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| PSYCH 216: ABNORMAL PSYCHOLOGYGLOBAL ASSIGNMENT |

**THE MUTUAL EMBEDDEDNESS OF CULTURE AND MENTAL ILLNESS**

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**ABSTRACT**

In this paper, we discuss the intricate relationship between culture and mental illness. Our central position is that there cannot be mental illness without culture. We argue and that our limited knowledge to the onset, manifestation, course and outcome of mental illness is due in part to the cross-cultural psychological conceptualization of culture, where culture is seen as an independent variable influencing mental illness, the dependent variable. This is in addition to the limitations of biomedical model in accounting for the origins of mental illness. Using depression and schizophrenia as examples, we argue for the need to see culture and mental illness as mutually embedded in each other.

**INTRODUCTION**

**Illustrative Examples**

A. A man who, until recently has been normal, suddenly began to behave in a bizarre way somewhere in**South East Asia**. His relatives suspected that he had **lost his spirit**, so they took him to the house of the local **shaman**. Upon careful examination, the **shaman** declared that indeed the man's **spirit had left him**. Soon afterwards, the man received lots of sympathy and was exempted from his usual social duties and work. Even though his behavior was seen as bizarre, he was not sanctioned because he was seen as not been directly responsible for his strange behavior, but the **departure of his spirit**. After further examination involving an all- night ceremony with sacred chants where various deities were called upon to enter into the body of the shaman, the shaman identified who is responsible for the **lost spirit**. He offers animal sacrifice to appease the deities, and then begins "**spirit-hooking**" ritual in which his own spirit journeys on a magical flight to the land of the dead to **track down the lost spirit**. Once the **lost spirit** is tracked down, he is brought back and deposited in various food dishes, which the man had to eat in order to regain the lost spirit. The shaman also removes poisonous harms from the man body and his household, during which time the man had to remain in the shaman's house for closer observation. Once the **shaman** correctly identified the whereabouts of the **lost spirit** and the prescribed rituals and rites conscientiously followed for a couple of months, the **lost spirit** returned into the man and he eventually got well again

B. A man who, until recently has been normal, suddenly began to behave in a bizarre way somewhere in**Western Europe**. His relatives suspected that **he was sick**, so they took him to **psychiatrist** in the nearby hospital. Upon careful examination, the **psychiatrist** declared that the man indeed is **sick**. Soon afterwards, the man received lots of sympathy and was exempted from his usual social duties and work. Even though his behavior was seen as bizarre, he was not sanctioned because he was seen as not been directly responsible for his strange behavior, but the **sickness**. After further careful examination including detailed medical history, psychological test results, and interviews, the **psychiatrist** came up with the**diagnosis**, and outlined the method for his treatment. These included different forms of **therapy** and the use of some **medications** from the nearby pharmacy shop. While the man had to take the drug medication himself, the psychiatrist undertook the psychotherapy. The man also had to make some changes in some of his daily routines (e.g., being admitted in the hospital for some few days for closer observation). Once the **psychiatrist** correctly diagnosed the **sickness** and the prescribed **therapy** and**drugs** were carefully administered for a couple of months, the **sickness** was eventually eliminated and the man got well again.

C. A man who, until recently has been normal, suddenly began to behave in a bizarre way somewhere in**West Africa**. His relatives suspected that **an evil spirit possessed him**, so they took him to the shrine of the local **witch doctor**. Upon careful examination, the **witch doctor** declared that the man indeed is**possessed**. Soon afterwards, the man received lots of sympathy and was exempted from his usual social duties and work. Even though his behavior was seen as bizarre, he was not sanctioned because he was seen as not been directly responsible for his strange behavior, but the **evil spirit**. After further careful examination and interviews with close family members and friends, the witch doctor **identified the evil spirit**. He then gave instructions as to how the evil sprit should be exorcised. This involved different forms of **rites** and **rituals**, such as the drinking of different kinds of herbs from a nearby forest. Some of the rites involving animal sacrifices were performed by the man himself, and others on his behalf by his relatives. The man also had to make some changes in some of his daily routines (e.g., being kept in the shrine for some few days for closer observation). Once the **witch doctor** correctly identified the **evil spirit** and the prescribed **rites** and **rituals** were conscientiously followed for a couple of months, the **evil spirit**was eventually exorcised, and the man got well again.

D. A man who, until recently has been normal, suddenly began to behave in a bizarre way somewhere in**North Eastern Latin America**. His relatives suspected that **he has been voodooed (um trabalho de umbanda)**, so they took him to "**pai de santo**" in the nearby "terreiro de macumba". Upon careful examination, the **pai de santo** declared that the man indeed was suffering from **malefic influence** sent from someone else who did not want him to be happy. Soon afterwards, the man received lots of sympathy and was exempted from his usual social duties and work. Even though his behavior was seen as bizarre, he was not sanctioned because he was seen as not been directly responsible for his strange behavior, but the "**influence of malefic spirits**". After further careful examination including the incorporation of different spirits that spoke through the "pai de santo" the **pai de santo** came up with the**diagnosis**, and outlined the method for his treatment. These included different forms of **treatment**, baths of herbs, lighting candles during the whole treatment and coming to the **terreiro** once a week for a session with the "**pai de santo**". Once the "**pai de santo**" correctly diagnosed the sickness and the prescribed baths, rituals with candle lightning and weekly sessions in the "terreiro" were carefully administered during a couple of months, the **sickness** was eventually eliminated and the man got well again.

From the illustrative examples above, please think about (or discuss if in class):

a. What are the similarities and differences in the family's response and the manner of treatment to the bizarre behavior of the man?
b. Are we dealing with the same or different phenomena?
c. From your background and perspective, can any one approach taken to deal with the man's bizarre behavior be more justified than the other and if so which one?
d. Can you think of reasons why "spirits" play such a dominant role in the examples from West Africa, South East Asia and North Eastern Latin America? To what extent are "sprits" responsible for one's "bizarre behavior" in your native society?
e. What is the role of culture in the different approaches taken here?
f. Is it possible to see in the examples the mutual embeddedness of culture and mental illness? How?
g. How will the man's bizarre behavior be explained and treated in an imaginary society that does not have culture?

The last three questions introduce us to the crux of the present paper, namely the inextricable relationship between culture and mental health problems. In this paper we propose that culture should be seen as an inherent part of mental illness. Culture does not just influence mental health and illness, but rather it is a constituent of them. Failure to see it as such leads to a myopic view of the onset, expression, course and prognosis of mental health problems. In the first part of the chapter, we briefly present theoretical orientations that dominate the field of mental health followed by a brief review of current research in cultural and cross-cultural psychology relating to mental health. Finally, we present a critique of the current research approaches to cross-cultural mental illness. A recurrent issue in this paper is the degree of universality of the expression of mental illness across cultures with special reference to depression and schizophrenia.

To deal with mental health is to deal with culture and visa versa. The two concepts are intrinsically linked, to the extent to that the definition of health depends on the manner of being and of thinking, or rather, on the culture (Bruner, 2001), and thus it varies in time and place. Traditionally, mental illness has been approached with a bio-medical model that is independent of culture. This approach is linked to an individualist ideology where mental illness is diagnosed and treated as something purely individual. Thus, even though the concern with culture has long been recognized since the time of Kraepelin, who proposed the development of a comparative psychiatry, the diagnosis and the treatment of mental illnesses, still ignore the inherent role of culture to mental illness. In cases where culture is taken into consideration, it is often marginalized and construed as an independent variable similar to the status given to culture in cross-cultural psychology with its inherent limitations (Moggadam & Studer, 1997). The marginalized status of culture to the understanding of mental illness is due in part to the dominant position medicine enjoys (Marsella & Yamada, 2000). As a scientific discipline, the bio-medical ideology has been powerful enough to keep the diagnosis and treatment of mental illness in the biological realm. This area is also deeply linked to the view of treatment using psycho-pharmaceuticals, which is of great economic interest to the large and ever growing pharmaceutical industries.

**Theoretical Orientations**

Until recently, the underlying theoretical presupposition of the bio-medical model was the so-called absolutist position that assumed that there is an "absolute truth" to the human phenomena (Berry, Segall, Poortinga & Dasen, 1992). Specifically, this position assumed the existence of a "psychic unity" together with a commonality in human experience. Human phenomena were viewed as being basically the same in all cultures, where among other things "depression" was viewed as "depression" just as "aggression" was seen as aggression" no matter where it was observed. From the absolutist position, culture is thought to have no role in either the meaning or expression of human behavior. Assessments of human behavior normally involved the use of standardized instruments where interpretations are readily made without any recourse to an alternative culturally based view. The absolutist position is currently seen as ethnocentric in perspective and its assumptions as only a logical possibility without any supporting evidence (Berry et al., 1992). Virtually, all writers on the subject agree that culture exerts some degree of influence on the process and manifestation of mental illness (Tanaka-Matsumi & Draguns, 1997). They vary only on the manner and the degree of importance assigned to culture, together with the underlying presuppositions, whether it is a relativist, Universalist or multicultural position.

The relativist position is in sharp contrast to the absolutist position, and in an effort to devoid itself of ethnocentric biases, assumes that all human behaviors are culturally patterned. Its goal is to understand people in "their own terms" without any recourse to an external viewpoint. Consequently human diversity is explained within the cultural context the individual has developed. Assessments are typically carried out using the values and meanings a cultural group gives to a phenomenon. Working within the relativist position are the rich accounts of the onset and manifestations of culture-bound syndromes.

The universalist position, which presently dominates the current bio-medical models to mental illness, assumes that basic human characteristics are common to all members of the human race (i.e., the psychic unity), and that culture shapes its development and display. Stated in another way, this position is an interplay between underlying basic human characteristics and culture (Berry, 1995).

Living in a post-modern age made up of networks of societies that are characterized by globalization and migration, the multicultural position is becoming more important. This position is in reality a hybrid between the relativist and universalist positions. The essence of this position is the need to develop a model to cater to the health and adjustment difficulties that arise as a result of moving from one cultural setting into another. Understanding mental health problems involves swinging between the universalist and relativist perspectives or an amalgam, and the position which eventually is taken depends on the background and inclinations of the helping agency.

The different theoretical positions naturally view and operationalize cultural differently. The universalist position regard culture to be an exogenous force that exerts its influence on behavior and mental illness. In that manner, culture can be manipulated and studied objectively. This view fits very well with the bio-medical scientific model, and has consequently been very prominent. The relativist position sees culture as an integral part of behavior itself and subsequently one cannot speak of mental health illness without taking cognizance of culture, as it is culture that defines normality and abnormality. Before elaborating further on this discussion, we turn our attention to current research.

**Current Cultural and Cross-cultural Research in Mental Health**

Depression is perhaps the single most common mental health problem; accounting for over 17% of the 8.1% of the Global Burden of Disease (calculated in Disability Adjusted Life Years - DALY) which mental health problems account for. It therefore serves as a good illustrative example when reviewing current cultural and cross-cultural research in mental health. In addition, it is one of the mental health problems that has received much research attention.

A historical landmark in research was a series of studies sponsored by the World Health Organization (WHO) between 1973 and 1986 (Draguns, 1990; Sartorius, 1983). Among the important results of these studies is the suggestion that the core symptoms of depression include dysphoria, anxiety, tension, lack of energy, and ideas of insufficiency. In addition, these studies also concluded that patients from Western countries tend to express guilt feelings more spontaneously than their non-Western counterparts. The latter group of patients, non-Western patients, on the other hand, more spontaneously reported bodily complaints when describing their distress than patients from Western countries.

The approach taken in these studies has been to use standardized instruments describing the extent to which symptoms are present in different national groups who reportedly have depression or other forms of distress. Without the use of in-depth interviews, many non-Western patients are often described as suffering from something other than depression. For instance, through interviews of 100 Chinese patients suffering from *shenjing shuairuo* (neurasthenia), Klienman (1986) concluded that 93 of them indeed might be suffering from depression. However, instead of spontaneously reporting dysphoria, ideas of insufficiency and the other core symptoms of depression, these "depressed" (or *shenjing shuairuo*) patients spontaneously reported headaches (90%), sleep problems (87%), and dizziness (73%).

This raises a fundamental question about the universality of depression, and whether these Chinese patients are suffering from - *depression*, *shenjing shuairuo* or *somatization*, as modern Western nosology would call it, following the spontaneous responses of headaches, dizziness, and the like. Furthermore, it is difficult to reconcile Scheiffelin's work (1985) with the universality of depression when in his 20-year work among the Kaluli people of New-Guinea he could not find a single case of depression among them.

In his review of depression and culture, Marsella (1980) concluded that "depression does not assume a universal form" (p. 260), and that "the psychological representation of depression occurring in the Western world is often absent in non-Western societies" (p. 201). Jadhav (1995) has also questioned the validity of the use of the term "depression" for symptom patterns that bear little resemblance to Western depression because he doubts that we have sufficient evidence to regard depression as an objective entity that can be transported from one setting to the other.

Although much less common than depression, schizophrenia is a serious and highly stigmatized mental health problem that affects millions of people each year, and has very poor prognosis. In spite of evidence suggesting a biological etiology (see e.g., Chua & McKenna, 1995; Davis, Kahn, Ko & Davidson, 1991), we still lack complete knowledge about the local prevalence rates and prognosis, as well as variations in symptom presentation. Following Spiro's (1984) position that "thinking and feeling are often determined by culture" (p. 324), and the meaning of schizophrenia as "a split between thought and feeling", we are bound to be limited in our understanding of schizophrenia (and nearly all other mental health problems) if culture is eliminated from the diagnostic equation.

Over the past quarter of a century, the WHO has undertaken several major studies on the expression, course, and prognosis of schizophrenia in 17 different countries, including Colombia, the former Czechoslovakia, Denmark, England, India, Nigeria and the former Soviet Union, Thailand, and the United States. Using standardized instruments, researchers have identified a set of symptoms that were present across all cultures in the schizophrenic samples. These symptoms include lack of insight, auditory and verbal hallucinations, and ideas of reference. However, a phenomenological study of the experience of schizophrenia in Brazil and Chile with patients diagnosed with paranoiac schizophrenia in public psychiatric hospitals showed some important differences (Moreira, 1999a). While the meaning of the experience of bodily alterations (present in outbursts of schizophrenia) is attributed to mental illness in Chile, in Brazil the same experience is attributed to *Umbanda* (i.e., a kind of spiritism). However, no significant differences were found between the two groups of patients in relation to their sense of space.

Several other studies show that some nosological categories relevant in one culture may be totally invalid in others, and this is the basis for the existence of so-called culture bound syndromes. The biomedical tradition from the West with its underpinnings in universalist position assumes that mental health categories found in either the DSM-IV (APA, 2000) or ICD-10 (WHO, 1992) apply to everyone. Considering the high prevalence of anorexia nervosa in Western countries compared to non-Western Asian cultures, one may wonder why this disorder is not referred to as culture bound syndrome. Another important fact is that the same diagnoses of mental illnesses may appear in different cultures, but their etiology may have different characteristics, as is the case with anorexia. In the West it is associated with a self-image of fatness and to the fear of becoming overweight, while in non-Western cultures anorexia has nothing to do with weight or body mass, but rather to religious beliefs linked to fasting for spiritual purification (Moreira, in press).

**A Critical Approach to the Problem**

Cross-cultural studies have in no doubt improved our understanding of culture and mental health. However, there is an ever-increasing need to note that many of the studies done in this area are limited when it comes to measuring the incidence and the expression of the mental illness in the various regions of the world. This restricts the concept of culture simply to the idea of different countries or different regions in the world. (Sloan, 2001). The nature of these studies have succinctly been described by Moghaddam and Studer (1997) when they state that:

Cross-cultural psychology has been quick to put on the white lab coat of the scientist as though it had forgotten about culture. It is clear that the researchers have not forgotten culture as an independent variable, as something that could be assumed to be a cause and affect behavior. But who knows that they neglect culture as the manufacturer of the 'mechanisms of central processing... (p. 197).

Restricting the concept of culture to the area of causal occurrence has serious ideological ramifications, albeit the cross-cultural researcher is seen as ideologically neutral. The question of neutrality is part of the limitation of tradition Clinical Psychology which, from within an individualist ideology, ignores the social, political and cultural contexts of those in need of psychological treatment. Many cases of mental illness diagnosed in day-to-day work in medical and psychological offices of the developing countries of Latin America, Africa and Asia questions the neutrality of the treatment both from ethical and ideological points of view. This is particularly relevant when an illness, to a greater extent, is related to experiences of political violence and social oppression than to biological factors to be treated in an individualist perspective of the problem. As Lira (2000) states, "neutrality is not ethically possible in such cases" (p.85).

According to Kleinman and Good (1985) one major limitation to gaining full realization of cross-cultural studies in psychopathology is the lack of a sophisticated anthropological view of culture. These authors emphasize the anthropological and relativist perspective in the studies of psychopathology, which resembles a phenomenological focus of research that searches for the meaning of an experience as lived out by the subject. Tatossian (1997) points out that a fundamental error in classical western cross-cultural psychiatry is its a-priori assumption that western psychiatric categories are universal, and that culture modifies the contents through a 'pathoplastic' action. (*Note*: The word 'pathoplástic' does not exist in English, but exists in French: pathoplastique. The meaning is of an exterior action (of the culture in this case) which modifies the illness or its meaning). What is then required is to determine the symptomatic forms the psychiatric disorders take in non-Western societies. As it is, "psychiatry" is the way Western society chooses to regulate the problem of its 'disorders'. However, there are other ways to do this where each culture could have its own "psychiatry" as our illustrative examples portray. The Western approach (i.e., psychiatry) should neither be seen as privileged nor better than the other approaches. It is also important to note that cultures can regulate the problems without constituting "psychiatry" or its equivalent, because the notions of mental illness, of etiology, and of treatment are not universal.

A risk cross-cultural researchers take is to translate, adapt, and transport the methodology of psychological tests, with the aim of discovering universal truths through testing of hypotheses among groups from different cultures (Moggadam & Studer, 1997). This is both serious and questionable as it involves stripping the value, evidently of ideological character, of the role of culture in the constitution of behavior, of mental health and mental illness. Rather than including issues of power and ideology into the concept of culture, culture is reduced to a simple independent variable that does not require any deeper thought about its meaning. Perspectives from critical psychology show that mainstream psychology is ideologically individualistic in nature and perpetuates a situation of inequality and social injustice (Fox & Prilleltensky, 1997; Sloan, 2000).

It would, however, be a great loss if those studies in cross-cultural psychology were to reinforce this perspective, when they themselves have the potential for critical understanding of mental health and illness, as well as psychology in general, at an anthropological, sociological and political level. Even though a critical approach of psychology recognizes its link to cultural studies (Sloan, 2000), the enormous critical potential of cultural and cross-cultural studies is lost when psychologists 'pscyhologize' the concept of culture and thus uncharacterized it as such. Consequently, studies that are restricted to measuring symptoms in different cultural settings take off.

When we propose that culture be understood as a constituent of mental health, it is important to recover not only the anthropological definition of the concept put forward by Kleinman and Good (1985) as *the intersection of meaning and experience*. It is equally important to transcend the concept by explicitly incorporating the inherent political aspects. This deals with a concept which is necessarily **not** naive (Freire, 2000) but de-ideologized (Martin-Baró, 1985). Culture as a fundamental constituent dimension of mental health deserves to be understood as an anthropological, historical, social, and political concept, including, fundamentally, an ideological discussion on its constituents. As Rovaletti (1996) affirms "one does not become crazy as he wishes, but rather as the culture foresees. At the heart of neurosis or psychosis, through which we try to escape, culture still tells us what personality of substitution we should adopt" (p. 125).

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**Questions for Discussion**

**Your instructor will inform you if you are to answer all or some of the questions below**

1. Once culture is eliminated from the diagnostic equation, one loses the capacity to recognize important social and cultural variables involved in the etiology and manifestation of mental disorders. Discuss.
2. Discuss how eliminating culture from mental illness will result in a limited understanding of the onset, manifestation, course and outcome of mental illness
3. All mental health problems should be viewed as a culture-bond syndrome
4. How will depression or schizophrenia manifest itself if there is no culture?
5. To what extent can we assume that the core symptoms of depression and schizophrenia identified by the WHO studies are "culturally neutral"?
6. Identify some aspects of your own culture that could be constituents of mental illness. Discuss how these aspects may influence mental illness.
7. Choose a mental illness as described in the DSM-IV-TR or DSM V or ICD-10 and discuss it onset, expression and prognosis from your cultural point of view.