicine

Akha use the term *yavghaq* to refer to any substance that, through appropriate techniques, is used for the treatment or prevention of natural disorders. The term has been translated as 'medicine' (P. W. Lewis, 1989). It comprises opium and a vast herbal pharmacopoeia whose knowledge is treasured by village herbalists (Ongaro, 2024), as well as biomedical treatments, which have become available to the community over the last 20 years. 'Natural disorders' is my own category for a set of disorders to which Akha accord the same properties, even if no Akha category name exists. These are disorders with a self-evident cause or that happen by their own accord – conditions that, at any rate, are not spiritually caused. *Yavghaq* typically provide relief for the aches and pains that ensue from the hazards of working in hilly fields and in the forest. I have seen it applied most frequently to treat ailments such as fractures, burns, cuts, stings, bruises, or animal bites, but also for skin rashes, stomach pains and as last resort for emergencies like cramps or seizures. *Yavghaq* can also treat what Akha call 'internal disease' (*nargawr*). When people describe this condition, gesturally, they place their half-clenched hand at the height of the stomach, in churning motion, to indicate that something troubling, an abnormal bodily mass, is lurking inside. Akha have become appreciative of the potential of biomedicine to treat such diseases, and natural diseases more generally, particularly

after vaccination campaigns and the establishment of a highland district clinic in 2006 have led to a dramatic rise in health standards. Beside the natural conditions just mentioned, Akha nosology comprises four other disorders: malaria (*mirhiq*), tuberculosis (*mawrhur*), epilepsy (*mawrbawq*) and 'madness' (*yaw ur*). The latter falls within this list because, most often, it is conceived as a disease of the brain that arises when the 'brain is defective' (as we will see, most cases that modern psychiatry would diagnose as mental illness would <u>not</u> be considered as cases of 'madness' by the Akha). Being natural, all these conditions are primarily treated with medicine. Where in the presence of a disorder of the soul, however, Akha think that there is nothing that medicine, whether herbs or drugs, can do to help.

The care of the soul

Health, among the Akha, is contingent on the unity of body and soul. The soul is conceived as a spiritual essence that animates humans from the time of birth. It is usually attached to the body, yet it can leave the body because this union is inherently unstable. When the soul outsteps its boundaries and wanders, it exposes the person to potential danger at the hands of spirits. The connection between body and soul is at its most volatile in youth, a time when a person receives a lot of ritual care but becomes more stable in adulthood as the groundedness of the soul with the body matures. Signs of having an unsteady soul are unwelcome emotional states such as being in a frightful mood or being preoccupied about the future, or other states of mild psychological distress.

Akha have a set of rituals to 'call back the soul' and prevent it from escaping. These rituals come in variants, but they have a set of common elements. They are performed at the house of the ill person and involve the sacrifice of a pig or chicken, accompanied by ritual verses that exhort the soul to return. They are attended by many family members, including at least a member from each household of the person's patrilineage. As part of the central act of this ritual, each participant ties a black cotton string around the wrist of the person before

joining the meal. On the day of the event, the sick person and their close family must abide by a set of rules, such as avoiding visiting other villages or shaving one's head or washing clothes, and other rules that mark the day with special significance.

The Akha soul-calling ritual is a patient-centred healing practice. The tying and the knotting of the cotton strings are expressive of the act of fastening the soul to the body, bestowing strength onto the person. The presence of the extended family affirms kinship ties and a sense of community. The rules and taboos to be observed by the family bespeak of the intimate and protective nature of these rituals, which, overall, are structured as to restore psychological morale in the sick person and the entire household. Having the soul in union with the body translates into sense of exuberance and security towards the world, including the spirit world.

Spiritual illnesses

The spiritual world and ritual sacrifice

In the anthropological literature, the Akha are described as 'animists' because they inhabit an environment in which sociality is not confined to humans but is extended to a plurality of non-human beings, namely spirits (*naevq*). Spirits might be invisible to people, but since people are visible to spirits, human affairs are often carried with spiritual intention in check. Hence people are often engaged in relationships of reciprocity, tension, negotiation, or exchange with a variety of spiritual forces. The latter witness the growth of rice, the spawning of fish and wild game, the illness and death of kin. Signs and consequences of spiritual actions are frequently seen and interpreted. Akha perceive the world they live in as permeated by a kind of 'wilful presence' (Telle, 2009), towards which they remain guardful.

People say that there are several types of spirits, each with its own features and place of abode. Some are ancestors who reside in the house. They offer protection but also punish

moral transgressions. Others are outright evil and wander about outside the house or the village. These are typically associated with features of the environment, for example termite hills, forest trees, bodies of stagnant water, or sites where someone died in the past. As Akha imagine them, spirits afflict by snatching the person's soul and slowly gnawing at it, leaving a part of the body in pain. They can attack singly or by joint action and are more prone to afflict people with a wandering soul or with an already existing natural illness. The conditions that are generally associated with spirit afflictions are sudden and unexpected illnesses (e.g. sudden cramps, non-epileptic seizures) or other disorders that are chronic or perceived as symptomatically unusual and for which there is no natural explanation. Likely due to high levels of somatisation (see next paper), I witnessed only a handful of episodes, out of over 200 documented explanations of spirit affliction, where the symptoms had a distinctively 'cognitive-behavioural' nature. Most cases of spirit afflictions had somatic manifestations, albeit without evident bodily lesion, such as back pain, headache, joint pain, etc.

Importantly, when Akha think that an illness is due to spirit affliction, they do not direct their treatment at the body of the sick person, but at the spirit that afflicted it. Their system of spiritual healing is an example of what Young (1976) called 'externalising systems', where sickness is a symptom of disrupted relations, not between organs, but between people and external beings. Accordingly, medical strategies are primarily organized around discovering what events could have brought the sick person to the attention of the afflicting agent. This system features a disconnection between bodily symptoms and the type of afflicting spirit. One type of spirit can cause a variety of different ailments and one type of illness can be attributed to a multitude of different spirits. The physical body itself, as far as both diagnosis and treatment are concerned, emerges as an uninformative 'black box', which reveals little about the underlying cause. To trace the cause of illness, people engage in aetiological thinking ("did she fall ill because she wronged the ancestors in some way? Or could it be that yesterday,

strolling through that swampy area, she disturbed the spirit living there?"), linking a personalised story to a commonly shared aetiological theory. Out of thoughts, people can also resort to oracular divination or to shamanic hand reading.

Once a spirit is identified as a possible cause of illness, a group of male relatives of the sick person performs a ritual sacrifice to propitiate it. Each type of spirit has its own specific demands. For instance, the 'rainbow spirit' requires the killing of a white chicken and the placing of a curved shrub stem over a puddle, in the forest, whence the spirit is thought to originate; the 'spirit of the gate' wants two brown chickens and a bamboo altar by the village gates, which must hold a handful of soils from the rice fields owned by the sick person's family; etcetera. There is an elaborate theory behind animal sacrifice, replete with coherent symbolic imagery. The key to recovery rests on propriating the right individual spirit with the right sacrificial animals tailored to its demands. Tellingly, although proper names of spirits exist, these are usually named after the type of ritual that is supposed to appease them. The sacrifice must take place at the point of contact with the spirit, and plenty of ritual effort is put into finding the right place so to enter in communication with it. Rituals vary but they always involve the killing of domesticated animals (pigs, chickens, ducks, or dogs), the summoning of the spirit, and the offering of small parts of meat to it before communally eating the rest of the meal on site. Offering the sacrificed animal will coax the spirit into letting go of the stolen soul and restore health to the person. During all of this, the sick person is supposed to stay at home and does not attend the ritual.

The ritual economy of the Akha revolves around this culturally integrated complex of livestock rearing and animal sacrificing. These rituals are organized independently by individual families without the direction of any specialized healer. They represent the only means whereby ordinary people can enter into communication with spirits. However, ordinary people can do so only in limited and tentative ways. As Eliade once noted, 'real

communication' with spirits is the prerogative of shamans, individuals endowed with the special powers for bridging the human-spirits divide through 'ecstatic experience' (Eliade, 1964:265).

Shamanism

When illness turns serious, or when a series of healing sacrifices fail, people may summon the *nyirpaq*, which in the Akha literature has been translated as 'shaman'. There is usually one master shaman for each village, and several apprentices who assist her but might never upgrade to master. Most shamans are women. An individual becomes shaman by being 'called' by the spirits, usually after chronic, anomalous, or socially concerning conditions. Among the group of shamans I worked with, one of the most common was infertility, followed by a variety of chronic pains, seizures and social withdrawal. To attain the status of master, the apprentice must learn the huge corpus of Akha oral texts necessary to perform rituals and undergo a final installation ceremony. Once installed, a master shaman must perform healing ceremonies whenever summoned by fellow villagers. Shamans are known to have peculiar personalities but are not supposed to be 'mad'. They are considered skilled mediators between ordinary and non-ordinary reality, who must be able to move from one dimension to the other with discipline and focus in the service of the community. A person who is not well grounded in ordinary reality, who only dwells in 'madness', is deemed unfit for the role.

Shamanic performances take place at the house of the sick person and last three days and two nights. They are expensive affairs that involve the killing of several animals (at least four pigs and a dozen chickens) and communal meals that bring together the whole patrilineage and many other families. They are startlingly complex, procedure-wise (Ongaro, 2019:164-257). The central stage of the ritual is the shamanic chanting and dancing that takes place from the evening of the first day until the dawn of the second day. Through chanting and trance, the shaman enters the spirit world with the aim of finding the lost soul of the sick person. She acts

as a virtuoso soloist, tapping into the pool of ancestral texts to map out her journey along the way. Throughout, she visits the abodes of various spirits – the same spirits that ordinary Akha can propitiate individually through the sacrifices mentioned above. Deep into the spirit world, she enlists allied powers, quells unruly forces, and cajoles the afflicting spirit into releasing the sick person's soul, before tethering it back to the world of the living. In the room, the chanting is punctuated by moments of trance and body shaking. Sacrifices to the spirits take place the following morning before the preparation of other ritual acts and the main meal, which also involves the 'soul-calling' element in which every participant ties a string of cotton around the wrist of the sick person. Before that, throughout the long nocturnal performance, the sick person and their family will have slept in another room. This is of little importance because the shaman is meant to address the afflicting spirits, not the sick person. Unlike the soul-calling ritual, sacrificial rituals and shamanic performances are *not* patient-centred.

Shamans do not only perform for the sick people in the village; they also perform for themselves. Their initial sickness is interpreted as a spiritual call into the shamanic profession. As apprentices, they establish a tutoring relationship with the ancestral master shamans and other spirit familiars that must be periodically cultivated. This is done by visiting the spirit world on a frequent basis. Every other week or so, they convene at the house of the master shaman and chant through the night, with the purpose, so they say, of 'keeping pain away'. Not chanting for too long brings them sickness in the form of fever, joint pain, insomnia, or overall indisposition. These nocturnal sessions take the form of group therapy that stirs up body and emotions. The shamans dance, chant, and laugh together, and they might cry or fall into trance and into episodes of body shaking. My interlocutors' own narratives suggest that through the participation in the séances shamans cultivate the capacity for mental imagery. This begins by increasing the vividness of visions that may spontaneously arise as one begins to shamanize. The first step in the process is to understand unusual bodily sensations as the manifestation of

the presence of an external agent and react and engage with it until the experience grows shaper and more familiar. To this increased vividness of visions corresponds, later, an increased ability to control them.

While the efficacy of all the rituals I described above is 'restorative' – i.e. their purpose is to return the sick person to the state before illness – the efficacy of this type of communal ritual is 'transformative': its aim is not necessarily to remove the shamanic illness, which might linger on, but to bring about a new type of person that learns how to live with it (Waldram, 2013). Importantly, these ritual chanting sessions offer the novices the opportunity to learn the Akha oral shamanic texts and to 'store words in their heart.' Some of these words are taken as the embodiment of spirits and are perceived as powerful for this reason. Via the gradual acquisition of 'powerful words', a shaman *ipso facto* acquires new relationships with spirits with whom she remains in dialogue even in daily life outside the ritual (I have described the shaman as a 'socially augmented' person (Ongaro, 2019:256)). If ready and willing, the apprentice will upgrade to master and will begin to perform rituals herself.

A note on stigma

Before taking stock of this ethnographic material, I would like to briefly touch upon the issue of stigma. An aspect of the Akha approach to illness that clearly stands out is the absence of either enacted or perceived stigma attached to conditions of soul-wandering or spirit affliction, including the shamanic illness. The only stigmatizing narratives around health that I encountered pertain to certain non-spiritual conditions. For instance, individuals affected by neurodevelopmental disorders (which Akha consider 'natural disorders'), though well-cared for by their families, are labelled 'retards' (*aqkavkav*) and are kept out of relevant social activities. There is also stigma attached to congenital deformity and twin birth. Twins, along with hare-lipped or polydactyl babies ('human rejects', *tsawrpaer*) were until very recently killed at birth and their parents considered 'lower people' from then on. Individuals who

behave waywardly in social contexts are sometimes called 'mad' (*yaw ur*), in derisory or disparaging ways, but this does not seem to apply to people who suffer from 'madness' as a recognised natural condition. During my fieldwork, I encountered only one single episode fitting this description. This was the case of a young man from another village who, after developing deafness, began manifesting psychotic symptoms that persisted despite his family performing rituals over several months. Repeated ritual failure led his relatives and the shaman to say that he was probably 'mad', that his brain wasn't working properly, and that there was only so much that rituals could do. He was looked after by his family and the community and I heard many people commenting on his otherwise intelligent and caring personal character.

This was a rare case of a severely disordered individual. Usually, Akha people who modern psychiatry would no doubt diagnose as having a psychiatric condition – or various kinds of FNDs or chronic disorders – are considered to be victims of spirits. In no instance did I witness stigma or self-blaming narratives befalling on people with spirit affliction. A quick cross-cultural observation then comes at hand: the stigma that surrounds FNDs and other psychiatric conditions in biomedical contexts does not ultimately derive from the implication that such disorders might not have biological causes, as it is normally assumed (Akha people also think that such conditions might not have biological causes); it is ultimately due to the absence of an externalist aetiology that offloads agency, which people like the Akha have, and modern psychiatry does not.

Discussion

A full-fledged biopsychosocial model

Bringing together the Akha material just presented with the discussion of BPS model broached in the previous paper, I will now make three broad comparative observations. My initial and most extended observation is that the Akha's legitimately counts as a biopsychosocial medical

system. It is manifestly a tripartite system, but there is also a detectable correspondence between the 'biological' in the BPS model and the 'natural' in the Akha system, between the 'psychological' and the 'soul-related', and between 'social' and 'spirit-related' dimensions in the treatment of psychiatric conditions. Such correspondence does not hold so much at the level of content, but of form, particularly at the level of causal integration.

The 'natural' dimension of illness corresponds to the 'biological' dimension in a straightforward way. They both deal with illnesses whose *proximate* cause is independent of any purposeful action. It does not matter that the Akha understanding of biochemical processes differs (and is more rudimentary, by Akha own admission) to that of biomedicine. It matters that 'natural' ailments, like 'biological ones', have either a self-evident cause or arise randomly by their own accord; either way, they are not proximally caused by purposeful entities (see Janzen & Prins, 1981 for an anthropological definition of 'natural disorder').[i]

There is also a homology running between the 'soul-related' and the 'psychological'. Models of the 'mind' vary greatly across cultures (Luhrmann, 2011). The Akha 'soul' (*savqlar*) is much more of an embodied concept, associated with 'breath' (the name for soul name shares the same root of the verb 'to breathe', *savqghawr*), but like the Western 'psyche' it is the most fundamental element of the person, it is attached to the person (though it can temporarily wander), and it is on the person that the soul-calling ritual operates. The ritual involves interpersonal interaction with relevant kin which has an encouraging effect on the person. 'Soul-related' and 'psychological' therapies are homologous because they both aim to change aspects of the person through interpersonal means. Interpersonal healing, we have seen, also takes place within the shamanic circle by way of collective dancing and chanting. Its effects are similar to those of psychotherapy in that it trains particular sensibilities over the long term. One central difference is that the Akha shamanic experience is laced with spirituality, a phenomenon that I contend is of a distinctively 'social', rather than 'psychological', kind.

The homology between the 'social' dimension in the BPS model and the Akha spiritual requires some elaboration. The intuition that spirit afflictions and ritual sacrifice might be considered as proximate social causes of illness is likely hampered by genuine, common-sense reservations. A skeptic might say: "Spirits do not exist, so how could they possibly count as legitimate social causes of illness? Sure, I accept that rituals might work, but they do so due to the belief in spirits, through the 'placebo effect'. 'Placebo effects' are psychological effects, which seem different from the effects of legitimate social measures such as reducing poverty or tackling homelessness. If the Akha's is supposed to count as an externalist system on these grounds, then it seems a rather illusory one".[ii] Because the value of the paper rests on illustrating what I argue is a genuine example of externalist psychiatry, I am now going to address these doubts directly in a stepwise manner.

I'll start by noting that the fact that spirits don't really exist independently of people's imagination – in other words, that you can't see them and perceive them directly with the senses – does not matter in terms of the effect they can have when their presence and actions are taken for granted within a community. To simplistically prove this point just assume you've heard news that a relative living in another country has passed away. Perceptually, nothing has changed around you, but the knowledge of this change might affect you. It would be strange to say that the change has affected you because of your 'belief' in the existence of the relative. Receiving signs or information that a spirit has afflicted you does not represent an altogether different type of scenario. "It is only the nonbeliever who believes that the believer believes" writes Sahlins "The ethnographic "believe" is often an ethnocentric reality-check on what the people actually *know*" (2022:26).

But to fully appreciate that spirits can be a constitutive part of the social environment, it is necessary to realize that human sociality too, just like the spiritual realm, can take on a transcendental character. There are contexts in which we act towards each other not so much

in terms of how people appear to our senses but in terms of their essentialised properties. We might act towards an individual as a 'professor' or as a 'queen' irrespective of the kind of person they are in their day-to-day life. Our engagement with the world is deeply infused with this type of imaginary whereby we don't relate to physical people per se but with their invisible halo of essentialised roles and powers. This invisible halo is shared across both humans and non-humans. Spirituality is simply an extension of sociality and sociality an extension of spirituality (for humans count as spiritual beings too). This is a point long made by anthropologists who have lived in societies where this parallel is particularly salient (for example in parts of Africa where people can treat elders the same way they treat ancestors and vice versa, Kopytoff, 1971). This 'transcendental' level of sociality is entwined in daily life with a more 'transactional' type of interpersonal interaction that takes place irrespective of essentialised properties, but the two are analytically distinguishable: it is having this transcendental level that sets us apart from other primates (Tomasello, 2021). Human and nonhuman society are both equally imagined and both indissoluble part of what anthropologists call the 'transcendental social', or what philosophers call 'social ontology'. It is only due to an analytical distinction between the 'natural' and the 'supernatural', historically introduced by the Abrahamic tradition and reinforced by the European Enlightenment, that we have come to see the secular and the spiritual as fundamentally different, while they are in fact underpinned by the same, uniquely human, cognitive capacity for the transcendental (Bloch, 2008).

All this matters to the present concerns because psychiatric health tends to be greatly affected by the kind of relationships we hold within such network of transcendental powers, roles, and values – which vary across societies.

Let's now consider social causation in a more familiar context, one where legitimate 'social determinants of mental illness' include factors such as employment, housing, or inequality. Consider indeed what happens when a mentally distressed individual in a Western

country finds a rewarding occupation. This life event affects mental health positively because it signals a change in social status in the society the individual participates in. Unemployment comes with 'low subjective social status' (Farré et al., 2018) and 'feelings of uselessness' (Neubert et al., 2019). These are socially constructed experiences that depend on collectively ingrained ideas about status, value, and self-realisation that a person accepts – one could say 'believes in' – by virtue of living in a particular society. They are neither natural nor universal: unemployment is not an issue affecting mental health in a non-capitalist society like the Akha, just as secure housing is not much of an issue in a nomadic society. Further proving this point is the fact that individuals who manage not to care about, or 'believe in', conforming to a society's mainstream values (people who, for example, couldn't care less about having a career) tend not to be affected by these predicaments. For most of those who do, events such as finding rewarding work or housing security essentially bring back the person from 'social defeat' (Luhrmann, 2007), that experience of being chronically subjected to negatively valued social relations and power differentials that are known to precipitate mental illness. It would be pretty weird to say that these events bring about a 'placebo effect'. They represent a change in social environment.

A key argument of this paper is that it is misleading in equal measure to say that Akha healing rituals work by way of 'placebo effect', namely, by the 'belief' in the power of the ritual. To comprehend this point, we must follow the anthropological tradition of embedding the analysis of cultural practices within their own socio-political context. Social worlds differ. Different values and cosmological ideas reciprocally affect power dynamics, how people utilize resources, exchange goods, and relate to each other and other beings in a given ecological niche (Descola, 2014; Pina-Cabral, 2017). What is perceived as a social cause of illness in one place is not perceived the same way in another. I suggest that in a closely knit egalitarian society like the Akha, where phenomena classed as 'social determinants of illness'

in the West – e.g. wealth inequality, unemployment, social isolation, racial discrimination, etc. – are mostly either negligible or non-applicable, it is people's perceived or expressed relationships with spirits that take on a salient role in affecting health and well-being. It is with spirits, here, that major power differentials and culturally specific forms of 'social defeat' are experienced, and it is ritual that accomplishes a favourable change in this social environment.

It's worth stressing that spirits among the Akha are, at once, constituent elements of the cosmos and constituent elements of illness and healing. An illness that is explained as a rupture of human-spirit relationship is thereby experienced as a 'problem in living' (Szasz, 1960:114) that affects the person in an immediate and meaningful way. Here lies a fundamental difference with modern psychiatry and its diagnostic system, which, in contrast, forms a compartmentalised sphere of knowledge that is largely severed from what's most relevant and important to a person's life. I suggest, therefore, we recalibrate our frame of analysis as we approach the Akha material. To the extent in which cross-cultural analogy helps us understanding the native point of view, I suggest we see ritual healing among the Akha as more akin to welfare policies among us than to modern psychiatry. We should see the effects of Akha rituals as more analogous to the effects of finding housing security among us than, say, to the effects of taking a placebo antidepressant. These are social effects. To be sure, rituals do not always work in lifting a psychiatric illness. But the same goes for finding a secure home or rewarding work.

There are some important differences between spirit affliction and housing insecurity as 'social causes of illness'. There can be extraordinary dimensions to spiritual forces that do not apply to secular ones, even though what counts as 'extraordinary' depends dramatically on culture and context (Jenkins, 2015). For example, spirits and rituals among the Akha are often dealt with in a very quotidian manner. A more important difference has to do with political power and the threat of violence that underpin the effects of 'social determinants'. Because this

is of key relevance to the prospects of developing an externalist psychiatry, I will explore it in depth in the next paper. The point I wish to stress at present is that we should draw no metaphysical distinction between the two domains because they both depend on the acceptance (voluntary or not) of a given social ontology. Recent calls for a biopsychosocio*spiritual* model of health that seek to compensate Engel's neglect of religion (Koh, 2018), though important, feel misplaced because the spiritual or religious falls within the domain of the 'social'. On these grounds, Akha fully realise a biopsychosocial model of health.

How, ultimately, are these three dimensions related to one another from the Akha perspective? One intriguing aspect of their conception of biopsychosocial integration is that it shows remarkable similarity with the enactive notion of 'circular causality' broached earlier (Ongaro, 2019:295-299. Not only do Akha frame illness in causal terms; they also interpret most illness as a variable combination of natural, soul-related, and spirit-related forces that play a role to different degrees depending on the case. Treatment will succeed if it is tailored to the biopsychosocial composition of a given illness. Some Akha ideas about causation also run parallel to established findings in psychosomatics. For instance, the idea that "spirits feed on unhealthy bodies" chimes with the finding that bodily disease makes a person more vulnerable to negative social influences, which in turn exacerbate symptoms. The Akha claim that rituals cannot counter natural causes of illness aligns with the fact that 'psychosocial context' carries limited power in countering upward organic causes of disease. I have witnessed on some occasions that if someone does not heal after a series of rituals, the shaman herself might declare that she has "finished working on the spirits" and will encourage the person to visit the hospital. It seems that, at least in abstract theoretical terms, whereof scientists speak generally of 'social factors', Akha speak of spirits, or at least accord them a very similar causal role. On a case-by-case basis, of course, it becomes hard to tell apart the biopsychosocial composition of specific illness. Akha, too, face an 'integration challenge'. While they do not

approach this challenge scientifically, they tackle it by way of medical pluralism. Under conditions of uncertainty about the cause, trying out treatments of different causal nature becomes the norm. Medical pluralism thrives in this context because the idea that illness is multidimensional and no single treatment can take care of it all is widely shared in the community, among specialists and non-specialists alike.

When nosology coincides with social aetiology

My second set of observations relates to the Akha category of 'spirit affliction', the externalist component of their system. Akha do not formally commit to what philosophers call 'active externalism', or 'vehicle externalism', the idea that the mechanisms of the mind comprise external phenomena (Clark & Chalmers, 1998), but they organise much of their social life as if this held true in most explicit form. The soul extends into the environment and can be snatched by spirits; treatment must address the spirits directly. This arrangement carries important implications for the classification of illness. We have seen that Akha have a limited symptom-based nosology for natural disorders (tuberculosis, malaria, etc). However, since bodily symptoms are uninformative regarding the spiritual cause, no such thing exists for spiritual disorders. If we can speak of a nosology at all here, it consists of the whole range of potentially afflicting agents that make up the Akha cosmos. In such externalist system, it coincides with social aetiology.[iii]

In what ways, the reader might ask at this point, can spirits make people ill among the Akha? The explanatory category of spirit affliction encompasses a wide variety of pathways whereby spirits can act as pathogens – pathways that a scientist would care to investigate naturalistically and tell apart, but which the Akha, not approaching the social world from a naturalistic perspective, consider indistinguishably as spirit affliction. For example, there might be cases where the awareness of having wronged a spirit (e.g. by accidentally knocking off a termite hill), directly brings about illness. In the scientific literature these would be explained

as 'nocebo effects', which at their extreme can lead to 'voodoo death' (Samuels, 2007). There might also be cases where the very awareness of being ill – from natural illness – exacerbates symptoms, which are in turn experienced as spirit affliction. Moreover, there might be cases where social tensions among humans engender illness that is then expressed, experienced, and treated as spirit affliction. Tension with spirits, here, might sometimes obscure friction among people. (I will explore this case at length in the following paper). Lastly, there might be cases where social interactions and social tensions that are simply hard to identify – because of their subtle, complex, and temporally diffuse nature – still engender illness that is also experienced as a fraught relationship with the spirit world.[iv]

For all this range of possibilities, the category of spirit affliction turns amorphous pains into meaningful and familiar experiences. The Akha system thus overcomes the problem of causal indeterminacy that bedevils the modern approach to conditions such as FNDs. No matter what 'objective' causal pathway might or might not lie behind the sociogenic dimension of an illness, the latter is socialised and rendered meaningful indiscriminately. As I explain more fully in paper #3, this is enabled by adopting an anti-realist and social constructivist outlook on the social world. Overall, Akha combine a realist understanding of biopsychosocial integration with an anti-realist attitude towards social aetiology. This allows them to create a meaningful language and an explanatory framework for social illnesses whose cause is otherwise hard to capture naturalistically. It allows them to 'fill in' the causal domain of the 'social' that remains relatively empty in modern psychiatry.

An upshot of this move is that it also allows to frame all illnesses in actionable terms. Insofar as they are removed from the process of finding a solution, modern psychiatric diagnoses are known to be disempowering. By contrast, the creative process of identifying an afflicting spirit automatically comes with a rationale for treatment that involves ritual action (it is telling that most Akha spirits are named metonymically after the ritual that is supposed to

appease them). The result is opposite to the 'trapping' effect of psychiatric diagnosis: by casting illness in terms of soul loss – which can be recovered – Akha rituals already imply the possibility of healing in their very framing.

Shamans vs psychotherapists

The contrast between externalist and internalist systems gets even more salient when considering the role that practitioners play within them respectively. Shamans and psychotherapists have often been likened (the former being sometimes described as the 'precursor' of the latter), but similarities are superficial. As Lévi-Strauss noted long ago, an important difference is that while "the psychotherapist listens, the shaman speaks" (Lévi-Strauss, 1963:195). An even greater difference is that the shaman might well speak, but to the spirits, not to the sick person. Shamanism is not patient-centred, at least not primarily. The Akha case is telling in this regard, for it shows that the work of empathic care is performed by the kin and extended family of the sick person rather than by the healer. For most of the performance, the patient sleeps in another room and barely engages in the ritual. Like a biomedical doctor who zeroes in on the biological disease, the shaman casts her attention exclusively on the patient's social world. Many similar cases could be pulled out of the anthropological record. Even in the many instances where shamans do capture the attention of the sick, an exclusive focus on the quality of interpersonal engagement (on the drama, visual tricks, emotional bursts, etc.) conceals the social framework in which the performance is embedded, which is far more important. In terms of readjusting the relationship between organism and environment, psychotherapy and shamanism stand at polar opposites (Nathan and Stengers 2018).

One of the major effects of psychotherapy consists in the psychologization of the illness. Its goal is to change the mind of the patient so that the latter can better adapt to the environment, but is relatively powerless in affecting the environment itself (some argue it can

actually work against this prospect: by 'welding' symptoms onto the patient it produces an isolating effect that thwarts the possibilities of finding healing sources outside the therapeutic alliance (Taussig, 1980)). The main effect of shamanism is almost antithetical; it is that of broadening the social field around the patient. Partly, this happens because, at least among the Akha, the shamanic performance itself gathers the family at the house of the sick person in what is a celebration of kinship and mutual care. The rules and taboos surrounding the ritual apply to the entire household, so all members feel engaged in the treatment process (Wang, 2019).

Partly, this happens because the shamanic process evokes the existence of a social universe of spirits that the community accepts and takes for granted. Treatment does not lie so much in operating on the patient's psyche; rather, the core of the treatment consists in reminding people that their well-being rest on their relationship with spirits, before affirming that the shaman has the power to act on these relationships. It is this externalised explanatory framework, more than the performance itself, that creates the conditions for healing.

Comparatively speaking, there is nothing very unusual about the process of building associations between one's illness and other explanatory constructs (external or not). This is also a central component of psychotherapy. However, whereas the latter must build these associations individually over time, shamanism operates within a socially established framework already in place that is shared by members of a trusted community. This explains why psychotherapy must come in several sessions whereas healing rituals are one-off events, just like finding employment or housing are one-off events. One has a psychological effect; the other a social one. Shamanism does not aim at changing aspects of the person; rather, it changes the social environment around the person.

A final word about shamanism and psychedelics. Like most shamans around the globe, Akha *nyirpaq* do not make use of psychedelic substances, but as we are witnessing a

psychedelic renaissance in psychiatry, with advocates appealing to the long-standing use of psychedelics in some shamanic traditions to promote clinical use (Pollan, 2019), I cannot resist a couple of broader anthropological observations. The first is about social context. This emphasis on the role of the social context in shaping psychedelic experience, which some researchers in psychedelic medicine do make (e.g. Hipólito & Tzima 2023), takes on an even stronger significance in light of the argument laid out in this paper. For example, it invites us to consider that the experience of taking psylocibin as part of a clinical trial differs fundamentally from taking it in ritual contexts where psylocibin is considered to be, as a famous book put it, 'the flesh of the gods' (Furst, 1990). Externalism will be more pronounced in the second case, where we have a social ontology that admits the presence of beings the mushroom purportedly gives access to. Visions are thoroughly socialised here (Dupuis, 2022). But there is something else, and more important, to bear in mind about shamanism. Psychedelic science has largely failed to grapple with the fact that in the great majority of cases it is shamans, *not patients*, who take psychedelics (except for when shamans themselves undergo transformative healing journeys as patients). Shamans use them as revelatory means to divine the source of a patient's illness. One might wonder what specific therapeutic effect psychedelics could possibly have here on the sick person. I suggest that if psychedelics have any healing effect in such contexts, it is precisely that of revealing and lending legitimacy, by proxy (through the words and action of the shaman in altered state of consciousness), to that social ontology of external agents that the patient's illness becomes entangled with and is potentially overcome. Psychedelics might act here more like externalist props than 'active superplacebos' (Dupuis & Veissière, 2022). (See table 1).

Conclusion

When philosophers look out for psychiatric systems other than the one they are familiar with, they generally reckon with examples from the history of Western psychiatry. The problem of

doing so is that this is the history of one narrow and culturally specific kind of psychiatry. Such selective outlook is at variance with the widely accepted anthropological view, held at least since Devereux (1969) and reaffirmed thereafter (e.g. Gone, 2016), that indigenous collective knowledge about mental illness can constitute genuine psychiatric systems that should be treated on intellectually equal terms. I hope this paper has bolstered support for this view. Akha do have a conception of natural and psychological causes to mental illness (albeit rudimental in comparison), but these are integrated with a more developed externalist therapeutic system that modern psychiatry has long disengaged with. With renewed philosophical interest in psychiatric externalism, the anthropological record on non-Western medical knowledge should be a go-to source of inspiration.

This paper concentrated on one single ethnographic case and has therefore limited comparative value. Within it, however, we find concrete evidence of a functioning BPS model of psychiatric illness, where the 'social' domain is not semantically void but is filled with meaningful causative elements that can be channelled by a practitioner. Because blame falls on external entities rather than the person, the system pre-empts stigma and negative looping effects associated with modern diagnosis. It accommodates medical pluralism and shows alternative and potentially more effective ways of treatment. Constantly in flux, the Akha environment is a rich "field of affordances" (Conix and Stilwell, 2021) for sociogenic conditions (e.g. FNDs). The system accomplishes shifts in the patient's world that would fall outside the purview of modern psychiatry, through a specialist – the shaman – for whom modern psychiatry has no real equivalent (See table 2).

A takeaway from this anthropological detour might be that efforts in realising a BPS model should look beyond the current focus on the therapeutic alliance. Much as this aspect remains fundamental, an enhanced patient-centred care on its own won't bring about the volte-face that the field needs. To rediscover the therapeutic potential of the social dimension, the

discipline will have to cast attention at patients' social world. To ask questions such as: what are the social causes of mental illness made of? More on point: what kind of society would it take for practitioners to have the capacity of acting upon sociogenic dimensions of illness? It is by bearing these questions in mind that the following paper, returning on more familiar turf, will look for the methodological shifts required to make externalism a reality.

Table 1

Psychotherapist	Shaman
Primarily patient-centred	Primarily spirit-centred
Mostly listens	Mostly speaks
Care and empathy	Care and empathy unnecessary
Therapy comes in sessions	Therapy is a one-off event
Explanatory framework shared by group of experts	Explanatory framework shared by the entire community
Might administer psychedelics (as psychiatrist)	Might take psychedelics

Table 2

	Akha biopsychosocial system		Biopsychosocial psychiatry	
	Treatment	**Practitioner**	**Treatment**	**Practitioner**
BIO	Medicine (plants or biomedical remedies)	Herbalist, biomedical practitioner	Biomedical treatment	Biomedical practitioner
PSYCHO	Soul-calling ritual, shamanic communal séance	Kin, shamanic circle	Psychotherapy	**Psychotherapist**
SOCIAL	Ritual	**Shaman**, shamanic circle	'Life events' (e.g. finding employment), social policies	Ø

Endnotes

[i] There is a famous debate in anthropology on whether or not all peoples make distinctions between 'nature' and 'culture', with a number of important anthropologists leaning towards the non-dualistic position (e.g., Strathern, 1980). Though I employ the term 'natural', my point falls outside the remit of this debate because of its narrower focus. I am not referring to the Akha concept of 'nature', but to ways of thinking about illness causation that *I* term 'natural' by exclusion insofar as they do not involve any proximate social cause. I believe that all people, everywhere, make this more basic distinction in their inferential reasoning about the world. See Astuti (2001) for experimental support.

[ii] I am paraphrasing doubts advanced by a reviewer of an early version of this paper, which I believe are widely shared.

[iii] That people's way of classifying spiritual illness is chiefly aetiological became clear to me a few months into fieldwork, when I asked a group of elders to make a list of Akha disease categories, or what would be translated in Akha as 'types of pain' ('*nar jei*'). I was surprised when the elders began to reel off a of long list of *rituals* (*aqpoeqlawrpa, ghaxawrnyaevqsawr, sanqmaqmirmaquqcav, pahqmatsurivcuvqxaer, ardeirleirkhancavq, xivqpirpyev, xavcavcavq,* etc.). "What I meant to ask", I politely interjected, "was a list of types of pain like fever, stomach pain, etc…". At this point, the elders found the question quite odd. "Oh, so you want to know how spirits *manifest* themselves in the body…", they said. "Ehm, okay, so, there is fever, stomach pain, headache, cough, ehm… knee pain, back pain… what else?". What the elders listed in response to my clarification were not diseases but symptoms. When asked about 'types of pain' in the first instance, their attention was spontaneously drawn to the causes of these symptoms – spirits – and their treatment by way of healing ritual. As I explained earlier, people think of spirits metonymically in terms of the ritual that appeases them. See G. Lewis, 1975 for analogous material from Melanesia.

[iv] The work of Laurence Kirmayer has been especially important for mapping out the diverse range of pathways of symptom amplification and cultural mediations of illness (Kirmayer, 2003; Kirmayer et al.,

2004; Kirmayer & Sartorius, 2007; Kirmayer, 2008; Kirmayer & Bhugra, 2009; Gómez-Carrillo &

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