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tinue beyond a reasonable length of time, intervention may be indicated. Carried out appropriately, the intervention assists individuals in considering options and moving away from nonproductive activities.

Interventions may be initiated by the individuals themselves, family friends, physicians, or others familiar with the situation. The utilization of self-help groups has become an integral part of crisis intervention. Persons and groups that have experienced problems similar to those presented by the individual have been shown to be effective in providing support as well as assisting in the development of alternative coping strategies. The proliferation of problem- and issue-oriented self-help groups is testimony to their utility.

Crisis and Older Persons

The increase in longevity in the United States presents a crisis for health policy formulations at the state and national level as well as for older persons and their families. What constructive actions should be taken? Is there utility in models available from other industrialized nations? What are the responsibilities of the individual, the family, the community, and the government? The answers are not yet in.

Gerontologists have emphasized that the older population—70-plus years—is at risk for a series of crises within a relatively short period of time. Failing memory, decreased mobility, loss of autonomy, and increased financial burdens may occur almost simultaneously, overtaxing a person's coping capacities. Anticipatory guidance is urged for older persons and their families to help them become more aware of existing support systems and options. Counseling should focus on the realities of aging, emphasizing positive aspects as well as preparation for potential decreases in physical and mental functioning. In recognition of the potential crises facing an increasing number of persons, the American Psychological Association in 1997 made the study and delivery of psychological services to the aged one of its highest priorities.

Future Perspectives

Many current problems such as health care, education, and violence can be viewed as crises. Rapid technological advances, increasing cultural diversity, and lifestyle changes will create other crises. Research and practice in crisis intervention will lead to increased sophistication in crisis prevention as well as crisis resolution.

[See also Intervention.]

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Ira Iscoe

CRITICAL PSYCHIATRY, or "antipsychiatry," refers to a body of thought originally identified with the work of American psychoanalyst Thomas S. Szasz (b. 1920), British psychiatrist Ronald D. Laing (1927–1989), and Italian psychiatrist Franco Basaglia (1924–1980). Critical psychiatry challenged the disease or medical model of disturbed or disturbing behavior, mounted an enduring critique of institutional psychiatry, and sought to ethicize and politicize the twin discourse of madness and psychiatry. Early works by American sociologist Erving Goffman (1922–1982) and French philosopher Michel Foucault (1926–1984) are occasionally included in this corpus because they are among the first extensive critiques of psychiatry. The concurrent development of labeling theory in sociology also fertilized critical psychiatry. An American, Marxist-influenced "radical psychology" movement also expressed sympathy with critical psychiatry. From the mid-1960s, partly as a reaction to Laing's hold on the public imagination, a countercultural "antipsychiatry movement" flourished briefly.

The term *antipsychiatry*, coined by Laing associate David Cooper, was applied to these thinkers early on and is commonly encountered in the literature. Szasz and Laing, however, rejected it as unsuitable or absurd—they did not believe that psychiatry had to be abolished, but did expect it to emerge radically transformed if it discarded mystifying dogmas and coercive practices.

Mistakenly, Szasz's and Laing's ideas have sometimes been discussed as if they were interchangeable. Similarities include a rejection of determinism (exemplified by psychoanalysis and biological psychiatry) to explain human behavior; the idea that behavior, no matter how disturbed or disturbing, is not *disease* unless we use that term metaphorically; and the belief that psychiatry usually exercises repressive social control. Szasz, the most prolific and intellectually influential figure, remained consistent with the arguments he first set out in *The Myth of Mental Illness* (New York, 1961), extended in *Law, Liberty, and Psychiatry* (New York, 1963) and *The Manufacture of Madness* (New York, 1970), and refined in *Insanity* (New York, 1991) and *The Meaning of Mind* (New York, 1996).

Szasz's opposition is not to the disease model *per se* or its deterministic and positivistic underpinnings. Indeed, Szasz defines disease strictly as deviation from biological norms. It is the extension of the disease model to human motives and human actions, to mind, that he sees as fundamentally erroneous. A "human science" cannot be derived from measurement and mathematical calculation, the methods of biology or physics, essential for knowledge of the body. One obtains knowledge of the mind through language and the interpretation of meanings. Szasz proposed that classifying thoughts, feelings, or behaviors as diseases was a category error, or "myth," because facts from one logical category were presented in language more appropriate to another. He argued that because psychiatry sought to classify "problems in living" as diseases requiring medical treatment, psychiatric thinkers bent the rules of what, in the Western world and in the twentieth century, constitutes disease or illness.

The political foundation of Szasz's sustained criticism is classical or Jeffersonian liberalism, which emphasizes individualism. Szasz is an existential thinker and moral philosopher because of his preoccupation with individual freedom, free will, personal responsibility, and the moral dilemmas which confront human beings by virtue of their humanness and for which they wrongly seek technical remedies. His most important works are histories and critiques of psychiatry as an immensely elaborate pseudo-medical enterprise constructed to manage—by brute force or subtle indoctrination—various types of deviances after medicalizing them. In the age of science, psychiatry also serves to relieve individual guilt and provide norms of conduct. Szasz has continually denounced involuntary mental hospitalization of competent adults as "a crime against humanity."

In contrast, Laing's work provides little analysis of the mental health system, its institutions, or the power relations therein. From the start, Laing sought to understand unusual human experiences, such as schizophrenia, and to develop helping approaches to make these experiences less troubling. His first book, *The Divided Self* (London, 1959), offers a straightforward account of the experience of becoming mad, with descriptive categories derived from such existentialists as Jean-Paul Sartre and Martin Heidegger, phenomenologists such as Maurice Merleau-Ponty, and theologians such as Paul Tillich. In two books partly influenced by American research into family interactions, *Sanity, Madness and the Family* (written with Aaron Esterson, London, 1964), and *The Politics of the Family* (London, 1969), Laing argued that prolonged psychological violence and communication deviance often occurs in families, making madness intelligible in these contexts. In *The Politics of Experience* (London, 1967), his most famous and controversial work, he proposed that psychosis could—with the proper support and context—contain a healing dimension, akin to a rite of initiation involving loss of ego and emergence into a more enlightened being. This departure into new territory, coupled with an absence of articulated political principles in his calls for reform of the psychiatric system—in addition to his temporary role as a counterculture figure—has made it difficult to assess Laing's insights into the understanding of deeply troubled persons. Recent biographical studies of Laing have attempted to remedy this situation.

For his part, Franco Basaglia represents the strain of Marxist-influenced critical psychiatry that attempted to reform the mental health system as part of a collective effort for political change. Basaglia was also inspired by phenomenology and existentialism but he barely focused on the nature or experience of madness, concentrating instead on the mental hospital as society's main response to madness. For him, the hospital embodied psychiatry's central contradiction, the dual mandate of cure and control, and had to be abolished. Conceptual and spatial segregation of psychiatric patients perpetuated the false idea that our needs and those of mental patients were fundamentally different. Basaglia's reform work in Italy as director of two hospitals and leader of the "Democratic Psychiatry" movement culminated in 1978 with the adoption of the now-famous regional "Law 180," which dismantled the insane asylum, though the long-term consequences appear to have been largely diluted. The U.S. Community Mental Health movement, initially based on a new model of psychosocial care, also reached a similarly disappointing end.

To a large extent, since the remedicalization of psychiatric thought and practice in the early 1980s, critical psychiatry is no longer led by psychiatrists but by ex-psychiatric patients and social scientists, ethicists, and philosophers. There is agreement that, aside from increased user participation in mental health services, the extensive, intellectually compelling criticism generated by critical psychiatry has not yet translated into

obvious political gains. However there is a renewed interest today in this approach. This validates the critical psychiatric insight that, unlike outmoded scientific hypotheses that vanish when discredited, both deterministic psychiatry and antipsychiatry may be likened to belief systems which retreat and reemerge depending on cultural needs and norms.

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David Cohen

CROSS-CULTURAL COMMUNICATION refers to the exchange of information between people of different cultural backgrounds. It is a well-studied field of research in several disciplines, including psychology, speech and communication, sociology, anthropology, and business.

Cross-cultural communication is highly related to a similar term, *intercultural communication*. In actuality, there is no difference between these terms in the context of communication. However, there is an important and notable difference between cross-cultural and intercultural *research*. The former refers to the comparison of two or more cultures on some variable of interest (e.g., differences between cultures A and B in the expression of emotions). The latter refers to the study of the interaction between people of two cultures (e.g., differences in how people of cultures A and B express emotions when they are with people of cultures B and A, respectively). There is yet a third term, *intracultural communication*, which refers to communication among people within a culture. The bulk of information in cross-cultural communication comes from cross-cultural research, but has considerable application to our understanding of intercultural and intracultural communication processes.

Cultural Influences on the Communication Process

These influences are at work via both verbal and nonverbal communication.

Verbal Communication. Verbal language is a system of symbols that denote how a culture structures its world. As such, by examining language, it is possible to see how a culture relates to its world. For example, some languages have words that do not exist in other cultures. The Eskimo language, for instance, has multiple words for snow while the English language has only one (Whorf, 1956). The German word *Schadenfreude* (joy in another person's misfortunes) and the Japanese word *amae* (sweet dependence), which do not exist in English, are other examples.

That the words do not exist in other languages does not mean that the concepts are nonexistent. In American culture, for example, it is very common to see people derive joy from others' misfortunes! Rather, such words reflect the fact that the concept is important enough to the culture for its language to have a separate linguistic symbol for it. In this way, verbal language is a manifestation of the larger culture within which it exists.

Another example of this manifestation is the case of self and other referents. In American English, for example, we typically refer to ourselves as "I," and to someone else as "you." There are many other languages of the world, however, that do not use such simplistic terms for self and others. The Japanese language, for instance, includes an extensive choice of terms referring to oneself and others, all dependent upon the relationship between the people interacting (Suzuki, 1978). In Japanese, you refer to your teacher as "teacher" or your boss at work as "section chief" when in English the word *you* would normally be used. In Japanese, terms denoting status are also used within the family. There are even different terms for *I*, depending on the nature of status relationships. The degree