Anthropological Perspectives for Dance/Movement Therapy

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An anthropological perspective, because of its comparative, cultural and holistic approaches, is critical to working effectively with the unserved and the underserved people of other cultures. Recognizing different cultural patterns can lead to adaptations that could enhance the theory and practice of dance/movement therapy.

Anthropological perspectives are critical to those working with individuals or groups of other cultures. Dance/movement therapists need to be aware of human differences and to be flexible in their work in order to accommodate demographically changing populations. The comparative, cultural, and holistic approaches in the discipline of anthropology can provide dance/movement therapists with a context for understanding behavioral patterns.

Anthropology emphasizes the *comparability* of all human cultures. The anthropologist searches for similarities and differences among people in order to understand what is universal to the human species and what is culturally determined and unique to a group. Moreover, the discipline studies variation within cultures by, for example, age, sex, social class, and degrees of assimilation from one group to another. Anthropology's

This article is an updated version of paper originally prepared for the International Panel Discussion of the International Conference of the American Dance Therapy Association, Sheraton Centre, Toronto, Canada, October 27-29, 1977. The author gratefully appreciates the helpful comments of the *American Journal of Dance Therapy* reviewers, and Daniel Halperin, Celia Shapiro, and Joan Frosch-Schroder.

comparative approach includes the study of humans today and yesterday, in western and nonwestern societies, in remote tribes, and in sophisticated urban settings. Key questions are: How do varying group experiences generate different cultural patterns and what are the implications of cultural diversity?

The essence of an anthropological approach is to understand the *culture* of the individuals with whom one interacts. Culture is a dynamic *ever-changing* phenomenon encompassing the values, beliefs, attitudes, and learned behavior shared by a group. Anthropologists seek to understand the meaning of the webs of significance humans spin from their perspectives. Within this vantage, it is necessary to understand how individual clients, as well as the cultures to which they belong, define a problem, view its cause, and evaluate the progress of its resolution. Cultures, it should be noted, may be based on age, sex, ethnicity, race, occupational group, and so on. The handicapped, mentally disturbed, and mentally retarded may sometimes be conceived of as having their own cultures. Therapists also have a culture. It is conceivable that they might benefit by occasionally viewing it from an outsider's perspective.

Cultural differences are usually reflected in movement (Birdwhistell, 1970; Brower, 1983; Cottle, 1966; Curt, 1976; Efron, 1941; Ekman & Friesen, 1969; Hall, 1966; Hanna, 1976, 1978, 1979, 1983, 1984, 1987, 1988a, 1988b, 1988c; Kern, 1975; Kochman 1981; Pasteur & Toldson, 1982; Ramsey, 1984; Wolfgang, 1984) and attitudes about health (Acosta, Yamamoto & Evans, 1982; Atkinson, 1989; Ho, 1987; Kleinman, 1980; McElroy & Townsend, 1989). For example, among the Vietnamese, a smile communicates not only happiness and assent, but also the sentiments of anger, embarrassment, stoicism, and rejection. To look directly at a person with whom one is speaking is a sign of disrespect and rudeness. A touch on the head is offensive (Brower, 1983).

There are also differences in preferred modes of communication. For example, among American Indians (more than 400 tribes and 13 distinct language groups), there is a preference for venues of communication other than verbal interaction, such as the arts (Ho, 1987).

Another basic thrust in anthropology is the examination of the feelings, thoughts, and actions of human beings, not as isolated bits and pieces but in a *holistic* or systems context. An individual's health intermeshes with other aspects of cultural and group life. Among many people, altered body and mind states are not subsumed completely under a biologically derived vocabulary and world-view. Sickness for them is the result of a range of events and changes. Health and illness involve not only body functions but also interpersonal relationships, cultural values, emotions, and political, economic, and environmental factors that impinge on an individual and group. Commonly sociomorally construed, illness is often a way to explain or rationalize human conduct. Some people, such as the

Chinese, have difficulty in admitting social and emotional problems and a reluctance to self-disclosure. Thus it is necessary to see physical and mental symptoms as part of the personal history, politics, and ecology of the individual.

Within a holistic perspective movement should be considered in the context of how an individual learns to move and moves appropriately to his or her culture, sex, age, and/or social class. As therapists know, movements rarely have meaning in and of themselves. Rather, movements reveal meaning only when they are identified and explained as part of a larger pattern of behavior. The body has many components, each of which may send a different message. For the purpose of analysis it may be appropriate to isolate each unit. However, the actual meaning of body language is found through seeing the whole pattern in the context of the individual mover having a combination of personal, cultural, and environmental experiences. There should be evidence for emphasizing one component of behavior as significant rather than another. Furthermore, movement as communication needs to be considered along with accompanying verbalization. Each kind of language adds a unique dimension to the message.

Why are anthropological perspectives critical to those working with an individual or group from another culture? Wherever and whenever people are interacting, a sensitivity by a member of one culture to the culture of another person will help in understanding the motivations, behavior, and therefore the interpersonal relationships and therapeutic goals. By studying other societies' cultural behavior, dance/movement therapists can better help clients from cultures other than their own. Moreover, they can gain insights through the reflective act of comparison. Identifying and explaining differences in other groups' ways of doing, feeling, and thinking may catalyze the redefinition of one's own perceptual fields. Of course, it is important to dismiss the assumption of different being inferior (DeReuck & Porter, 1965).

Cross-cultural psychology is similar to anthropology in many ways. However, it differs in critical ways such as using experimental rather than holistic, ethnographic research. Ethnography, developed as a reaction to speculative history, entails a researcher engaging in participant observations, living among a group (usually for a year to encompass responses to seasonal changes) and asking questions and observing, in much the same way as a child learns its culture. Always questioning their own assumptions and apparent facts and observations, anthropologists attempt: To discover the insiders' ("natives") points of view, describe their behavior, note the relationship between them, and convey information about a group to other outsiders. The emphasis on universal aspects of cognitive development assumes invariance. Yet there are culturally mediated perceptions and understandings.

Since the body is composed of universal features, most members of the medical and therapeutic professions erroneously assume that the body is experienced in a universal manner (Manning & Fabrega, 1973). Because time, space, and energy are universals in human life, many professionals mistakenly believe all people experience them the same way. However, assumptions concerning the psychic unity of humans ignore the facts of cultural learning. Therapists deal with disturbed and/or dysfunctional persons who occupy positions in on-going sociocultural systems. For example, with respect to space, Anglos refer to four directions: East, west, north, and south. The Laguna Pueblo conceive of seven-directions: Up, down, and center, as well as the four Anglo directions (Albuquerque, Laguna spokesman, Pueblo Cultural Center, August 7, 1977). Whereas Anglos finish products, the fear of spatial closure that underlies Navaho culture leads Navahos to "always leave part of the design in a pot, a basket, or a blanket unfinished" (Kluckholn, 1968).

It is necessary to accommodate the relationships between body and self that are deeply rooted in biology and the relationships between body and self that are rooted in the social and cultural forms in which phenomenological experience occurs. Cross-cultural and social class problems are particularly evident in urban areas where most publicly and privately supported professional therapy occurs. Misunderstanding in diagnosis and treatment often results when the typical model of the middle-class, white, verbally oriented, and nonverbally limited individual is applied to individuals who belong to other groups.

Effective therapy requires an understanding of the cultural and ecological patterns governing a client's life, the different concepts of mind, body, parts, time, space, effort, color, texture, and other properties found in everyday life and the arts, as well as what movement is done where, when, how, and with and to whom (Hanna, 1988a). A client's perspective, at odds with the theory and method of the therapist, creates barriers to healing in addition to placing new stress upon the client (Hanna, 1988b).

If a female therapist mirrors a man's movement, is this acceptable, an insult, a sexual invitation? Invited to join the Ewe people's dance in Nima, Accra, Ghana, I was quickly corrected by the women for following the men's more energetic style. At a conference on Dance of India, held at the University of Toronto, 1985, Professor Sunil Kothari, Head of the Department of Dance, Rabendra Bharati University, remarked that Indians view a dancer in a leotard as if stark naked.

In a comparative study of artistic creation, Billig and Burton-Bradley (1974, 1977) found what is suggestive for all therapies: The universal occurrence of psychosis has culturally patterned thought and behavior. However, these cultural variations in symptomatology are manifest until the patient's personality becomes markedly disintegrated. In this stage of disorder, the content and the structure of the psychosis are the same for

all individuals. Billig and Burton-Bradley report that various cultural influences affect the content of New Guinean graphic creations as long as patients are comparatively well-integrated. Thus a patient's culture must be considered in diagnosis, treatment, and progress evaluation.

There is a variety of culturally conceived classes of afflictions, causal agencies, means of diagnoses, and kinds of cures. Following are a few examples of cultural difference from minorities who are unserved or underserved by the dominant American mental health system.

Kochman (1981) described differences between some European-Americans and African-Americans in the way perceived oppositions are handled. The former tend to minimize antagonism, to encapsulate it in "scenes" so that "bad feelings" are not carried away from the confrontation. The latter, on the other hand, tend to view oppositions as constant contrarieties that may affirm a sense of community through dramatizing opposing forces. The implications for therapy may be that although both groups have comparable feelings of hostility, one group may be culturally permitted to express it more readily and openly. The inference that African-Americans are angrier may not be correct (Hanna, 1988c).

Other stylistic differences exist. Compared to European-Americans, African-Americans are more onstage than offstage in fabricating their identities (Pasteur & Toldson, 1982). A common low-income style is characterized by greater physicality, higher energy, faster response, and less restrained emotion than that which is found among European-American and middle-class African-Americans.

The use of dance in therapy varies among groups that are often thought of as homogeneous in their way of life. For example, among the southwest American Indians, the Apachean and Pima peoples conduct ceremonies when something wrong occurs. Most of the Navajo Indian dances are prayers to cure a particular person's illness (Fergusson, 1931). On the other hand, the Pueblo groups have calendrically set ceremonials intimately involved with the creative cycle, production of rain, and concepts of like-cures-like (as in sympathetic magic). These Pueblo people are group- rather than individual-oriented. Indians on their reservations use their traditional healing methods. However, Indians in urban areas, who have taken on many of the "white man's ways," might better respond to therapies which bear similarity to deeply-ingrained traditional ways: individualist and situationally determined; *or* group and calendrically set sessions, depending on their particular cultural group.

The theory of illness that a group has is an another consideration in cultural diversity. The Pima Indians, for example (Bahr, Gregorio, Lopez & Alvarez, 1974), conceive of two kinds of illness. One is a wandering kind that is common to all peoples. Another form of illness is specific to the Pima. These *ka:cim* sicknesses are exempt from, or have little to do with, the physical processes accepted by western medicine. Each Pima-

specific sickness has a different procedure for diagnosis and cure. The shaman's role is to guard Pima health and also to preserve "Piman consciousness of their humanity as Indians" (Bahr, et al., p. 7). Movement is used by the shaman or curing agent to press, blow, or massage the body. "The body is a means for gaining access to the patients' past" (Bahr, et al., p. 171). Art and music are used to please the spirits so that they cease to be agents causing the illness. Sickness and morality intertwine. Thus the violation of moral norms is generally thought to cause illness.

If a people believe the cause of stress is external to the self, the therapist needs to ascertain the perceived boundaries of the self. If illness is punishment for transgression, then it is necessary to understand what is considered deviance and what amends should be made. If a disease is believed to result from sin, then expiation is necessary for a cure.

Farrer (1976) compared Anglo-American and Mescalero Apache Indian patterns and concluded that teachers–and we would add therapists–might provide familiarity and security for the Mescalero by drawing upon their cultural patterns. Change agents could provide role models for learning-by-observation rather than calling out rules, as in Anglo-American culture. Therapists might also use the disciplinary tack of removing an offender from the group rather than reprimand the person verbally, permit physical closeness and group work among relatives rather than have individual projects, and arrange desks and other patterns in circles rather than in rows and rectangular shapes. Coincidentally, many Anglo-American dance/movement therapists do work in circles.

Mexican-Americans in South Texas who were studied by the Hildalgo Project on Differential Culture Change and Mental Health from 1957–1961 were found to have distinct notions about therapy (Madsen, 1973). Curing behavior is expected to involve direct eye contact, rapid diagnosis, religious sanction, appreciation and respect for the patient's self-diagnosis, respect for the patient's beliefs, minimal physical contact, treatment in the family context, and consideration of male dominance over the female. These notions are counter to Anglo-American practice. Thus Anglo-American therapeutic approaches to serve this population have minimal success. Nonetheless, generalization to all Mexican-Americans is problematic. Attitudes toward therapy vary depending on the person's social class, level of acculturation, gender, and whether the patient is bilingual (Ruiz & Amado, 1983).

Therapists, particularly Anglo-Americans at this point in history, must bear in mind different notions about creative individual expression. Among Anglo-Americans, value is placed on each person shaping his or her own destiny. The opportunity for individual self-actualization is considered unlimited. Among many American Indian and Asian groups,

however, value is placed on anonymity—accepting group sanctions and routinized patterns. Spanish-Americans also tend to value routinized life and obedience to the will of God.

In April 1988, dance/movement therapist Joanna Harris, was invited to introduce dance/movement therapy to students at the National Academy for the Arts in Taiwan (personal communication). They found the Anglo-American model somewhat of an anathema. It was clear that the Chinese individual does not initiate activity. The idea of the therapist as facilitator for the client to initiate movement out of one's inner being was unacceptable. Rather the individual models the teacher. It was also apparent that anonymity in a group process and the desire to stay undefined were strong cultural norms. The verbal metaphors Anglo-American therapists use to stimulate movement were not common in Chinese culture. And there were problems of translation. In sessions teaching improvisation, students relied on the technically skilled person to lead. "The problem is," said Harris, "they're good; they conform totally." There were no student verbal responses. But the students liked the group's accomplishment.

Thus, a psychotherapist must work differently with members of groups who find individuality antithetical to their cultural norms (see Greenberg, 1968 for a summary of conflict in cultural values and Chilcott, 1968). Emphasis on creative self-expression in movement with a group and/or dependency-oriented person could harm the individual. Having the client imitate the therapist or act in unison with a group in which the individual does not stand out would be more appropriate. Because some groups are generally unaccustomed to change, therapy should be based on experiences familiar to the client.

Prince (1969), a psychiatrist who has worked with different cultures in several countries and among different classes within them, views the problem this way:

> There is a growing awareness that psychotherapeutic practices aimed at independence and insight are not appropriate for a large and important segment of our western population, the chronically poor . . . the vast majority of the emotionally disturbed of the non-western world can be successfully treated (and are being successfully treated) by techniques that foster dependency and unreasoned belief (p. 20).

A related problem is that the middle-class world view of many therapists clashes with a lower-class client world view. Often, the lower-class individual is capable of insight therapy that involves creative self-expression but the lower-class client is unwittingly rejected in one way or another by the therapist who has different verbal and nonverbal means of

communication. Karon and Vandenbos (1977) discuss the need for a therapist to be consciously aware of possible negative dynamics in working with people who have been economically poor throughout their lives:

> Reality problems elicit proto-typic counter-transferences. The therapist from lower class origins may perceive the patient as his bad self, himself as failure. The upper class therapist may . . . [have] guilt over never facing such difficulties, or idealize poverty. Therapy can fail because the patient is awed and does not want to reveal his own "inadequacy" or "criticize" the authority by saying that he does not understand the therapist or that the therapist does not understand him (p. 169).

Because poor clients tend to have little education and may come from an ethnic group other than the therapist's, client-therapist communication problems loom large. The client often does not understand the therapy process. It is therefore imperative that the therapist educate the client in a personal, nonbureaucratic way with language designed to create trust and build rapport.

The therapist must be alert to elements of change. Individuals often accept the values and behavioral patterns of groups other than the ones to which they belong; however, they rarely accept those values equally. Many acculturated individuals–those who have taken on dominant cultural ways–may still conceive of illness in traditional terms. It is a daunting dilemma because therapists cannot rely solely on the studies of different groups. Nonetheless, an understanding of these studies is critical in developing a sensitivity to diversity.

Several developments have catalyzed the need to take into account anthropological perspectives. The law mandates equal opportunity for all. A number of studies in the 1970's revealed the inadequate delivery of health services (Braginsky & Braginsky, 1973; Bullough & Bullough, 1973; Lerner, 1972; Miller, 1974; Willie, Kramer & Brown, 1973; Windham, 1976). The situation has only worsened as the American population has increased in diversity and federal and state spending budgets have decreased. Groups heretofore unserved or underserved now demand services. "Mainstreaming" in public school requires adaptive physical education. Mental health services have moved from institutional to diverse community-based facilities.

With the advent of the community health movement, mental health workers have discovered and documented that both the incidence and severity of psychological problems are highest among the lowest classes. These classes commonly include members of minority cultures. Moving beyond the medical "illness" model, "it becomes apparent that lower-class people are generally more hampered in fulfilling their psychological and social potential than are their middle and upper-class counterparts"

(Lerner 1972, p. 5). Because it has heretofore not been fashionable to work with the poor, the people who need mental health care the most receive the least. Moreover, lower-class clients have been regarded as deficient in an aptitude for individual psychotherapy.

> From its inception, psychotherapy has been, in essence, a medicine for mandarins, desired and prescribed primarily for mildly to moderately disturbed middle and upper-class individuals (Lerner, p. 3).

Mental health professionals are beginning to recognize the danger of labeling behavior. What is acceptable in one culture may be inappropriate in another. Frank (1973), a psychiatrist, notes:

> Cultural factors determine to a large extent which conditions are singled out as targets of psychotherapy and how they manifest themselves. The same phenomena may be viewed as signs of mental illness in one society, of demoniacal possession in another, and eccentricities to be ignored in a third. Moreover, the behavior of the afflicted person is greatly influenced by culturally determined expectations of how persons so defined should behave (p. 318).

How people view a problem affects their attitude and behavior toward solving it. Health practitioners are focusing on the social and cultural aspects of health in order to identify factors that facilitate or impede the utilization of a therapy (Cornyetz, 1972; Ho, 1987).

Therapists must choose among evocative or direct types of therapies on the basis of the individual's cultural experience (Frank, 1973; Ho, 1987). Evocative therapies help a person change his or her troublesome attitudes and behavior by indirectly creating favorable conditions for change but leaving the actual change up to the client. Directive therapies, by contrast, seek to structure the therapeutic situation as much as possible and reduce ambiguity to a minimum. Psychoanalyst Arthur S. Blank, Jr., (personal communication, November 20, 1977) would add interpretative, or psychoanalytic psychotherapy, among choices. He notes that this approach has much in common with some traditional therapies in Africa. There is a nondirective, evocative setting, but to this must be added interpretations, i.e., statements from the therapist concerning a theoretical system, whether expressed in terms of ego and id or ancestor spirit.

While therapy models based upon middle-class, Anglo-American culture may be helpful and applicable, they can sometimes be impractical, ineffective, and even harmful, creating stress and offending clients. Therapists need to decide between creative and imitative techniques and individual, family and/or group therapy on the basis of the individual's personal and cultural milieu. Effective therapy may involve networks of persons who radiate outward from the ill person and include family,

friends, and neighbors. Curing in many societies is a mobilization of personal networks.

In summary, it is critical for dance/movement therapists to know how therapeutic activities are culturally conceived; what the criteria are for who participates, when, where, how, and with whom; what is preferred, prescribed, and prohibited; and what movements, postures, gestures, use of space and transitions, phrasing, dynamics, etc. mean. In this brief overview I have suggested that the perspective of comparability, culturalism, and holism animate anthropological observations and explanations. I attempted to indicate the importance of anthropology to therapy if it is to be more than a "medicine for the mandarins." By becoming aware of other peoples' belief systems and behavior, we can better serve them, gain insights into our own culture and society, and draw upon the values and techniques of other societies in order to improve our own.

References

Acosta, F., Yamamoto, J. & Evans L.A. (Eds.) (1982). *Effective psychotherapy for low-income and minority patients.* New York: Plenum Press.

Atkinson, D.R., Martin, G., & Sue, D.N. (1989). *Counseling American minorities: A cross-cultural perspective.* (3rd ed.) Dubuque, IA: William C. Brown Publishers.

Bahr, D.M., Gregorio, J., Lopez, D.I., & Alvarez, A. (1974). *Piman shamanism and staying sickness.* Tucson: The University of Arizona Press.

Billig, O. & Burton-Bradley, B.G. (1974). Psychotic art in New Guinea. *Journal of Nervous and Mental Disease,* 159(1), 40-62.

Billig, O. & Burton-Bradley, B.G. (1977). *The painted message.* New York: Halsted.

Birdwhistell, R.L. (1970). *Kinesics and context.* Philadelphia: University of Pennsylvania Press.

Braginsky, D. & Benjamin, B. (1973). Psychotherapists: High priests of the middle class. *Psychology Today,* 15-20.

Brower, I.C. (1983). Counseling Vietnamese. In D.R. Atkinson, G. Martin & D.W. Sue (Eds.), *Counseling American minorities: A cross-cultural perspective* (2nd ed.). Dubuque, Iowa: William C. Brown Publishers.

Bullough, B. & Bullough, V.L. (1972). *Poverty, ethnic identity and health care.* New York: Appleton-Century-Crofts.

Chilcott, J.H. (1968). Some perspectives for teaching first generation Mexican-Americans. In J.H. Chilcott, C. Greenberg & H.B. Wilson (Eds.) *Readings in the socio-cultural foundations of education.* Belmont: Wadsworth Publishing Co.

Cornyetz, P. (1972). Movement therapy and total health. In *Dance therapy roots and extensions: Proceedings of the 6th Annual Conference of the American Dance Therapy Association, October 22-24, 1971,* Columbia, MD.: ADTA.

Cottle, T.J. (1966). Social class and social dancing. *Sociological Quarterly,* 7(2), 179-196.

Curt, C.J.N. (1976). *Nonverbal communication in Puerto Rico.* Cambridge, MA: National Assessment and Dissemination Center.

De Reuck, A.V.S. & Porter, R. (Eds.). (1965). *Ciba Foundation Symposium: Transcultural psychiatry.* Boston: Little, Brown and Co.

Efron, D. (1941). *Gesture and environment.* New York: Kings Crown Press.

Ekman, P. & Friesen, W.V. (1969). The Repertoire of nonverbal behavior: Categories, origins, usage and coding, *Semiotics, 1,* 49-98.

Farrer, C.R. (1976). Play and inter-ethnic communication. In D. Lancy & B.A. Tindall (Eds.), *The Anthropological study of play* (Proceedings of the First Annual Meeting of the Association for the Anthropological Study of Play) Cornwall, NY: Leisure Press.

Fergusson, E. (1931). *Dancing gods: Indian ceremonials of New Mexico and Arizona.* Albuquerque: University of New Mexico Press.

Frank, J.D. (1973). *Persuasion and healing: A comparative study of psychotherapy* (rev. ed.). Baltimore: Johns Hopkins University Press.

Greenberg, N.C. (1968). *Cross-cultural implications for teachers.* In J.H. Chilcott, N.C. Greenberg, & H.B. Wilson (eds.). Belmont: Wadsworth Publishing Co.

Hall, E.T. (1966). *The hidden dimension.* New York: Doubleday.

Hanna, J.L. (1976). *The anthropology of dance ritual: Nigeria's Ubakala Nkwa di iche iche.* Ph.D. dissertation, Anthropology Department, Columbia University. Ann Arbor: University Microfilms. Revision under publication review.

Hanna, J.L. (1978). African dance: Some implications for dance therapy. *American Journal of Dance Therapy, 2*(1), 3-15.

Hanna, J.L. (1979). Toward semantic analysis of movement behavior: Concepts and problems. *Semiotics, 25* (1-2), 77-110.

Hanna, J.L. (1983). *The performer-audience connection: Emotion to metaphor in dance and society.* Austin: University of Texas Press.

Hanna, J.L. (1984). Black/white nonverbal differences, dance and dissonance: Implications for desegregation. In A. Wolfgang (ed.), *Nonverbal Behavior.* Toronto: C.J. Hogrefe, Inc.

Hanna, J.L. (1987). *To dance is human: A theory of nonverbal communication.* Chicago: University of Chicago Press.

Hanna, J.L. (1988a). *Dance, sex and gender: Signs of identity, dominance, defiance, and desire.* Chicago: University of Chicago Press.

Hanna, J.L. (1988b). *Dance and stress: Resistance, reduction, and euphoria.* New York: AMS Press.

Hanna, J.L. (1988c). *Disruptive school behavior: class, race, and culture.* New York: Holmes & Meier.

Ho, M.K. (1987). *Family therapy with ethnic minorities.* Newbury Park, CA: Sage Publications.

Karon, B.P. & Vandenbos, G.R. (1977). Psychotherapeutic technique and the economically poor patient. *Psychotherapy: Theory, Research and Practice, 14*(2), 169-180.

Kern, S. (1975). *Anatomy and destiny: A cultural history of the human body.* New York: Bobbs-Merill Co.

Kleinman, A. (1980). *Patients and healers in the context of culture: An Exploration of the borderland between anthropology, medicine, and psychiatry.* Berkeley: University of California Press.

Kluckhohn, C. (1968). Queer customs, In J.H. Chilcott, N.C. Greenberg, H.B. Wilson, (eds.), *Readings in the socio-cultural foundations of education.* Belmont: Wadsworth Publishing Co.

Kochman, T. (1981). *Black and white: styles in conflict.* Chicago: University of Chicago Press.

Lerner, B. (1971). *Therapy in the ghetto: Political impotence and personal disintegration.* Baltimore: Johns Hopkins University Press.

McElroy, A. & Townsend, P.K. (1989). *Medical Anthropology in ecological perspective* (2nd ed.). Boulder, CO: Westview Press.

Madsen, W. (1973). *Mexican-Americans of South Texas* (2nd ed.). New York: Holt, Rinehart and Winston.

Manning, P.K., & Fabrega, Jr., H. (Eds.). (1973). The experience of self and body: Health and illness in the Chiapas Highlands. In *Phenomenological sociology: Issues and applications.* New York: Wiley.

Miller, D.H. (1974). *Community mental health: A study of services and clients.* Lexington, MA: Lexington Books.

Pasteur, A.B. & Toldson, I.L. (1982). *Roots of soul: The psychology of black expressiveness.* Garden City, NY: Anchor Press/Doubleday.

Prince, R. (1969). Psychotherapy and the chronically poor. In J.C. Finney (Ed.), *Culture change, mental health and poverty.* New York: Clarion (Simon and Schuster).

Ramsey, S. (1984). Double vision: Nonverbal behavior east and west. In A. Wolfgang (Ed.) *Nonverbal Behavior,* Toronto: C.J. Hogrefe, Inc.

Ruiz, R. & Amado, P. (1983). Counseling Latinos. In *Counseling American minorities: A cross-cultural perspective.* (2nd ed.) D.R. Atkinson, G. Martin and D.W. Sue (eds.). Dubuque, IA: William C. Brown.

Willie, C.V., Kramer, B.M. & Brown, B.S. (Eds.). (1973). *Racism and mental health.* Pittsburgh: University of Pittsburgh Press.

Windham, T.L. (Guest Ed.). (1976). Afro-Americans and mental health. *Journal of Afro-American Issues, 4*(1).

Wolfgang, A. (Ed.). (1984). *Nonverbal behavior.* Toronto: C.J. Hogrefe, Inc.